

Policy Items

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February 21, 2023

Agenda

1. Final Value Plan Certification Standards
2. 2024 Proposed Reinsurance Parameters
3. 1332 Waiver Extension Application

The background is a solid teal color. In the center, there is a stylized graphic of a flower or a starburst shape, composed of several overlapping, semi-transparent teal circles of varying shades, creating a layered, petal-like effect.

2024 Plan Certification Standards, Part II: Value Plans

2024 Plan Certification Standards Timeline

- Oct 13, 2022: Present proposed 2024 plan certification standards to MHBE Standing Advisory Committee
- Nov. 21, 2022: Present proposed 2024 plan certification standards to MHBE Board
- Nov. 28 - Dec. 30, 2022: Public comment period
- Dec. 22, 2022 - Jan. 27, 2023: Updated Value Plan designs released for additional public comment period
- Jan. 16, 2023: Present recommended final 2024 plan certification standards to MHBE Board (except Value Plan standards)
- **Feb. 21, 2023: Present recommended final 2024 Value Plan standards to MHBE Board**

Background: Value Plan & Affordability Workgroup History

- Value Plans were launched in 2020 to lower out-of-pocket costs with deductible caps and pre-deductible coverage
- In 2022, MHBE convened an Affordability Workgroup to recommend updates to Value Plan Standards and Plan Certification Standards for 2024 and beyond. MHBE asked the group to consider:
 - Changes to cost sharing to support affordability
 - Changes to support health equity and align with statewide health goals
- Insurers on HealthCare.gov must offer standard plans beginning in PY2023

Background: Affordability Workgroup Recommendations

- The 2022 Affordability Workgroup unanimously recommended updating Value Plans in 2024 to standardize cost sharing for commonly used services
 - Offer one Value Plan at the Bronze, Silver, and Gold metal levels
 - Identify plans by using “Value Plan” in the plan name, and only in Value Plan names
- Retire existing Value Plan requirements

Background: Policy Goals of Standardizing Cost Sharing in Value Plans

- Improve health care access and affordability
 - Pre-deductible coverage
 - Copays vs. coinsurance
 - Promote health equity through plan design
- Promote insurer competition
 - Transparency
 - “Apples-to-apples” plan comparison
- Simplify plan shopping

Background: 2024 Value Plan Guiding Principles

- **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 expense¹
- **Simplicity** - plans should allow consumers to easily understand their cost-sharing and compare plans
- **Alignment with State health goals** – plan design should support Maryland's population health goals
- **Equity** - reduce cost-sharing for high-disparity conditions, starting with changes that minimize impact to actuarial value
- **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

[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>

Background: Actuarial Value

- Generosity of qualified health plans must adhere to federal limits for each metal level (“Actuarial Value” or AV).
- The federal restrictions on AV mean that tradeoffs in cost-sharing must be made. Reducing or eliminating cost-sharing for one service may require an increase in cost-sharing for another.
- Annually, the federal government releases the Actuarial Value Calculator (AVC), which must be used to ensure each plan complies with federal limits.
 - When the 2023 AVC was released Dec. 2022, MHBE and MIA developed options for updating recommended Value Plan designs to ensure they complied with the AVC.

Standard Plans: Proposed Updates to Comply with 2024 AV Calculator (Out-of-Pocket Max)

- 3 of 6 plan designs were over the AV limit when run through 2024 AV calculator (Bronze plan and two Silver plan variants, 73% CSR and 94% Cost-Sharing Reduction (CSR) plans).
- MHBE first increased the out-of-pocket maximum for affected plans by \$300-\$500. This brought the 94% Silver CSR plan into compliance.

| | Subject to Deductible | Gold | CSR 94% | CSR 87% | CSR 73% | Base Silver | Bronze - Expanded |
|---|-----------------------|---------|---------|---------|---------|-------------|-------------------|
| Actuarial Value - Using 2023 AV Calculator | | 81.80% | 94.85% | 87.89% | 73.97% | 71.58% | 64.8% |
| Actuarial Value - Using 2024 AV Calculator (out of range highlighted) | | 81.20% | 95.14% | 87.48% | 74.71% | 71.89% | 66.0% |
| Actuarial Value - Using 2024 AV Calculator After Updated MOOPs (out of range highlighted) | | 81.20% | 94.77% | 87.48% | 74.22% | 71.89% | 65.4% |
| Medical Deductible | | \$1,000 | \$0 | \$1,000 | \$4,500 | \$4,500 | \$9,100 |
| Drug Deductible | | \$150 | \$0 | \$150 | \$750 | \$750 | n/a |
| Medical MOOP - Originally Proposed | | \$6,750 | \$1,350 | \$2,500 | \$5,750 | \$7,600 | \$9,100 |
| Rx MOOP- Originally Proposed | | \$600 | \$150 | \$500 | \$1,500 | \$1,500 | n/a |
| Medical MOOP - Updates Highlighted | | \$6,750 | \$1,750 | \$2,500 | \$6,050 | \$7,600 | \$9,450 |
| Rx MOOP- Updates Highlighted | | \$600 | \$250 | \$500 | \$1,500 | \$1,500 | n/a |

Standard Plans: Proposed Updates to Comply with 2024 AV Calculator (Copays)

- Additional changes required to bring Bronze and 73% Silver CSR plans into compliance. (Base Silver plan also affected.)
- MHBE worked with MIA to develop two options:
 1. Increase **specialist copay from \$80 to \$90** and increase **generic drug copay from \$20 to \$25** (staff recommendation); or
 2. Increase **specialist copay from \$80 to \$110** (Silver base and 73% CSR plans) **and from \$80 to \$125** (Bronze plan)

Summary of Public Comments

- Three commenters (individual market carriers)
- **Option 1 (modest increase in specialist and generic drug copays) favored** over option 2 (large increase to specialist copay only)
- See appendix for additional detail on public comments

| Commenter | Comment |
|-------------------|--------------------|
| Kaiser Permanente | Option 1 preferred |
| CareFirst | Option 1 preferred |
| United | Option 2 preferred |

Proposed Updated 2024 Value Plan Designs (1/2)

| | Subject to Deductible | Gold | CSR 94% | CSR 87% | CSR 73% | Base Silver | Bronze - Expanded |
|---|-----------------------|---------|---------|---------|---------|-------------|-------------------|
| Actuarial Value | | 81.20% | 94.77% | 87.48% | 73.8% | 71.5% | 64.81% |
| Medical Deductible* | | \$1,000 | \$0 | \$1,000 | \$4,500 | \$4,500 | \$9,450 |
| Drug Deductible* | | \$150 | \$0 | \$150 | \$750 | \$750 | n/a |
| Medical MOOP* | | \$6,750 | \$1,750 | \$2,500 | \$6,050 | \$7,600 | \$9,450 |
| Rx MOOP* | | \$600 | \$250 | \$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 | \$90 | \$90 | \$90 |
| Mental/Behavioral Health and Substance Use Disorder Office Visits | Yes - No | \$10 | \$2 | \$10 | \$35 | \$35 | \$35 |
| Mental/Behavioral Health and Substance Use Disorder All Other Outpatient Services | Yes - No | \$10 | \$2 | \$10 | \$35 | \$35 | \$0 |
| 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 | \$25 | \$25 | \$25 |
| 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 |

*Deductibles and MOOPs for family coverage are 2x the individual values listed on this chart. See Appendix for more information.

Proposed Updated 2024 Value Plan Designs (2/2)

| Additional Standardized Service Categories | | | | | | | |
|---|----------|-------|------|-------|-------|-------|------|
| Durable Medical Equipment | Yes - No | 20% | 10% | 20% | 30% | 30% | n/a |
| 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 | n/a |
| Hospice Services | Yes - No | \$0 | \$0 | \$0 | \$0 | \$0 | n/a |
| 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% |

Additional Proposed 2024 Value Plan Details

- Enrollees with a primary diagnosis of diabetes pay \$0 cost-sharing for:
 - PCP visits
 - Dilated retinal exam (1x per year)
 - Diabetic foot exam (1x per year)
 - Nutritional counseling visits
 - 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 agent's drug class, as defined by the insurer. An insurer is not required to change the drugs that are on the insurer's formulary.
- Insurers may charge less than the copays shown for services delivered via telehealth.
- Insurers may combine the two outpatient surgery copays into a single copay.

Request to Approve 2024 Value Plan Certification Standards

MOTION: I move to [approve/defer/reject] the proposed value plan certification standards for plan year 2024 [as presented] *or* [as amended].

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State Reinsurance Program Estimated Payment Parameters for 2024

SRP Parameters - Regulatory Requirements

COMAR 14.35.17.04

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

- (1) An attachment point;
- (2) A coinsurance rate;
- (3) A reinsurance cap; and
- (4) A market-level dampening factor provided by the Commissioner, if determined necessary by the Board.

C. For each benefit year after 2019, the Board shall set the estimated payment parameters for the State Reinsurance Program on or before April 1 of the calendar year preceding the applicable plan year.

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

Calendar Year 2023 SRP Key Dates

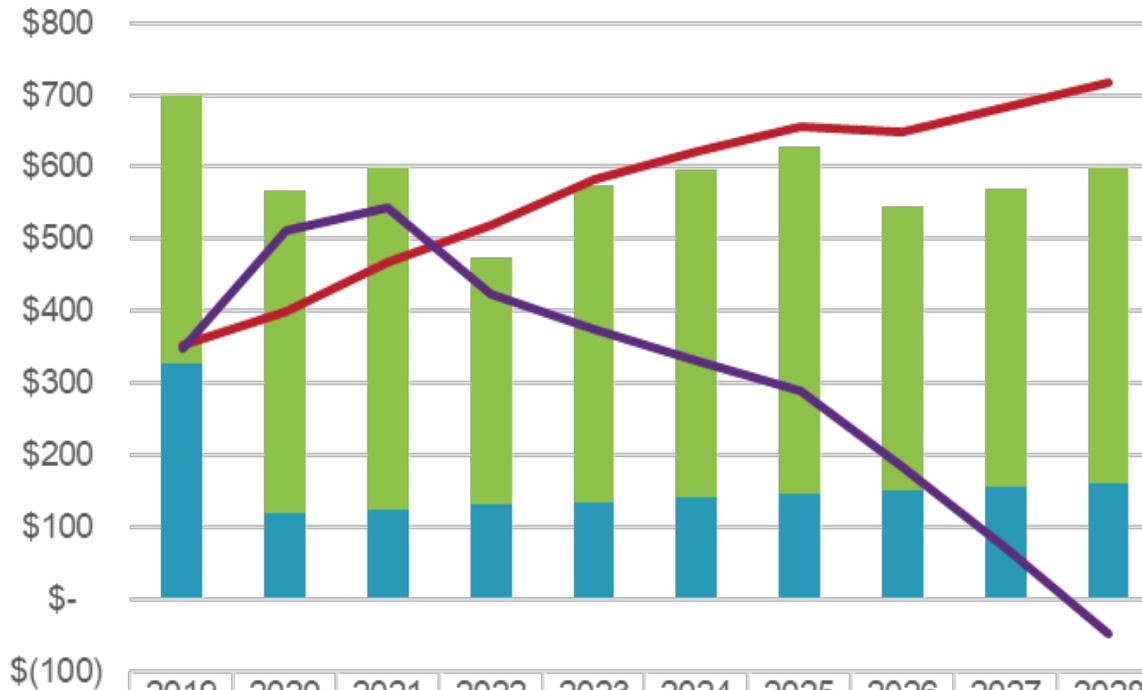
| February 21, 2023 | MHBE Board | Set estimated 2024 SRP parameters. |
|------------------------------|-------------------|---|
| May 22, 2023 | MIA | 2024 Rate Filing Deadline |
| May 2023 | MHBE Policy | 2022 Carrier Data Submission: - 2022 and emerging 2023 claims continuance table - 2022 Carrier EDGE Server Data |
| June 30, 2023 | MHBE Policy | 2022 Carrier SRP Accountability Reports Due |
| Early July 2023 | MHBE Policy | - Finalize recommended 2024 SRP parameters and recommendation for SRP & Risk Adjustment Interaction - Estimate 2022 SRP payments |
| July 17, 2023 | MHBE Board | Set final 2024 SRP parameters. |
| Mid-August – Early September | MIA | MIA 2024 rate release |
| September 2023 | MHBE | Issuers receive SRP payments for 2022 claims experience |

Estimated 2024 SRP Parameters – Staff Recommendation

- For the purposes of 2024 rate filing, MHBE staff recommend an attachment point of \$19,500, coinsurance rate of 80%, and cap of \$250,000.
- MHBE staff recommend that the Board again determine that a dampening factor, to be provided by the Commissioner, is required.

| Parameters | Final 2019 | Final 2020 | Final 2021 | Final 2022 | Final 2023 | Estimated 2024 |
|-------------------------|------------|------------|------------|------------|------------|------------------|
| Attachment Point | \$20,000 | \$20,000 | \$20,000 | \$20,000 | \$18,500 | \$19,500 |
| Coinsurance Rate | 80% | 80% | 80% | 80% | 80% | 80% |
| Cap | \$250,000 | \$250,000 | \$250,000 | \$250,000 | \$250,000 | \$250,000 |
| Dampening Factor | .800 | .785 | .760 | .805 | .840 | Yes |

Reinsurance Cost and Funding Projections Through 2028: Attachment Point Up \$500/year

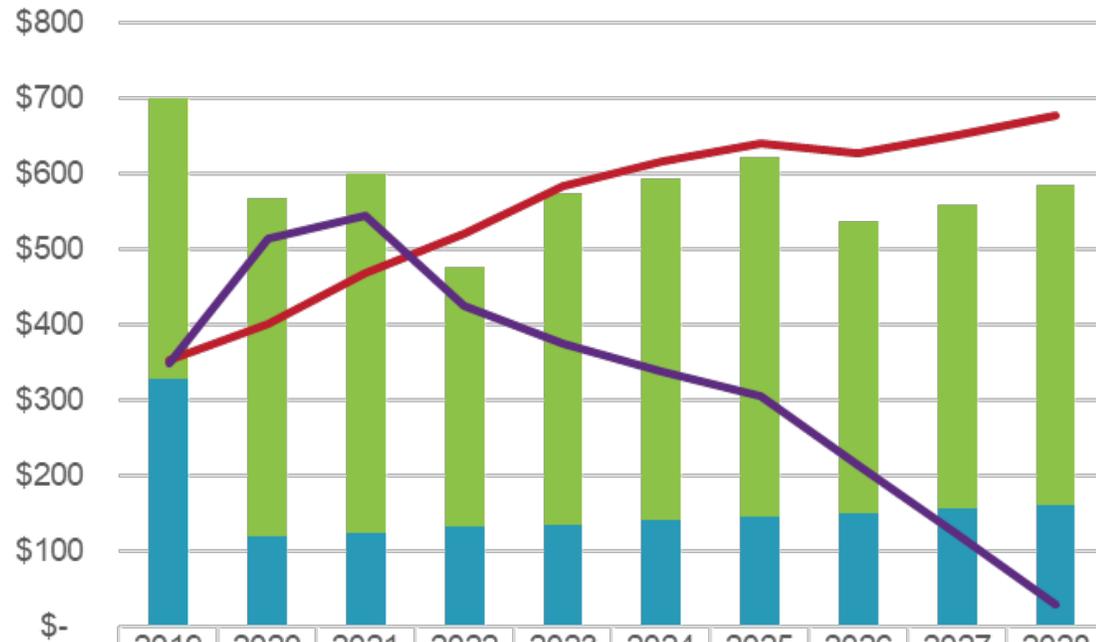


| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
|--------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|
| Federal Funding | \$373 | \$447 | \$475 | \$344 | \$439 | \$456 | \$482 | \$395 | \$415 | \$437 |
| State Funding | \$327 | \$119 | \$124 | \$131 | \$135 | \$140 | \$145 | \$150 | \$155 | \$161 |
| Reinsurance Cost | \$353 | \$400 | \$468 | \$520 | \$582 | \$623 | \$655 | \$649 | \$682 | \$717 |
| Fund Balance End-of-Year | \$347 | \$513 | \$544 | \$424 | \$374 | \$332 | \$289 | \$184 | \$72 | \$(48) |

■ State Funding
 ■ Federal Funding
 — Reinsurance Cost
 — Fund Balance End-of-Year

- Reflected in end-of-year balance, but not otherwise shown: **\$219M removed from state SRP fund for other programs** across FY21-25, and est. \$30M used for Young Adult Subsidy.
- Projections assume attachment point increases by \$500 each year starting in 2024 through 2028; enhanced federal subsidies end in 2025.

Reinsurance Cost and Funding Projections Through 2028: Attachment Point Up \$1,000/year 2024



| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
|--------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Federal Funding | \$373 | \$447 | \$475 | \$344 | \$439 | \$453 | \$476 | \$386 | \$404 | \$422 |
| State Funding | \$327 | \$119 | \$124 | \$131 | \$135 | \$140 | \$145 | \$150 | \$155 | \$161 |
| Reinsurance Cost | \$353 | \$400 | \$468 | \$520 | \$582 | \$615 | \$639 | \$626 | \$651 | \$677 |
| Fund Balance End-of-Year | \$347 | \$513 | \$544 | \$424 | \$374 | \$337 | \$304 | \$214 | \$123 | \$29 |

State Funding Federal Funding Reinsurance Cost Fund Balance End-of-Year

- Reflected in end-of-year balance, but not otherwise shown: **\$219M removed from state SRP fund for other programs** across FY21-25, and est. \$30M used for Young Adult Subsidy.
- Projections assume attachment point increases by \$500 each year starting in 2024 through 2028; enhanced federal subsidies end in 2025.

Considerations

- Program solvency
- Impact to individual market rates

| Attachment Point Change in 2024 | Estimated Rate Impact |
|---------------------------------|-----------------------|
| \$500 | 0.6% |
| \$1,000 | 1.2% |

- Impact to individual market enrollment
 - Projected 2024 impact of \$1000 attachment point increase compared to \$500 increase: decrease in average total market enrollment of 260 individuals (0.1%)

- Uncertainty
 - Program cost
 - Federal funding
 - Whether enhanced federal subsidies will end in 2025 (an extension would improve the solvency of the program)
- MIA, MHBE, and MHCC are developing a report to the legislature, due Dec 1, on program parameters, funding, and other items

Reinsurance Program Carrier Accountability Reports

- MHBE regulations require carriers to submit an annual report that describes activities to manage the costs and utilization of the enrollees whose claims were reimbursed by the SRP and efforts to contain costs, so enrollees do not exceed the reinsurance threshold
- The initial annual reports cover plan years (PYs) 2019-2021
 - CareFirst
 - Kaiser Permanente
 - United (2021 only)
- 2021 reports currently under review; some preliminary/draft findings presented in the following slides

Information Collected in Carrier Accountability Reports

- Initiatives to manage costs and utilization of enrollees whose claims were reimbursed by the SRP
- The total population of enrollees whose claims were reimbursed by the SRP, the allocation of these enrollees across each of the initiatives described above, and the allocation of enrollees who do not participate in these initiatives and programs
- The effectiveness of the initiatives and programs, as measured by the estimated reduction of claims and utilization
- The actions the carrier will take to improve effectiveness
- The estimated savings to the SRP based on the effectiveness of these initiatives
- The estimated rate impact of the initiatives
- The methodology used to determine which programs to include, their estimated effectiveness, and estimated savings
- Population health initiatives and outcomes

Targeted Conditions in Carrier Accountability Reports

- MHBE collected specific information on carrier initiatives targeting state population health goals including:
 - Diabetes
 - Behavioral health
 - Asthma
 - Pregnancy/Childbirth
- Also collected information about COVID-19 in PYs 2020-2021
- Reporting instructions and templates are available [here](#)

Summary of PY 2021 Care Management Initiatives

Asthma: None

Pregnancy: None

Behavioral Health

- CareFirst: Behavioral Health & Substance Use Disorder Care Management Program, PYs 2019-2021
- Kaiser Permanente: Depression Care Management Program, PYs 2020-2021

Diabetes

- CareFirst: Diabetes Care Management Program, PYs 2019-2021
- Kaiser Permanente:
 - Diabetes Care Management Program, PYs 2019-2020
 - Diabetes Educational Video Program, PY 2019
 - Diabetes Glucometer Program, PYs 2020-2021
 - Diabetes Messaging Program, PY 2021

United was new to the market/had limited enrollment in 2021 and had no care management initiatives meeting the reporting threshold of 300 or more enrollees. However, United has a behavioral health program focused on opioid use disorder and a broader Case Management Program that coordinates care for high-risk patients with chronic or acute health care needs.

Top 5 Most Frequent Hierarchical Condition Categories (HCCs) among SRP Claims

| PY 2019 | PY 2020 | PY 2021* |
|---|---|---|
| Cancers, including breast, prostate, lung brain, colorectal, and metastatic | Diabetes with and without complications | Diabetes with and without complications |
| HIV/AIDS | HIV/AIDS | HIV/AIDS |
| Diabetes with and without complications | Cancers, including breast, prostate, lung brain, colorectal, and metastatic | Cancers, including breast, prostate, lung brain, colorectal, and metastatic |
| Major Depressive and Bipolar Disorders | Congestive Heart Failure | Ongoing pregnancy without delivery with no or minor complications |
| End Stage Renal Disease | Asthma and COPD | *Preliminary Heart Failure |

- Diabetes, one of the state’s public health priorities, was among the 3 most frequent HCCs among SRP enrollees in all 3 years.
- HIV/AIDS and various cancers were also in the top 3 in each year.

Top 5 HCCs among SRP Claims by Total Allowed Claims

| PY 2019 | PY 2020 | PY 2021* |
|---|---|---|
| Cancers, including breast, prostate, lung brain, colorectal, and metastatic | Cancers, including breast, prostate, lung brain, colorectal, and metastatic | Cancers, including breast, prostate, lung brain, colorectal, and metastatic |
| Congestive Heart Failure | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock |
| Diabetes with and without complications | Respiratory Arrest, Failure, and Shock | Hemophilia |
| Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | Diabetes with and without complications | End Stage Renal Disease |
| Respiratory Arrest, Failure, and Shock | Congestive Heart Failure | Inflammatory Bowel Disease |

*Preliminary analysis

- Various cancers were the highest cost HCCs among SRP enrollees in all 3 years.
- Diabetes and Respiratory Arrest were in the top 5 in 2 out of 3 years
- Septicemia, sepsis, and systemic inflammatory response syndrome/shock were also among the top 5 in each year.

Summary of Next Steps

- 1. Feb. 21:** Board sets estimated 2024 reinsurance parameters to inform rate filings due May 22
- 2. February-March:** 30-day public comment period on estimated reinsurance parameters, excluding dampening factor
- 3. May:** Carriers submit 2022 and emerging 2023 claims data; MHBE and MIA analyze in May and June to recommend final 2024 reinsurance parameters
- 4. July:** Board sets final 2024 reinsurance parameters

Request to Approve 2024 Estimated State Reinsurance Program Parameters

MOTION: I move to [approve/defer/reject] the estimated parameters for the 2024 State Reinsurance Program [as presented] or [as amended], with:

- an attachment point of \$19,500,
- a coinsurance rate of 80%,
- a cap at \$250,000, and
- a dampening factor to be provided by the Insurance Commissioner.

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1332 Reinsurance Waiver Extension Application

Application Contents

1. Extension Request
 - 5 year waiver extension (2024-2028)
 - No substantive changes to the waiver conditions
2. Program Outcomes
3. Updated Economic or Actuarial Analysis for Extension Period
4. Evidence of Sufficient Authority Under State Law
5. Public Input

Appendix A: Actuarial and Economic Analysis for Continuation of Maryland's 1332 Waiver

Appendix B: MHBE 1332 Waiver Extension Application Public Hearing Presentation

Appendix C: Written Comments Received During Public Comment Period

Program Outcomes: First Waiver Period

Maryland has maintained compliance with the 1332 guardrails during the first waiver period:

| 1332 Waiver Guardrail | Estimated Waiver Impact |
|--|---|
| Comprehensiveness: Provide coverage that is at least as comprehensive as the coverage provided without the waiver | No impact |
| Affordability: Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver | Premiums reduced >30% in 2019-2023 compared to a scenario without reinsurance |
| Coverage: Provide coverage to at least a comparable number of residents as without the waiver | Increased enrollment by 6.4% per year, new insurer joined the market in 2021 |
| Federal Deficit: No increase to the federal deficit | 5-year federal saving of \$2.1B (expected to be passed through to MD) |

Program Outcomes: Comparison to Other States

Exhibit 5 – Impact of 1332 Waiver Versus Non-Waiver States

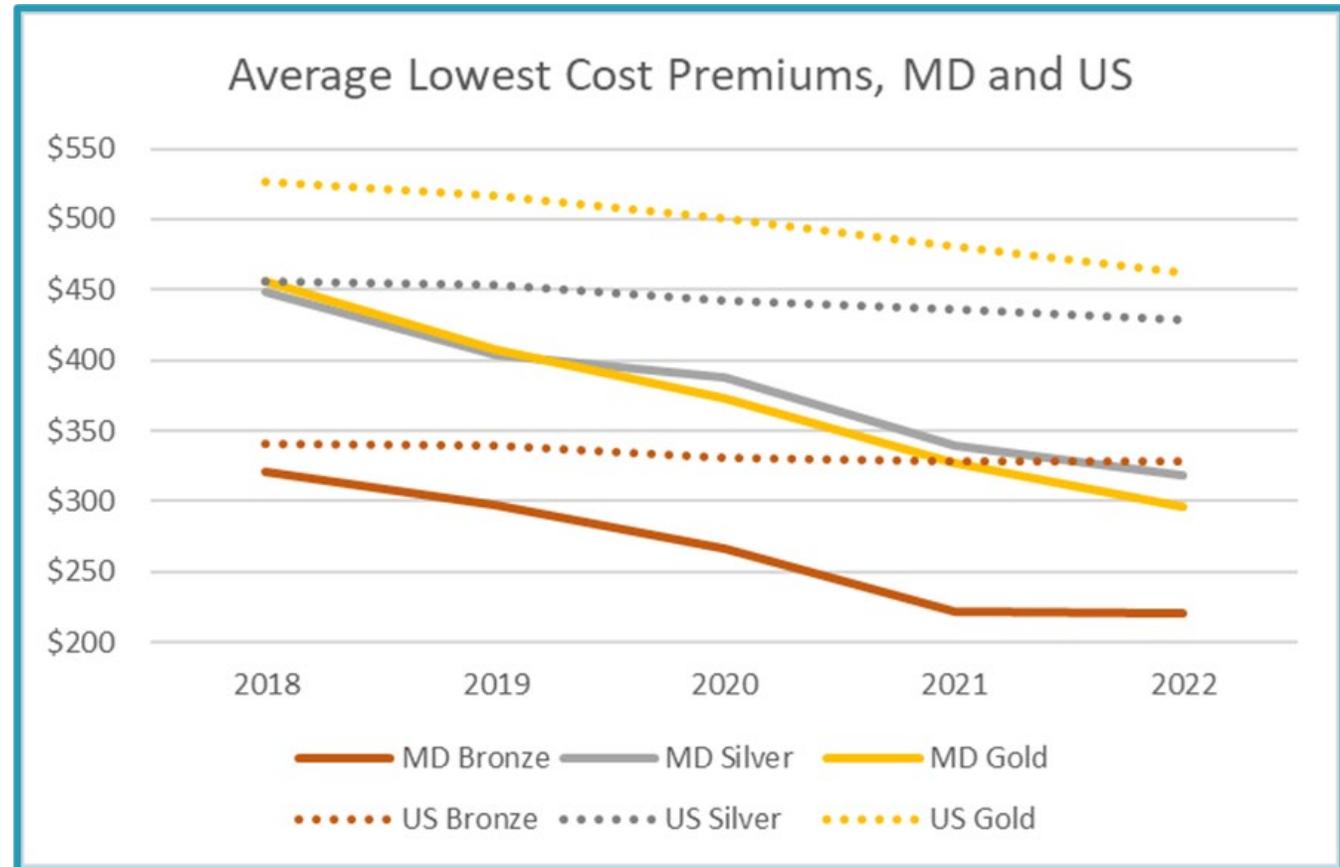
| | Premium Change 2018 - 2023 | | Individual Market Enrollment Change 2018 - 2021 | |
|--------------------------|-------------------------------|---------|--|---------|
| | Dollars | Percent | Member Months | Percent |
| Maryland | -\$151 | -31% | 344,617 | 15% |
| Comparison Group Average | \$11 | 2% | 89,646 | 3% |

Exhibit 6 – Impact of Maryland’s 1332 Waiver Versus other 1332 Waivers

| | Premium Change 2018 - 2023 | | Individual Market Enrollment Change 2018 - 2021 | |
|--------------------------|-------------------------------|---------|--|---------|
| | Dollars | Percent | Member Months | Percent |
| Maryland | -\$151 | -31% | 344,617 | 15% |
| Comparison Group Average | -\$60 | -13% | 126,999 | 8% |

Program Outcomes: Premium Detail

- Premiums are down more than 25% compared to 2018.
- Maryland's lowest cost plans are about 25-30% below US averages

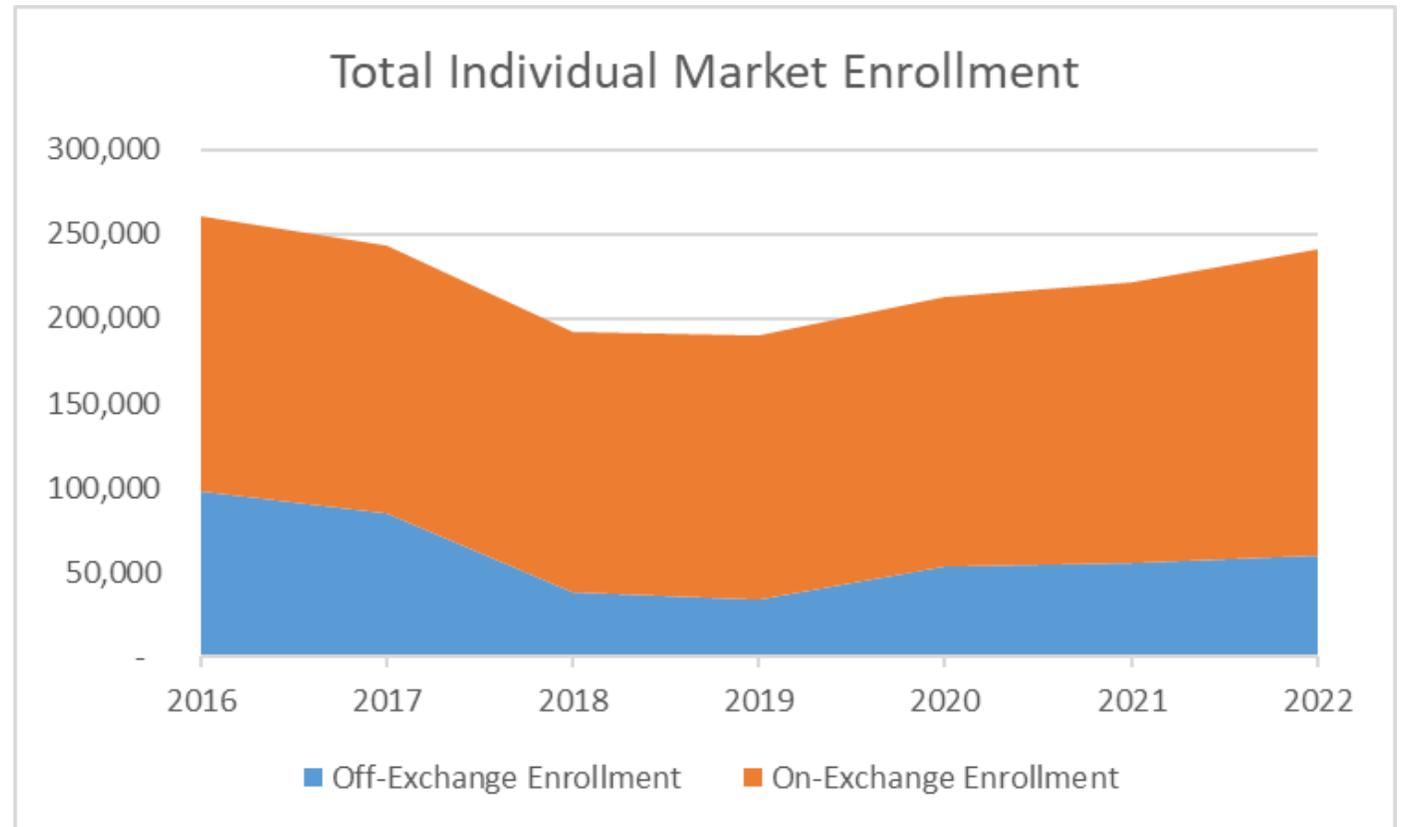


Data source: Kaiser Family Foundation, <https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier>

Program Outcomes: Enrollment Detail

Between June 2019 and June 2022:

- On-exchange enrollment is up 25%
- Total individual market enrollment (on- and off-exchange) is up 22%.



Total market enrollment data from MIA, data as of 3/31 for 2016, 2017, and 2022, as of 6/30 for 2018, 2020, and 2021, and as of 7/31 for 2019. On-exchange data from MHBE as of the end of open enrollment for each plan year. Off-exchange enrollment calculated as total enrollment minus on-exchange enrollment.

Program Outcomes: Second Waiver Period

Maryland anticipates continued compliance with the Section 1332 guardrails in the second waiver period.

| 1332 Waiver Guardrail | Estimated Waiver Impact |
|--|---|
| Comprehensiveness: Provide coverage that is at least as comprehensive as the coverage provided without the waiver | No impact |
| Affordability: Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver | Premium reduction of 34% compared to a scenario without reinsurance |
| Coverage: Provide coverage to at least a comparable number of residents as without the waiver | Increase enrollment by 6.4% |
| Federal Deficit: No increase to the federal deficit | 5-year federal saving of \$2.2B (expected to be passed through to MD) |

Waiver Extension Timeline

The section 1332 waiver extension request should be submitted **within the first quarter of the year** leading up to the initial waiver's end date. The federal government will approve or deny the extension request **within 90 days** of receipt.

| COMPLETED ACTIVITIES FOR 1332 WAIVER EXTENSION REQUEST | |
|---|--|
| Fall 2022 | MHBE staff draft letter of intent |
| November 2022 | MHBE Board authorizes MHBE to submit letter of intent to the federal government |
| December 2022 | MHBE submits letter of intent to the federal government |
| February 2022 | MHBE holds public hearing on waiver extension application 2/15/23 Written public comments accepted February 7 - March 7 |
| REMAINING ACTIVITIES FOR 1332 WAIVER EXTENSION REQUEST | |
| March 2023 | MHBE submits waiver application to the federal government |
| March-June 2023 | MHBE works with CMS to get application approved |
| <u>January 1, 2024</u> | New 5-year waiver period begins |

Request for Approval to Submit Extension Application

MOTION: I move to [approve/defer/reject] submission of the 1332 Reinsurance Waiver Extension Application to the U.S. Departments of Health and Human Services and Treasury following the end of the public comment period on March 7, 2023 [as presented] *or* [as amended].

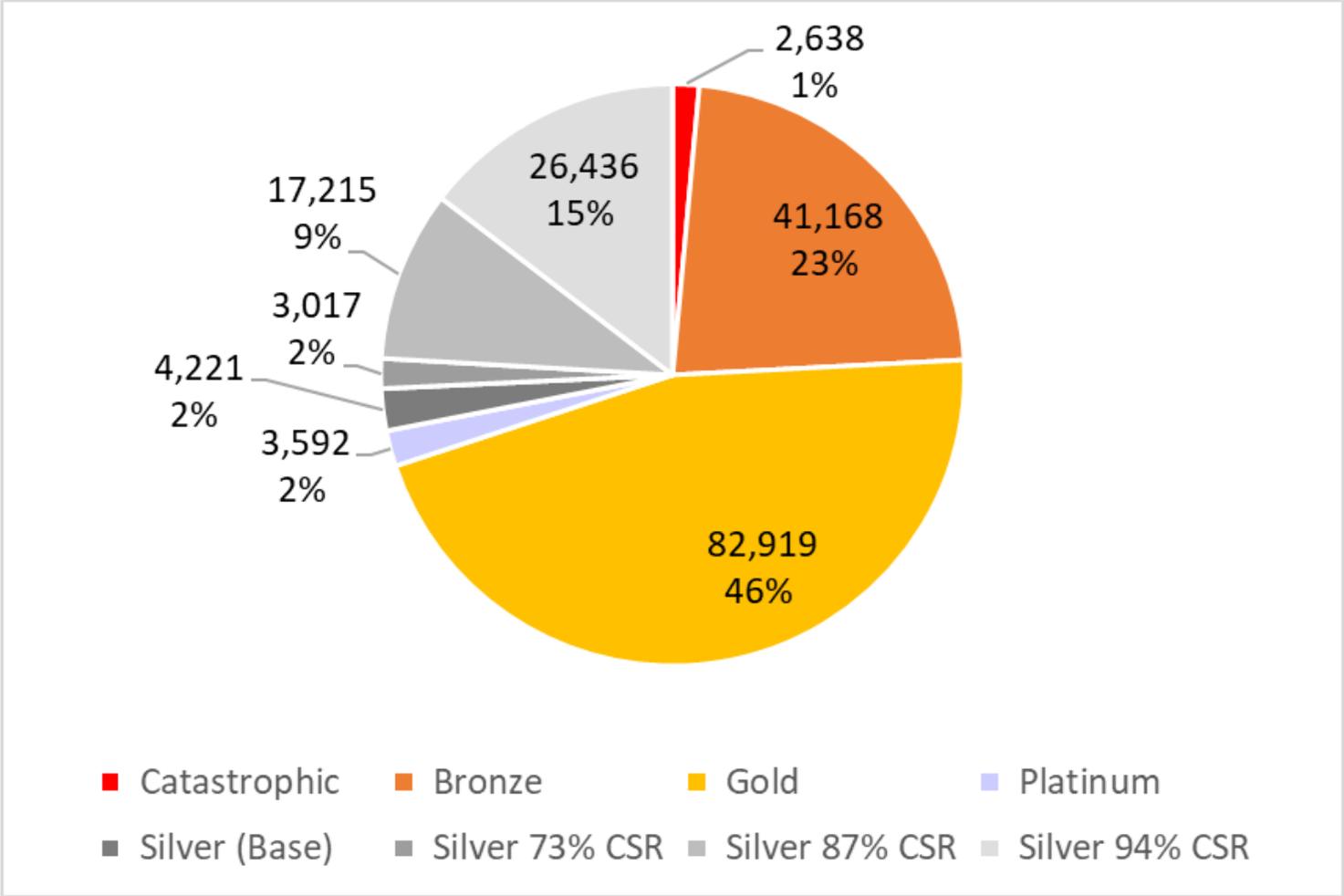
Appendix



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) |

Total MHC Enrollment by Metal Level, 2022



Enrollment data as of January 31, 2022.

Public Comments on 2024 Value Plan Standards (1/2)

| Commenter | Comment | MHBE Response |
|-------------------|---|---|
| Kaiser Permanente | Is the Rx MOOP different for a family plan? | The deductibles and MOOPs shown are for a self-only plan. For a family plan, each member has an individual medical and Rx deductible and MOOP of the amount shown. An individual family member cannot contribute more than the self-only deductible or MOOP toward meeting the family deductible or MOOP. The family has a total medical and Rx deductible and MOOP that is twice the amount shown for a self-only plan. Once the family deductible or MOOP has been met, this satisfies the deductible or MOOP for all family members. |
| United | How can carriers demonstrate compliance with federal mental health parity requirements in the bronze plan design? | Carriers can subclassify outpatient office visits and all other outpatient services when performing the parity analysis for outpatient services. The list of covered services has been updated to show these as two service categories with \$0 applied to all mental health and substance use disorder outpatient services other than office visits. |
| CareFirst | Integrate MOOP on silver plans to further the long term viability of the designs | Separate medical/drug MOOPs are consumer-friendly; will revisit AV compliance in future years as necessary |

Public Comments on 2024 Value Plan Standards (2/2)

| Commenter | Comment | MHBE Response |
|-----------|---|--|
| CareFirst | Lower the outpatient surgery physician copays on the 87% and 94% Silver CSR plans so they are less than or equal to physician fee, consistent with other plan designs. Offset AV impact by increasing medical MOOP by and, on the 94% plan, lab copays. | Will consider adjusting the outpatient surgery physician copays in future years |
| CareFirst | Increase the ER copay on the 87% and 94% Silver CSR plans. They are low compared to the Inpatient Hospital Services copay and Imaging copay and are inconsistent compared to the other plan designs. | Increasing the ER copays on these plans does not reduce the AV, so this would negatively impact the consumer without yielding any benefit (i.e., additional flexibility) from an AV standpoint. However, we will consider this feedback in future years. |
| Various | Technical questions | Clarifications provided as needed |