



Final Recommendation Report 2022 Affordability Workgroup

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I. Executive Summary

MHBE's 2022 Affordability Workgroup aimed to continue the work of the 2019 Affordability Workgroup, which launched Value Plans and other affordability initiatives. The new Workgroup was asked to consider potential updates to MHBE's Value Plan requirements, with the goal of developing recommendations for how MHBE can continue to make high-value coverage more affordable and make plan shopping more straightforward, so that consumers can more easily choose and use affordable, high-value coverage. The group also sought to implement the Health Equity Workgroup's recommendation to reduce cost-sharing for health conditions with highly disparate impacts on people of color, such as diabetes.

Enrollment in Qualified Health Plans (QHPs) is at a record high due largely to state and federal initiatives to reduce the cost of premiums, including the State Reinsurance Program and enhanced federal Advance Premium Tax Credits (APTCs), which were extended through 2025 under the Inflation Reduction Act. However, health insurance remains a complicated product to shop for and some consumers are not enrolled in their best-value plan. Research shows that Standardized Plans help consumers make better plan selections. Standardized Plans were the inspiration for MHBE's successful Value Plans and in 2023 will be required by nine state-based marketplaces, Washington D.C., and all states using the HealthCare.gov platform (as of 2022, 33 states use the federal platform).¹

The Workgroup discussed Standardized Plans, prescription drug affordability, Washington DC's approach to Standardized Plans and cost-sharing to promote equity, and several draft versions of possible standardized benefit designs for Maryland Health Connection (MHC) plans. The draft plan designs were developed with the principles of affordability, simplicity, equity, alignment with state health goals, and minimal market disruption in mind.

Ultimately, the Workgroup developed three recommendations. First, that MHBE replace its Value Plan requirements with the Standardized Plan designs in Appendix A for plan year 2024, with the understanding that some changes may be necessary to the plan designs to comply with the 2024 Actuarial Value Calculator. Insurers would be required to offer one Standardized Plan at the bronze, silver, and gold metal levels, as well as a Standardized Plan for each of the Silver cost-sharing variants. Second, the Workgroup recommends that MHBE differentiate Standardized Plans with icons and branding to assist consumers with plan selection. Third, the group recommends that MHBE limit the total number of plans that insurers can offer at each metal level to three, starting with plan year 2025.

¹ "HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet," *CMS.gov Newsroom*, April 28, 2022, <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet>.

II. Background

The 2022 Affordability Workgroup builds on the work of two previous workgroups, an earlier Affordability Workgroup convened in 2019 and a Health Equity Workgroup convened in 2021.

The earlier Affordability Workgroup made recommendations to improve affordability and access for three priority populations: young adults ages 18-34, individuals with chronic illness, and consumers eligible for financial assistance. MHBE has accomplished most of the short- and long-term goals of the 2019 Workgroup, including implementing a state-based premium subsidy for young adults, launching Value Plans, implementing the Maryland Easy Enrollment Program, developing an out-of-pocket cost calculator on Maryland Health Connection, and analyzing State Reinsurance Program claims for conditions that drive costs.

At the request of the MHBE Standing Advisory Committee, MHBE convened the Health Equity Workgroup to explore how MHBE could use its authority to reduce inequities in healthcare coverage and health outcomes faced by people of color. Among the workgroup's recommendations were two focused on plan design and affordability. The Health Equity Workgroup recommended that MHBE and insurers explore the feasibility of applying 2022 Value Plan standards, which eliminated cost-sharing for diabetes supplies including insulin and glucometers, to all private plans on MHC starting in PY2024. In addition, it recommended that MHBE continue exploring the feasibility of reducing cost-sharing for high-disparity conditions, starting with small changes that minimize impact to actuarial value and do not increase patient cost-sharing.

In 2022, MHBE convened a new iteration of the Affordability Workgroup to recommend updates to Value Plan Standards and Plan Certification Standards for 2024 and beyond. The new Affordability Workgroup was also tasked with considering the recommendations from the Health Equity Workgroup mentioned above and incorporating them into its work as appropriate.

Lastly, MHBE asked the new Affordability Workgroup to develop a recommendation to the Maryland General Assembly regarding the continuation of the Young Adult Subsidy Pilot Program. Because data regarding the impact of the pilot program was not ready for the group's review as of the date of this final report, the group expects to reconvene later in 2022 to review available data and provide a recommendation, which will be added to this report as an addendum.

III. Affordability Landscape

Enrollment

Enrollment on Maryland Health Connection (MHC) is at a record high due to the enhanced federal Advance Premium Tax Credits (APTC) and State Reinsurance Program. Enrollment in Qualified Health Plans (QHP) topped 170,000 as of August 31, 2022.² During the open enrollment period for 2022 coverage, 47,000 individuals newly enrolled in coverage, including an increase in Black and Hispanic enrollment of 11 percent and 14 percent from 2021 levels, respectively.³

Figure 1 shows enrollment by metal level. Under the ACA, metal levels correspond with actuarial value (AV), which is a measure of the share of health care costs an insurer will cover, on average. Plans are classified as Bronze, with an AV of about 60 percent; Silver, with an AV of about 70 percent; Gold, with an AV of about 80 percent; and Platinum, with an AV of about 90 percent. Low-income consumers are eligible for Silver plans with Cost-Sharing Reductions (CSRs), or reductions in copays and other amounts the consumer is expected to pay, that increase the value of a Silver plan (AVs of 73, 87, or 94 percent depending on income). The federal government establishes how much variation in the actuarial value is allowed within each metal level.

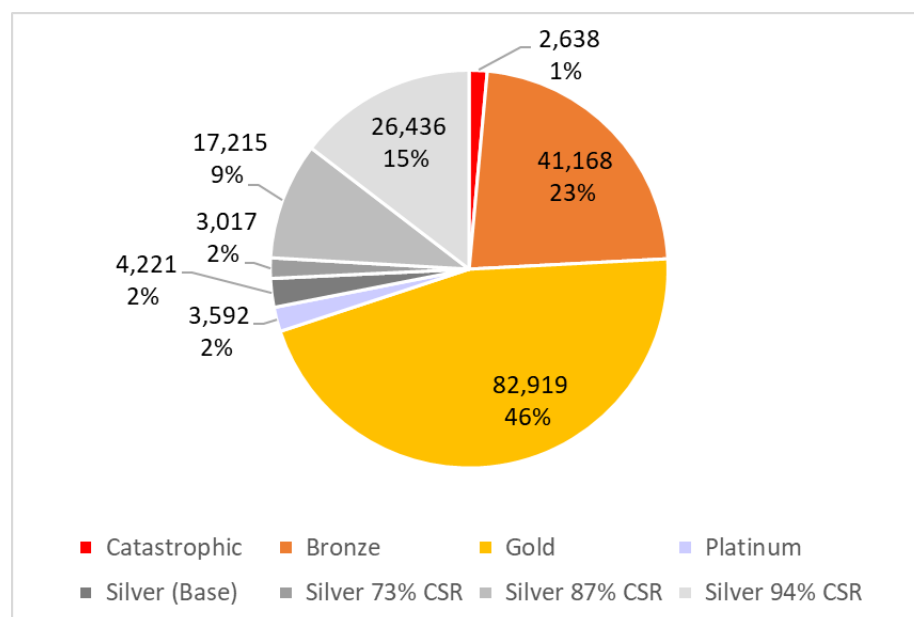
The majority of MHC enrollees are enrolled in relatively high-value plans, with 72 percent of enrollees in a plan with an actuarial value of 80 percent or higher, meaning the insurer covers an average of 80 percent of costs under the plan, and the average individual pays 20 percent of the cost of care. Two percent of consumers are enrolled in Platinum plans, 46 percent in Gold plans, 15 percent in high-value Silver 94% CSR plans, and nine percent in Silver 87% CSR plans. Only one percent of consumers are enrolled in a Catastrophic plan.⁴

² “Executive Data Report,” *Maryland Health Benefit Exchange*, August 31, 2022, <https://www.marylandhbe.com/wp-content/uploads/2022/09/MHBE-Executive-Report-08-31-2022.pdf>.

³ “State-Based Marketplaces Say Many Will Lose Affordable Coverage if Premium Assistance Expires,” *National Academy for State Health Policy*, updated July 20, 2022, <https://www.nashp.org/state-based-marketplaces-say-many-will-lose-coverage-if-premium-assistance-expires/#tab-id-6>.

⁴ MHBE enrollment data as of January 31, 2022.

Figure 1: Enrollment on Maryland Health Connection by Metal Level (January 31, 2022)



Health insurance is a complicated product and it can be difficult for consumers to accurately determine which plan or type of plan is the best value for them. Indeed, we see that some consumers are not enrolled in the best-value plan for which they are eligible. Individuals in certain low-income brackets are eligible for CSRs, which increase the AV of a Silver plan to that of a Gold or Platinum plan.⁵ For those with incomes between 138 and 150 percent of the Federal Poverty Line (FPL), a Silver plan with CSRs will always be a better value than a Gold plan because the Silver plans with CSRs plan have a higher AV than Gold plans. Due to enhanced federal premium subsidies available through 2025 under the Inflation Reduction Act, these enrollees are eligible for at least two such silver plans that are free or nearly free. However, MHBE’s enrollment data by income shows about 9,000 people enrolled in Catastrophic, Bronze, or Gold plans despite being eligible for higher-value, free or nearly-free Silver CSR plans (Table 1).⁶ An additional 16,000 people with incomes between 150 and 200 percent of FPL who are enrolled in Catastrophic, Bronze, or Gold plans could pay slightly higher premiums for a higher-value Silver CSR plan.

⁵ “Cost-Sharing Reductions,” *Health Reform Beyond the Basics*, Center on Budget and Policy Priorities, August 2020, <https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/>.

⁶ As of May 31, 2022.

Table 1: MHC Enrollment by Income and Metal Level (May 31, 2022)

FED POVERTY LEVEL	BRONZE	CATASTROPHIC	GOLD	PLATINUM	SILVER	TOTAL
< 100%	831	22	3,455	125	12,276	16,709
>= 100% FPL and <138% FPL	346	8	1,402	67	5,268	7,091
>= 138% FPL and <150% FPL	734	13	2,582	107	6,325	9,761
>= 150% FPL and <200% FPL	4,079	70	12,381	632	16,410	33,572
>= 200% FPL and <250% FPL	5,495	78	15,834	715	3,308	25,430
>= 250% FPL and <300% FPL	4,998	126	9,998	416	1,167	16,705
>= 300% FPL and <350% FPL	4,642	129	7,091	247	553	12,662
>= 350% FPL and <400% FPL	3,153	107	4,626	149	306	8,341
>= 400% FPL	5,904	321	9,081	454	582	16,342
UNKNOWN	8,405	1,367	14,349	737	1,584	26,442
Grand Total	38,587	2,241	80,799	3,649	47,779	173,055

Premiums

Premiums have decreased by about 30 percent since the inception of the State Reinsurance Program (SRP) in 2019 (Table 2).⁷ Through the SRP, the State reimburses insurers for high-cost claims with a goal of stabilizing the individual marketplace and reducing premiums across the market. The program has helped Maryland drive premiums substantially lower than national averages (Figure 2).⁸

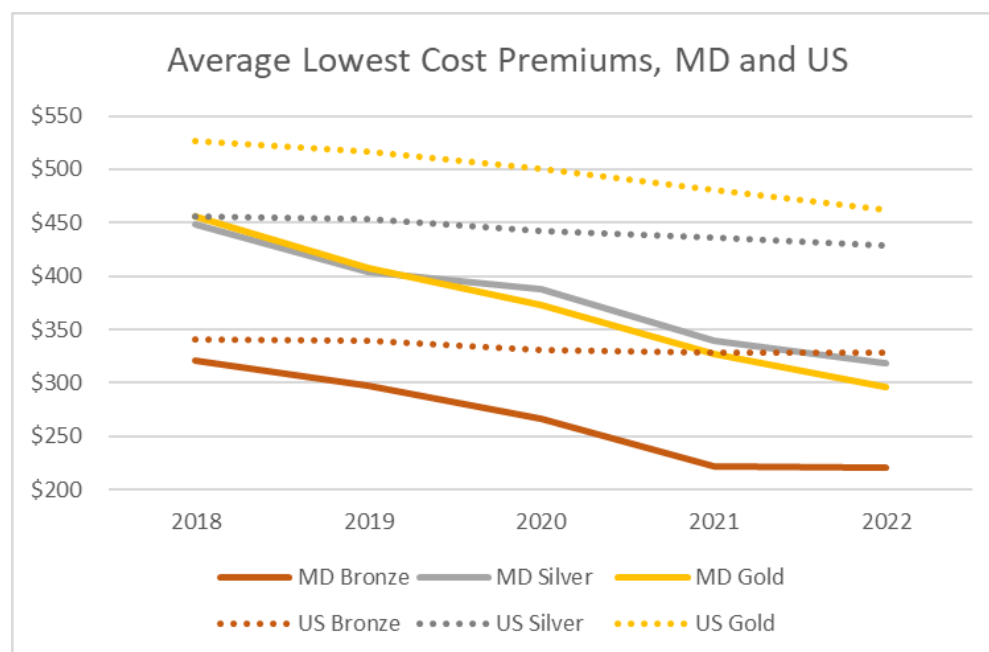
Table 2: Premium Change by Year

Plan Year	Individual Premium Change
2014	n/a
2015	10%
2016	18%
2017	21%
2018	50%
2019	-13%
2020	-10%
2021	-12%
2022	2.1%

⁷ MHBE data.

⁸ Kaiser Family Foundation data.

Figure 2: Average Lowest Cost Premiums, MD & US



Young Adult Premium Assistance Program

The Young Adult Premium Assistance Program is a pilot program conceived by the original MHBE Affordability Workgroup and established by Senate Bill 729 of 2021. The two-year pilot, which is currently running 2022-2023, provides a premium subsidy based on age and income for young adults aged 18-34.⁹ The program’s goal is to improve the risk pool of the individual market and reduce premiums for all by helping more young adults enroll. As of September 14, 2022, about 30,000 enrollees were receiving an average subsidy of about \$38 per member per month.¹⁰

Advance Premium Tax Credits

Enhanced federal APTC have also reduced premiums. The federal subsidies cap the amount an individual must pay towards premiums for a benchmark plan based on their household income (see Table 3). The American Rescue Plan (ARP) lowered the amount individuals must pay toward the benchmark premium, thereby increasing federal subsidies, effective for 2021 and 2022. The Inflation Reduction Act extended the ARP enhanced federal subsidies through the end of 2025. The continuation of the enhanced subsidies saves Maryland consumers an average of \$80 in premium spending per member per month and will help to preserve the enrollment gains seen since 2021.

⁹ More information on the 2022 and 2023 Young Adult Subsidy program can be found in the materials for the May 2021 and June 2022 MHBE Board meeting materials, available at <https://www.marylandhbe.com/board/>.

¹⁰ MHBE data.

Table 3: Premium Tax Credit Applicable Percentages Under the American Rescue Plan Compared to & Prior Law

Income Range (% of FPL)	Range of Applicable Percentages for 2021 under Prior Law	Range of Applicable Percentages for 2021 and 2022 under the ARP
100% – 133%	2.07%	0%
133% – 150%	3.10% – 4.14%	0%
150% – 200%	4.14% – 6.52%	0% – 2%
200% – 250%	6.53% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6% – 8.5%
400% and higher	N/A	8.5%

The applicable percentage is the share of a consumer’s income they must generally pay towards a benchmark (second-lowest-cost silver) plan with the PTC. Within the ranges shown the applicable percentage increases linearly.

Cost-Sharing

As explained previously in the Enrollment section, plans in the individual market are grouped into federally-defined metal levels, which correspond with AV, the measure of the share of health care costs (excluding premiums) that an insurer pays, on average, compared to an enrollee. The lower the actuarial value, the more the consumer can expect to pay when they use health care services. The metal levels provide a framework for how much of the cost of care a consumer can expect to bear. The actual mechanisms that insurers use to share costs with consumers are copays, coinsurance, deductibles, and out-of-pocket maximums.

A copay is a fixed dollar amount that the consumer pays for a covered service. For example, a consumer might have a \$20 copay for primary care visits, so the consumer pays \$20 and the insurer covers the balance of the cost. Coinsurance is a percent of costs the consumer pays for a covered service. For example, a consumer might have a 40% coinsurance on inpatient hospital services, meaning the consumer pays 40 percent of the cost for their hospital services, and the insurer pays the other 60 percent.

A deductible is the amount the consumer has to pay for covered health care services before the insurer starts to pay. Depending on the plan design, all services may be subject to the deductible, or some services may be subject to the deductible and others may not be. If a consumer has a \$3,000 deductible, and all services are subject to the deductible, the consumer must pay the first \$3,000 of their health care costs; after the deductible is reached, the consumer pays only the copays or coinsurance assigned to the services in their plan. On the other hand, if a consumer has a \$3,000 deductible and certain services are not subject to the deductible - say, primary care visits have a \$20 copay not subject to the deductible - the consumer pays the \$20 copay for their visit from the start of the plan year, regardless of whether they've reached their deductible.

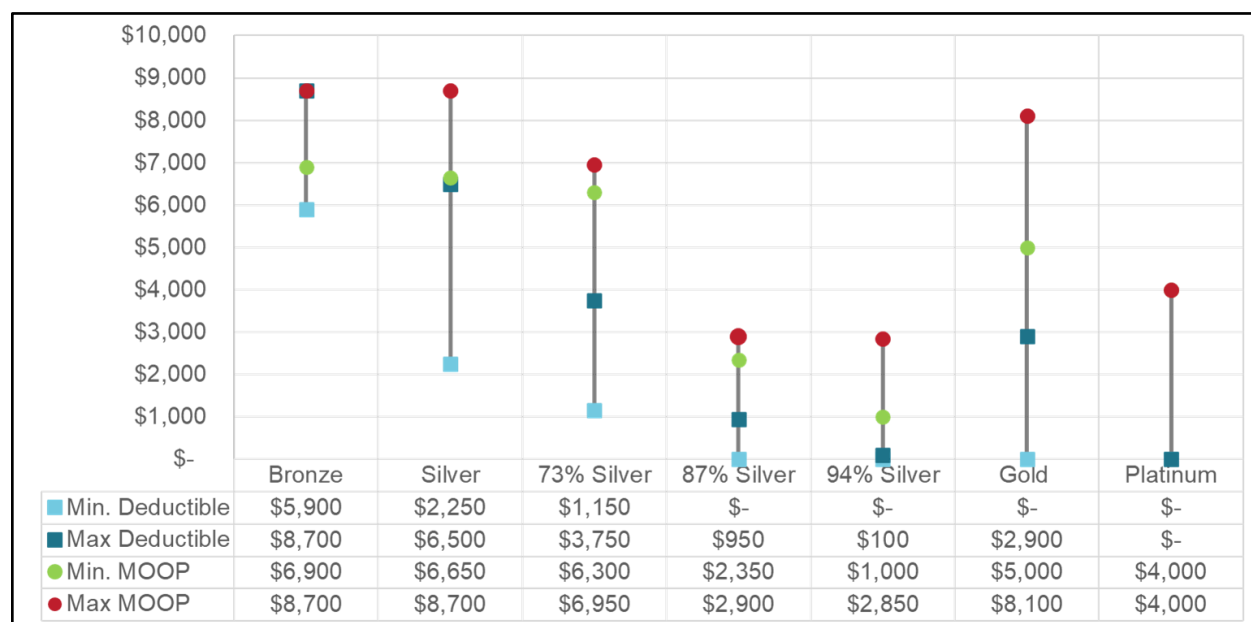
The last key cost-sharing concept is the maximum out-of-pocket (MOOP). The MOOP is the most a consumer has to pay for covered services in a plan year. After the consumer spends this amount on deductibles, copayments, and coinsurance for in-network care, the insurer pays 100% of the costs of covered benefits. The MOOP doesn't include premiums, out-of-network services, or services not covered by the plan. The federal government sets out-of-pocket maximums each year. For the 2023 plan year, the MOOP can't be more than \$9,100 for an individual and \$18,200 for a family. Lower MOOPs are set for the silver CSR variant plans.

Figure 3 shows the range of deductibles and MOOPS for 2022 individual plans on MHC. As the figure shows, deductibles range from a low of \$0 on platinum, gold, and some silver CSR variant plans to a high of \$8,700 in the bronze tier. MOOPs range from a low of \$4,000 in the platinum tier to high of \$8,700 in the silver and bronze tiers. The highest-enrollment plan on MHC as of August 2022 was a gold plan with a \$1,750 individual deductible and \$6,650 MOOP followed by a gold plan with a \$1,000 deductible and \$6,650 MOOP.¹¹

As further described in the following section, pursuant to recommendations of the 2019 Affordability Workgroup MHBE developed Value Plans to ensure consumers had plan options that prioritized affordable cost-sharing for consumers, including reasonable deductibles and key services covered with copays prior to the deductible.

¹¹ Maryland Health Connection Data Report, Aug 31, 2022. <https://www.marylandhbe.com/wp-content/uploads/2022/09/MHBE-Executive-Report-08-31-2022.pdf>

Figure 3: Range of Deductibles and Out-of-Pocket Maximums (MOOPs) for 2022 Individual Market Plans on Maryland Health Connection



IV. Plan Design

The benefits that are covered in plans sold through Maryland Health Connection are largely standardized by state and federal law. All plans must cover Essential Health Benefits, which are established in reference to a benchmark plan selected by the state. However, within the framework of the metal tiers and the MOOP limits, insurers have substantial flexibility to design the cost-sharing that applies to benefits. For example, insurers can vary which benefits are subject to the deductible, the level of the deductible, whether benefits are covered with a copay or coinsurance, and the amount of copays and coinsurance.¹² This leads to substantial variation in cost-sharing designs among plans on the market. On one hand, this can be viewed as beneficial because consumers have a range of options; however, research shows that consumers can be overwhelmed by choice when shopping for health insurance, struggle to understand and compare benefit designs across insurers, and ultimately may enroll in a plan that is not the best option for them financially.¹³

¹² Under state and federal law, all plans sold through Maryland Health Connection must cover preventive services with \$0 cost-sharing.

¹³ Chu, Rose, Jacquelyn Rudich, Aiden Lee, Christie Peters, Nancy De Lew, Benjamin Sommers, "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces," *Assistant Secretary for Planning and Evaluation*, December 28, 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

Value Plans

Maryland's Value Plans are designed to improve the affordability of key services and the consumer friendliness of plan designs. Value Plans grew out of the work of the 2019 Affordability Workgroup. Throughout 2018, during the public conversation on establishing the reinsurance program, MHBE received public comments expressing concern with deductibles and out of pocket costs. In response to these concerns, the Value Plan standards were developed and implemented for the 2020 plan year and have been required each plan year since then, with minor modifications to the requirements over the years.¹⁴

All insurers on MHC are required to offer a Value Plan at each of the Bronze, Silver, and Gold metal levels. These plans have deductible ceilings and requirements for services that must be covered with copays before the deductible. In addition, the 2023 Bronze Value Plan caps the copays for the services covered before the deductible. The Silver and Gold Value Plans do not set standards related to the level of copay that may be used for the pre-deductible services.

Value Plan enrollment has steadily increased, both in absolute numbers and as a percent of total enrollment.¹⁵ Now, 44 percent of QHP consumers are enrolled in Value Plans. Value Plans differ from Standardized Plans in that although the applicability to the deductible or cost-sharing range are standardized for some services, copays and other cost-sharing are not.

¹⁴ For past value plan requirements, see the annual letter to issuers, available at <https://www.marylandhbe.com/carriers/>

¹⁵ Enrollment data as of January 31 of each year.

Table 4: 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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)

Standardized Plans

Standardized Plans are plans that have standardized cost-sharing for all services, regardless of the insurer offering the plan. The standardized cost-sharing can include identical deductibles, copayments, and coinsurance by service within each metal level. These plan benefit designs also standardize the services that are subject or not subject to the deductible. Maryland’s Value Plans adopt some aspects of Standardized Plans but do not standardize cost-sharing to the extent that is typical in Standardized Plans.¹⁶

Research shows that standardization allows consumers to more easily compare plans (sometimes referred to as “apples-to-apples” comparison). Instead of competing based on small differences in cost-sharing features, which is often confusing for consumers, insurers compete based on network and quality.¹⁷

Insurers with plans on HealthCare.gov (the Federally-Facilitated Exchange) will be required to offer Standardized Plans in plan year 2023. Colorado will begin requiring Standardized Plans in 2023 as well. California, Oregon, Washington, New York, Vermont, Maine, Massachusetts, Connecticut, and Washington DC already require that insurers on their exchanges offer Standardized Plans.

Given the growing prevalence of Standardized Plans nationally and the potential consumer benefits they bring by simplifying the plan shopping experience and offering further opportunity

¹⁶ “Standard Plans: Presentation for Maryland Health Benefit Exchange Affordability Workgroup,” Georgetown University Center on Health Insurance Reforms, June 22, 2022, <https://www.marylandhbe.com/wp-content/uploads/2022/06/Schwab-Standard-Plan-Presentation-MHBE-Becca-Lane-MHBE-.pdf>.

¹⁷ [Chu et al, 2021](#)

to develop cost-sharing structures that support affordability and state health initiatives, MHBE asked the workgroup to develop a recommendation on whether the Exchange should expand on the Value Plan requirements to develop comprehensive Standardized Plan requirements for 2024, and if so to advise on and recommend Standardized Plan designs.

Limiting the Number of Plans Per Metal Level

On Healthcare.gov, insurers are not limited in the number of plans they can offer and consumers have an average of 100 plans to choose from. To reduce choice overload, six of the nine state-based marketplaces offering Standardized Plans also limit the number of non-Standardized Plans that insurers are allowed to offer. California is the only state to prohibit non-Standardized Plans. Currently, insurers on Maryland Health Connection may offer four plans per metal level, one of which must be a Value Plan.¹⁸

MHBE asked the Workgroup to provide a recommendation on whether MHBE should limit the number of plans per metal level to three rather than four, in order to further simplify the consumer shopping experience, which can support improved consumer decision-making. An analysis of 2022 plans and enrollment reveals that two out of three individual market insurers on MHC offer four plans per metal level at the silver and gold tiers. If each of these insurers eliminated their lowest enrollment silver and gold plans, a total of approximately 1,700 MHC enrollees, or less than 1 percent of MHC enrollment, would be impacted.¹⁹ Impacted consumers would be automatically renewed into the most similar plan available to them from their existing insurer, in accordance with the hierarchy established under federal regulation.²⁰ Like all consumers, these individuals would have the option to switch to any other plan from any other insurer during open enrollment.

Equity Considerations

Plan design can be a tool for promoting health equity. Many chronic conditions disproportionately impact people of color: Black Marylanders have higher rates and higher severity of many diseases, including COVID-19, diseases of the heart, cancers, and cerebrovascular diseases.²¹ MHBE already works to increase health insurance enrollment in the Black and Latinx/Hispanic communities, but increasing affordability of the services used to treat these high-disparity conditions is an important way to address health disparities.

¹⁸ [COMAR 14.35.15.08\(C\)](#)

¹⁹ MHBE data.

²⁰ Federal regulations regarding renewals can be found at 45 CFR 155.335(j), available at [https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-D/section-155.335#p-155.335\(i\)](https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-D/section-155.335#p-155.335(i))

²¹ "Health Equity Workgroup Recommendation Report," *Maryland Health Benefit Exchange*, December 2021, <https://www.marylandhbe.com/wp-content/uploads/2022/07/2021-MHBE-Health-Equity-Workgroup-Recommendation-Report-Becca-Lane-MHBE-1.pdf>.

The Health Equity Workgroup’s recommendations and the Standardized Plan benefit designs recommended in this Workgroup report focus specifically on reducing cost-sharing for diabetes. Deaths from diabetes are 40 percent higher among the Black population than among the population overall (32.4 per 100,000 compared to 19.6 per 100,000).²² Maryland has identified diabetes as a statewide health priority.^{23,24} Diabetes is also consistently one of the top five most common and most costly conditions among enrollees whose claims costs are reimbursed under the State Reinsurance Program.²⁵ Reducing the cost of managing diabetes has the potential to improve health disparities as well as reduce health care costs.

The Affordability Workgroup examined Washington D.C.’s and Colorado’s approaches to reduced cost-sharing to promote equity within Standardized Plans. Colorado is taking a broad approach, with \$0 cost-sharing for all enrollees for primary care visits, first-tier (preventive) prescription drugs, diabetic supplies, and continuous glucose monitors; enrollees can access diabetes education for \$5.²⁶

Washington D.C.’s approach is targeted only to enrollees with a primary diagnosis of Type 2 diabetes and includes \$0 cost-sharing for:

- PCP visits
- Dilated retinal exam (1x per year)
- Diabetic foot exam (1x per year)
- Nutritional counseling visits (unlimited)
- Select 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)

²² Maryland Statewide Racial and Ethnic Mortality Data 2018, Office of Minority Health and Health Disparities, Maryland Department of Health, <https://health.maryland.gov/mhhd/Documents/Maryland%20Statewide%20Racial%20and%20Ethnic%20Mortality%20Data%202018%20.pdf>.

²³ “Diabetes Action Plan,” *Maryland Department of Health*, June 2020, <https://health.maryland.gov/phpa/ccdpc/Pages/diabetes-action-plan.aspx>

²⁴ “Statewide Integrated Health Improvement Strategy,” Maryland Health Services Cost Review Commission, <https://hsrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx>

²⁵ “Fourth Annual Reinsurance Forum,” *Maryland Health Benefit Exchange*, July 2022, <https://www.marylandhbe.com/wp-content/uploads/2022/07/Reinsurance-Fourth-Annual-Forum.pdf>.

²⁶ “Regulation 4-2-81 CONCERNING COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLAN,” *Connect For Health Colorado*, [Regulation 4-2-81 Concerning Colorado Option Standardized Health Benefit Plan- REVISED 5.12.22](https://www.connectforhealthcolorado.com/Regulation-4-2-81-Concerning-Colorado-Option-Standardized-Health-Benefit-Plan-REVISED-5.12.22)

Additionally, “a select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the insurer, are provided with no cost-sharing. An insurer is not required to change the drugs that are on the insurer’s formulary.”²⁷

MHBE asked the Affordability Workgroup to consider the Health Equity Workgroup’s recommendations that MHBE and insurers explore the feasibility of applying 2022 Value Plan standards, which eliminated cost-sharing for diabetes supplies including insulin and glucometers, to all private plans on MHC starting in PY2024; and that MHBE continue exploring the feasibility of reducing cost-sharing for high-disparity conditions, starting with small changes that minimize impact to actuarial value and do not increase patient cost-sharing.

Subsequent to the Health Equity Workgroup’s conclusion, House Bill 1937 of 2022, the Insulin Cost Reduction Act, was passed and limits cost-sharing for insulin to no more than \$30 for a 30-day supply, effective for plans issued on or after January 1, 2023.²⁸ Further, test strips must already be covered at \$0 by all non-high-deductible health plans.²⁹ Because of these developments, the workgroup focused more on improving access to diabetes care management services through Standardized Plans rather than on applying market-wide diabetes cost-sharing requirements. MHBE will continue to monitor the issue of affordability of diabetes care management services and revisit it in the future as necessary.

²⁷ “Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority,” *DC Health Benefit Exchange Authority*, November 8, 2021, 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.

²⁸ [Legislation - HB1397](#)

²⁹ Md. Ins. Art. §15-822(d)(3)

V. Workgroup Overview

Members

Name	Affiliation
Allison Mangiaracino	Kaiser Permanente
Andrew York	Prescription Drug Affordability Board
David Stewart	Co-Chair; AHEC West
Emily Hodson	Chase Brexton
Evalyne Bryant Ward	University of Maryland Charles Regional Medical Group
Lindsey Finne	Health Services Cost Review Commission
Lisa Solomon	Senior Health Benefits Assistance
Matt Celentano	League of Life & Health Insurers of MD, Inc.
Maya Greifer	UnitedHealthcare
Robert Metz	CareFirst Blue Cross Blue Shield
Stephanie Klapper	Maryland Citizens' Health Initiative
Steven Chen	Maryland Hospital Association
JoAnn Volk	Georgetown Center for Health Insurance Reforms
Brad Boban	Maryland Insurance Administration
Crystal Watkins	MedStar Harbor Hospital
Michelle Livshin	On Our Own MD
Crystal Shivers-Lester	Seedco
Jonathan McKinney	The Advocacy Factory
Kavita Patel	Mary's Center
Howard Haft	Maryland Primary Care Program

Meeting Summaries

Summaries of Workgroup meetings are provided below. Video recordings of each meeting and meeting minutes are available at <https://www.marylandhbe.com/policy/work-groups/affordability-work-group/>

Session 1

Speaker: Pamela Williams, Bureau Director, Prevention and Health Promotion Administration of the Maryland Department of Health, on the Statewide Integrated Health Improvement Strategy (SIHIS)

MHBE staff presented on MHBE's role and scope, premium and enrollment data, takeaways from the previous Affordability Workgroup in 2019, and existing MHBE affordability initiatives. Pamela Williams presented on the SIHIS and how its priority area of diabetes prevention is aligned with one of the goals of the Affordability Workgroup, which is to reduce cost-sharing for

high-disparity conditions, starting with diabetes. Discussion centered on the high cost of healthcare in general and the importance of health literacy.

Session 2

Speaker: Rachel Schwab, Research Associate, Center on Health Insurance Reforms, Georgetown University Health Policy Institute, on Standardized Plans

Rachel Schwab from Georgetown University gave an overview of the benefits of standardized plans, including increased health care access and simplified plan choice for consumers. Standardized plan design allows consumers to more easily compare plans (sometimes referred to as “apples-to-apples” comparison). Instead of competing based on the minutiae of cost-sharing design, which can be confusing for consumers, insurers compete based on network and quality. Insurers with plans on HealthCare.gov will be required to offer Standardized Plans in plan year 2023, and a number of other states either have already been or will begin offering Standardized Plans.

MHBE staff presented on MHBE’s Value Plans, which were conceived of as a variation on Standardized Plans and require certain pre-deductible coverage. Value Plans have been popular since they were introduced in 2020, with 44 percent of Maryland Health Connection consumers now enrolled in Value Plans. Standardized Plans would build on this success. MHBE staff also reviewed and compared the federal standardized plan designs as well as standardized plan designs in California, Colorado, and Washington, DC.

Workgroup members discussed whether it would be advisable for MHBE to adopt the federal Standardized Plan designs, but concluded that it would be better for MHBE to develop Standardized Plan designs of its own that are tailored to Maryland’s needs and build on the foundation of the MHBE Value Plans.

Session 3

Speaker: Andrew York, Executive Director, Prescription Drug Affordability Board and Member, MHBE Affordability Workgroup, on Prescription Drug Affordability

MHBE staff circulated a survey in advance of session 3 for Workgroup members to weigh in on key design features of Standardized Plans. Survey responses confirmed that most members wanted MHBE to pursue Standardized Plans. Members also weighed in on which services should be covered pre-deductible and whether to prioritize lower premiums or more generous benefit coverage when designing plans (see meeting materials for more information). Staff explained that survey responses would be used to develop benefit design options for the Workgroup to consider.

In his presentation on drug affordability, Andrew York shared research that has found that higher drug costs result in lower adherence. He observed that pre-deductible prescription

coverage and separate medical and drug deductibles are plan design options that can reduce drug costs.

Workgroup members were supportive of these drug affordability measures. They also discussed how to call attention to new Standardized Plans on the MHC plan shopping page so that consumers are aware of them and the value they offer.

Session 4

Speaker: Jennifer Libster, Chief Equity Advisor, Washington DC Health Benefit Exchange Authority, on Diabetes Cost-Sharing for Equity

MHBE staff presented background on the reason for focusing on cost-sharing for diabetes: it is a common condition with a disparate impact on populations of color, and although it can be costly, costs can be reduced and outcomes improved if the condition is managed well. Further, diabetes is a key priority for Maryland Department of Health's Statewide Integrated Health Improvement Strategy; by focusing on diabetes, MHBE would be in alignment with statewide goals.

Jennifer Libster presented on Washington D.C.'s Value-Based Insurance Design process that led the DC Health Benefit Exchange to its recommendation for \$0 cost-sharing for a specific suite of diagnosis-specific, Type 2 diabetes management services (as described on page 14). Washington D.C. found that these changes did not have much impact on the Actuarial Value of the plans. The Workgroup also considered Colorado's broader approach, which is to eliminate cost-sharing for primary care visits for all consumers.

The group discussed how the diabetes cost-sharing changes have a relatively small impact on AV and would not require cost sharing increases to other services in order to meet the AV de minimis range requirement. They also discussed drug pricing, which is especially salient for diabetics.

Session 5

MHBE staff presented the first draft of standardized benefit designs for the Workgroup's consideration. These included two Gold, two Silver, and one Bronze design for consideration, but no standardized Catastrophic or Platinum plans because enrollment in those plans is so low. The draft plans featured separate medical and drug deductibles and no coinsurance, only copays. For each of the two respective Gold and Silver designs, one had a higher AV and higher deductible and the other had a lower AV and lower deductible. The services included in the initial benefit design drafts were based on the services included in the federal Actuarial Value Calculator. This calculator is used to ensure that all Qualified Health Plans meet federal actuarial value requirements by metal level.

The Workgroup discussed the composition of the draft designs and asked for certain changes, including lower physical therapy, occupational therapy, and speech therapy copays. Members

also wanted to ensure that mental health parity requirements would be met by the new designs and that copays for outpatient mental health services would be affordable enough for weekly visits. Some members reflected that consumers do not seem to mind a somewhat higher deductible as long as there is significant pre-deductible coverage included.

MHBE staff also asked the Workgroup to consider limiting insurers to offering three plans per metal level on MHC – one fewer than the four per metal level currently allowed by regulation. Workgroup members shared that this could be too much change if it occurred in the same year as the introduction of the new Standardized Plans and may be disruptive to the small number of enrollees whose plans will be discontinued as a result of the new limit.

Session 6

MHBE staff presented second-draft standardized benefit designs that had been revised to reflect members' feedback from session 5. The updated designs had copays that reflected the overall plan generosity so consumers can easily see how the plans compare. A copay for a specialist visit, for example, is the lowest in Gold, higher in Silver, and highest in Bronze. This design holds true across the Silver Cost-Sharing Reduction plans as well.

Insurers in the Workgroup requested flexibility for setting telehealth copays below the standardized copay amounts. One member suggested that plan designs be updated to ensure that outpatient surgery cost-sharing was lower than inpatient cost-sharing across all metal levels. For more details on feedback, please see the meeting minutes from August 17. Staff asked for feedback on Bronze plans: should the Standardized plan have lower copays, but cover fewer services pre-deductible, or should it have higher copays, but more pre-deductible coverage? The group supported the option with more pre-deductible coverage, to maximize the services covered before reaching the deductible.

The Workgroup also revisited the idea of limiting the number of plans per metal level per insurer, and supported this policy beginning in plan year 2025, a year after the Standardized Plans will have been implemented.

Session 7

MHBE staff presented a third draft of the standardized benefit designs (see Appendix A). The Workgroup discussed outpatient and inpatient hospital cost-sharing and whether it would make sense to combine the facility fee with the physician services fee; Workgroup members raised several reasons why it may be preferable to keep copays for these items separate. See meeting minutes from August 31 for details on the full discussion.

Staff also presented a list of services that are included on Summaries of Benefits and Coverage (SBCs) and typically standardized in other states that have Standardized Plans, but that do not have enough of an impact on actuarial value to be included in the federal Actuarial Value Calculator. These services include urgent care, pediatric vision and dental, durable medical equipment (DME), and others. Staff shared that because DME costs vary so widely, cost-

sharing would be standardized as coinsurance (an exception to the copay-only cost-sharing across the other standardized benefits).

Staff proposed \$0 cost-sharing for pediatric vision services. The Workgroup was amenable to the proposal. The group also discussed whether there should be standardized limits on the number of frames per year or allowed amount for frames, but ultimately did not recommend standardizing limits. Staff asked for preliminary feedback on approaching pediatric dental services, which the group agreed is a complex category because of the sheer volume of types of dental services. The Workgroup supported the pediatric dental service categories that staff proposed, as well as applying coinsurance to pediatric dental services.

Session 8

MHBE staff presented recommended pediatric dental cost-sharing and the Workgroup had no objections. The group discussed reducing the urgent care copays but generally concluded that the proposed copays were reasonable. The group agreed that they would be ready to vote after viewing this report.

VI. Findings & Recommendations

A. MHBE should implement Standardized Plans for 2024 that are designed to advance affordability, simplicity, alignment with state health goals, equity, and minimize market disruption.

Standardized plans should be designed to make commonly-used services feasibly affordable for consumers to access, keeping in mind that 35% of adults don't have \$400 to cover an emergency expense.³⁰ Deductibles should be minimized and commonly used services should be covered pre-deductible. The plans should include separate drug and medical deductibles.

Plans should have a simple design that allows consumers to easily understand their cost-sharing and compare plans. Cost-sharing for common services should be standardized, and the plans should feature copays instead of coinsurance as much as is feasible. To the extent possible, cost-sharing should also be structured so that as the AV of a plan increases, the amount the consumer pays for a service decreases. This helps to send clear signals to consumers that they can generally expect to pay less out-of-pocket in a higher-AV plan. This design principle can be especially important to distinguish the 87% and 94% Silver CSR plans from Gold plans, to help consumers understand that the Silver CSR plans offer a higher AV than Gold plans.

Standardized plan benefit designs should support Maryland's statewide population health goals. Cost-sharing should be designed to reduce barriers and facilitate access to primary care, substance use disorder treatment, and services to manage diabetes. Access to these services support the Statewide Integrated Health Improvement Strategy.

The plans should have reduced cost-sharing for high-disparity conditions, starting with the targeted elimination of cost-sharing for services to manage diabetes.

Standardized plans should be designed with awareness of current Value Plan designs and endeavor to minimize disruptive changes to insurers' existing Value Plan cost-sharing values and structures, particularly for the most used services. However, some initial disruption may be necessary to achieve other goals, such as standardizing cost-sharing across plans and prioritizing use of copays over coinsurance.

Draft Standardized Plan designs that adhere to these priorities and are officially recommended by the Workgroup can be found in Appendix A. The Workgroup caveats that these plans were

³⁰ "Economic Well-Being of U.S. Households in 2020," *Federalreserve.gov*, May 2021, <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.>

designed with the Actuarial Value Calculator (AVC) for Plan Year 2023. Upon the release of the 2024 AVC, the plan designs will need to be re-tested for adherence to federal AV requirements for each metal level before they are implemented. If changes are needed, adjustments will first be made to the out-of-pocket maximums to preserve the cost-sharing design approved by this Workgroup. If further changes are necessary, MHBE staff will propose changes that align with the priorities established by the workgroup, such as keeping commonly used services pre-deductible, prioritizing copays over coinsurance, and structuring cost-sharing for each service so that it is as or more favorable to the consumer as AV increases, compared to lower-AV plans. Any proposed changes to the recommended plan designs will be shared with the Workgroup and the public and written comments will be invited. Staff may then update the proposed changes in consideration of comments received. The last step to finalize the plans will be to present them to the MHBE Board for approval to include in final 2024 plan certification standards, which is planned for the January or February 2023 MHBE Board meeting, depending on when the AVC is released.

B. MHBE should differentiate Standardized Plans with icons and branding to assist consumers with plan selection.

MHBE must convey the value of Standardized Plans to consumers. Highlighting the Standardized Plans on the plan shopping page will assist consumers during the plan selection process.

C. MHBE should further limit the number of plan offerings on MHC beginning in plan year 2025.

Insurers are currently allowed to offer four plans per metal level on the Exchange. The Workgroup recommends that MHBE limit the number of plans each insurer is allowed to offer to three per metal level starting with plan year 2025. Limiting the number of plans per metal level can simplify the consumer shopping experience. Implementing the additional limit in 2025 will allow the market a year to adjust to the transition from Value Plans to Standardized Plans in 2024, before this additional change is implemented. If insurers are offering four plans per metal level and need to discontinue a plan at a particular metal level to meet the new limit, they will have discretion as to which plan to eliminate. Enrollees in any plans that are discontinued will be renewed into the most similar plan available to them from their current insurer, but will have the option to select any other available plan during open enrollment.

VII. Appendix A: Standardized Plan Designs

	Subject to Deductible	Gold	CSR 94%	CSR 87%	CSR 73%	Silver - NEW	Bronze - Expanded
Maximum MOOP		\$9,100	\$3,000	\$3,000	\$7,250	\$9,100	\$9,100
Actuarial Value		81.8%	94.85%	87.89%	73.97%	71.58%	64.8%
Medical Deductible		\$1,000	\$0	\$1,000	\$4,500	\$4,500	\$9,100
Drug Deductible		\$150	\$0	\$150	\$750	\$750	n/a
Medical MOOP		\$6,750	\$1,350	\$2,500	\$5,750	\$7,600	\$9,100
Rx MOOP		\$600	\$150	\$500	\$1,500	\$1,500	n/a
Emergency Room Services	*† Yes - No	\$350	\$75	\$150	\$500	\$500	n/a
All Inpatient Hospital Services (inc. MH/SUD)	Yes - No	\$450	\$150	\$350	\$550	\$550	n/a
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	Yes - No	\$10	\$2	\$10	\$35	\$35	\$35
Specialist Visit	Yes - No	\$30	\$15	\$30	\$80	\$80	\$80
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	Yes - No	\$10	\$2	\$10	\$35	\$35	\$35
Imaging (CT/PET Scans, MRIs)	Yes - No	\$400	\$125	\$350	\$600	\$600	n/a
Speech Therapy	Yes - No	\$10	\$2	\$10	\$35	\$35	\$35
Occupational and Physical Therapy	** Yes - No	\$10	\$2	\$10	\$35	\$35	\$35
Preventive Care/Screening/Immunization	Yes - No	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory Outpatient and Professional Services	Yes - No	\$25	\$5	\$25	\$80	\$80	\$80
X-rays and Diagnostic Imaging	Yes - No	\$50	\$20	\$50	\$150	\$150	\$150
Skilled Nursing Facility	†† Yes - No	\$75	\$30	\$75	\$150	\$150	n/a
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes - No	\$250	\$50	\$75	\$150	\$150	n/a
Outpatient Surgery Physician/Surgical Services	*** Yes - No	\$125	\$60	\$125	\$150	\$150	n/a
Generic Drugs	Yes - No	\$10	\$0	\$5	\$20	\$20	\$20
Preferred Brand Drugs	Yes - No	\$30	\$5	\$25	\$75	\$75	n/a
Non-Preferred Brand Drugs	Yes - No	\$60	\$15	\$50	\$80	\$80	n/a
Specialty Drugs (i.e. high-cost)	Yes - No	\$75	\$25	\$60	\$100	\$100	n/a

* Enrollees with a primary diagnosis of Type 2 diabetes pay \$0 cost-sharing for:

- PCP visits
- Dilated retinal exam (1x per year)
- Diabetic foot exam (1x per year)
- Nutritional counseling visits (unlimited)

** Enrollees with a primary diagnosis of Type 2 diabetes pay \$0 cost-sharing for the following 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 insurer, are provided with no cost-sharing. An insurer is not required to change the drugs that are on the insurer’s formulary.

† Insurers are permitted to charge less than the copays shown for services delivered via telehealth.

†† Insurers are permitted to combine the two outpatient copays into a single copay if they choose.

Additional Standardized Service Categories								
			Gold	CSR 94%	CSR 87%	CSR 73%	Silver (Base)	Bronze - Expanded
Durable Medical Equipment	Yes - No		20%	10%	20%	30%	30%	40%
Emergency Transportation/Ambulance	Yes - No		\$300	\$50	\$100	\$350	\$350	n/a
Habilitation Services	Yes - No		\$10	\$2	\$10	\$35	\$35	\$35
Home Health Care Services	Yes - No		\$30	\$10	\$25	\$45	\$45	\$50
Hospice Services	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Inpatient Physician and Surgical Services	Yes - No		\$30	\$10	\$25	\$40	\$40	n/a
Outpatient Rehabilitation Services	Yes - No		\$10	\$2	\$10	\$35	\$35	\$35
Substance Abuse Disorder Outpatient Services	Yes - No		\$10	\$2	\$10	\$35	\$35	\$35
Urgent Care Centers or Facilities	Yes - No		\$40	\$15	\$30	\$75	\$75	\$75
Pediatric Vision								
Routine Eye Exam for Children (optometrist)	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Eye exam by an Ophthalmologist	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Basic Lenses	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Frames	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Contacts – elective (i.e. in lieu of lenses and frames)	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Contacts – medically necessary	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Low vision testing	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Low vision aid	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Pediatric Dental								
Class I Preventive & Diagnostic Services	Yes - No		\$0	\$0	\$0	\$0	\$0	\$0
Class II Basic Services	Yes - No		20%	20%	20%	20%	20%	20%
Class III Major Services	Yes - No		20%	20%	20%	20%	20%	20%
Class IV Major Services – Restorative	Yes - No		50%	50%	50%	50%	50%	50%
Class V Orthodontic Services	Yes - No		50%	50%	50%	50%	50%	50%