MARYLAND HEALTH BENEFIT EXCHANGE

# Joint Chairmen's Report:

## Reinsurance Program Costs and Forecast

**Maryland Health Benefit Exchange**

September 30, 2025

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## I. Introduction

The 2025 Joint Chairmen's Report on the Fiscal 2024 State Operating Budget (SB 350) and the State Capital Budget (SB 351) and Related Recommendations[1] requests that the Maryland Health Benefit Exchange (MHBE) provide a report on the State Reinsurance Program (SRP) costs and future spending. Specifically, MHBE is requested to provide for the reinsurance program:

> "a report that provides an updated forecast of spending and funding needs."

The purpose of the SRP is to mitigate the premium impact of high-cost enrollees in the individual market. The SRP has been highly successful, having reduced rates significantly and provided relief for Marylanders who experienced significant premium increases in the years before the SRP took effect.

## II. Background

During the 2018 legislative session, the Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program (HB 1795), which was then signed into law by Gov. Larry Hogan on April 5, 2018. HB 1795 was an emergency measure that directed the Maryland Health Benefit Exchange to submit a Section 1332 State Innovation Waiver to the U.S. Secretaries of Health and Human Services (HHS) and the Treasury to establish a State Reinsurance Program.

Senate Bill 387, Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018) (Ch. 37, Acts 2108), also passed during the 2018 session. It created a new § 6-102.1 of the Insurance Article and established a health plan assessment to be collected in 2019 to help fund the SRP. Section 9010 of the Affordable Care Act (ACA) created a federal health insurance provider fee ("9010 fee") for covered entities engaged in the business of providing health insurance. The 9010 fee was based on the entity's net premiums for the year and was estimated at about 2.75% to 3%.[2] The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019. SB 387 applied a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state and allows the state to collect certain funds that the federal government would have collected under Section 9010.

On May 18, 2018, the MHBE submitted an application to HHS to waive Section 1312(c)(1) of the ACA for a period of five years to implement the SRP. The waiver proposed to cover plan years 2019 through 2023 and allow Maryland to include

[1] Available at https://dls.maryland.gov/pubs/prod/RecurRpt/Joint-Chairmens-Report_2025.pdf.
[2] Levitis, Jason. Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee. State Health and Value Strategies. Jan 30, 2020. https://www.shvs.org/considerations-for-a-state-health-insurer-fee-following-repeal-of-the-federal-9010-fee/

expected state reinsurance payments when establishing the market wide index rate, decreasing premiums and federal payments of advance premium tax credits (APTCs).

MHBE proposed that the SRP would operate as a traditional, claims-based reinsurance program that reimburses qualifying health insurers for a percentage of an enrollee's claims between an attachment point and cap. For plan year 2019, Maryland implemented a cap of $250,000, a coinsurance rate of 80 percent, and an attachment point of $20,000.

On August 22, 2018, the Centers for Medicare and Medicaid Services (CMS), on behalf of HHS and the Department of the Treasury ("the Departments"), approved Maryland's State Innovation waiver for a period of January 1, 2019 through December 31, 2023.[3]

During the 2019 Session, House Bill 258/Senate Bill 239 was passed to establish a state-based health insurance provider assessment of 1% to fund the SRP through 2023. In 2020, the U.S. Congress enacted the Further Consolidated Appropriations Act, which repealed the federal 9010 fee for calendar years beginning after December 31, 2020. Consequently, the General Assembly passed a technical correction to the applicability of the assessment (Senate Bill 124 of 2020, Maryland Health Benefit Exchange – Assessment Applicability and State–Based Individual Market Health Insurance Subsidies) to remove the language from House Bill 258/Senate Bill 239 that attached Maryland's assessment to the now repealed 9010 fee and to ensure that the state-based health insurance provider assessment continued to apply as intended.

During the 2022 Session, House Bill 413/Senate Bill 395 was passed to extend the 1% health insurance provider assessment through calendar year 2028, in order to facilitate the state's application to the federal government to extend the SRP for a second 5-year waiver period, through 2028, and to provide state reinsurance funds to support the SRP during that time. The legislation also tasked the Maryland Insurance Administration, in consultation with MHBE and the Maryland Health Care Commission, with submitting a report to the General Assembly by December 1, 2023 on the impact of the SRP, including the adequacy and appropriateness of the 1% assessment, the SRP's program design, and market reforms needed to provide affordable health coverage in the individual market.

On June 28, 2023, the Departments approved MHBE's application to extend the 1332 State Innovation Waiver authorizing the SRP for an additional five-year period, through December 31, 2028.

During the 2024 Session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all otherwise-qualified residents to enroll on-Exchange, regardless of immigration status (a

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf

waiver of section 1312(f)(3) of the Affordable Care Act. On July 15, 2024, MHBE applied to the Departments to amend Maryland's 1332 Waiver.[4] The Departments determined the application complete on August 22, 2024[5] and approved MHBE's request on January 15, 2025.[6] After the approval of the waiver amendment, CMS proposed and finalized the Marketplace Integrity and Affordability Final Rule (June 25, 2025)[7] and on July 4, 2025, the President signed House Resolution 1,[8] both of which change eligibility rules for both Medicaid and Marketplace plans and require states to implement significant changes to Exchange systems and operations. MHBE will be involved in implementation for both Marketplace and Medicaid changes as Maryland has an integrated eligibility system. Due to these unforeseen obligations, MHBE is working with CMS to update the implementation plan for the waiver amendment.

During the 2025 Session, the Maryland General Assembly passed House Bill (HB) 1082 requiring MHBE to implement a new State-Based Subsidy program to address the anticipated loss at the end of 2025 of the enhanced federal tax credits authorized under the American Rescue Plan Act and extended by the Inflation Reduction Act. The bill contains language that MHBE is only required to implement the new subsidy if Congress fails to extend the enhanced federal tax credits. HB1082 requires MHBE to use the SRP Fund to pay for the new subsidy program.

On August 18, 2025, the MHBE Board of Trustees finalized the 2026 SRP parameters of an attachment point of $24,000, coinsurance rate of 80%, cap of $250,000, and a dampening factor to be determined by the Insurance Commissioner. The Board finalized a higher attachment point than the estimated $22,000 that it approved in February to ensure an effective level of funding for both the new State-Based Subsidy program pursuant to HB1082 and the SRP itself.

[4] Maryland's 1332 Waiver Amendment Application can be accessed at https://www.marylandhbe.com/wp-content/uploads/2024/08/MD-1332-Waiver-Amendment-Request-FINAL-w-updated-exhibits.pdf.
[5] The Departments' August 22, 2024 Determination of Completeness Letter to Maryland can be accessed at https://www.cms.gov/files/document/1332-md-amendment-completeness-letterfinal.pdf.
[6] The Departments' January 15, 2025 Letter including Specific Terms and Conditions for Maryland's Amended 1332 Waiver https://www.cms.gov/files/document/1332-md-waiver-amendment-approval-letter-stcs-signed.pdf
[7] https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability
[8] https://www.congress.gov/bill/119th-congress/house-bill/1

## III. Impact of the State Reinsurance Program

The SRP continues to stabilize the individual market: premiums are down, enrollment is up, and twice as many carriers participate on the individual market as before the program launched.

| Plan Year | Average Individual Market Premium Change |
|---|---|
| 2014 | n/a |
| 2015 | 10% |
| 2016 | 18% |
| 2017 | 21% |
| 2018 | 28% |
| **2019** | **-13%** |
| 2020 | -10% |
| 2021 | -12% |
| 2022 | 2.1% |
| 2023 | 6.6% |
| 2024 | 4.7% |
| 2025 | 6.2% |
| 2026 | 13.4 |

The SRP was designed to reduce rates by 30% in three years and, thereafter, to align future rate increases with increases in claim and cost trends. The program has performed as expected or better. Individual market rates fell more than 30% from 2019-2021. For the following four years, increases were in the single-digits and consistent with claim trends. Average premiums for 2026 increased by 13.4% for unsubsidized members.[9] The expiration of the enhanced subsidies was projected to increase rates by 68% for those who are receiving subsidies.[10] Healthier enrollees are likelier to drop coverage than those who are sicker, resulting in a more expensive risk pool and higher overall premiums.

Prior to implementation of the SRP, on-exchange enrollment had declined in 2017 and 2018 by 3.1% and 2.6%, respectively, while total individual market enrollment declined by 15.0% and 14.9%. In contrast, enrollment has increased significantly since the inception of the program. As of July 2025, on-exchange enrollment is up 70% compared to July 2019.[11] Looking more broadly at both on- and off-exchange individual market enrollment, we also see substantial gains, with total individual market enrollment up 54% since 2019.[12] Although multiple factors have contributed to on-exchange enrollment increases, including the Tax Time Easy Enrollment Program beginning in 2020, the COVID-19 special enrollment period in place from March 2020 through August 2021, the enhanced federal premium subsidies launched in April 2021 under the American Rescue Plan Act, the Unemployment Easy Enrollment Program that launched in 2022, and the unwinding of the Medicaid continuous coverage requirement in 2023-2024, the SRP's reduction in baseline health insurance premiums has made purchasing health insurance more attainable. Without the reinsurance program, premiums would be an estimated 30 to 35 percent higher.[13]

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[9] https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2025381

[10] MHBE internal projections.

[11] Maryland Health Connection Data Reports, July 31, 2019, and July 31, 2024. Enrollment increased from 136,397 to 216,116. Data available at https://www.marylandhbe.com/wp-content/uploads/2024/08/Executive-Report-as-of-07.31.24.pdf and https://www.marylandhbe.com/wp-content/uploads/2019/09/Executive-Report_07_31_2019.pdf.

[12] Enrollment increased from 190,480 in 2019 to 294,189 in 2025. https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2019221 ; https://insurance.maryland.gov/Documents/newscenter/newsreleases/2026-ACA-Press-Release-Approved-Rates-with-exhibits.pdf.

[13] https://insurance.maryland.gov/Documents/newscenter/newsreleases/2026-ACA-Press-Release-Approved-Rates-with-exhibits.pdf.

Several carriers began participating on MHC since the inception of the program, indicating growing carrier confidence in the Maryland individual market as a result of the SRP. Wellpoint Maryland, Inc. joined the individual market for plan year 2025 and will continue for plan year 2026. Wellpoint's entrance followed Aetna Health, Inc's entrance to the market for plan year 2024. After two years offering plans on MHC, Aetna Health Inc. is exiting the Individual Market but this change is not unique to Maryland, as Aetna is exiting the Individual market in all states in which they operated.[14] UnitedHealthcare reentered the individual market in 2021, the first year with an increase in the number of individual market carriers since 2015. Wellpoint, UnitedHealthcare, and CareFirst all offer plans statewide as of PY2026, meaning that individual market enrollees in all counties have at least three carriers from which to choose.

*Table 5: MHBE On-Exchange Summary Data, 2014-2025*

| Benefit Year | Participating carriers (#) | Enrollment[15] | Subsidized/ Unsubsidized (%)[16] | Average Premium Change (%) |
|---|---|---|---|---|
| 2014 | 4 | 81,553 | 80/20 | - |
| 2015 | 5 | 131,974 | 70/30 | 10% |
| 2016 | 5 | 162,652 | 70/30 | 18% |
| 2017 | 3 | 157,637 | 78/22 | 21% |
| 2018 | 2 | 153,571 | 79/21 | 50% |
| 2019 | 2 | 156,963 | 77/23 | -13% |
| 2020 | 2 | 158,934 | 76/24 | -10% |
| 2021 | 3 | 166,038 | 73/27 | -12% |
| 2022 | 3 | 181,206 | 79/21 | 2% |
| 2023 | 3 | 180,958 | 76/24 | 6.6% |
| 2024 | 4 | 214,892 | 77/23 | 4.7% |
| 2025 | 5 | 249,603 | 77/23 | 6.2% |
| 2026 | 4 | TBD | TBD | 13.4% |

[14] Min, Penny, "Aetna Drops Out of ACA Exchange In 2026—Here's How It Could Affect You," *Forbes,* July 15, 2025, https://www.forbes.com/advisor/d/aetna-exit-aca-2026-impact/.
[15] Enrollment reported as of the end of open enrollment preceding the applicable plan year.
[16] The American Rescue Plan Act removed the 400% federal poverty limit cap on eligibility for federal premium subsidies, leading to an increase in the percent of enrollees receiving subsidies in 2022 and beyond.

## IV. Program Costs for Plan Year 2024

### *A. 2024 Program Spending and Funding*

In October 2024, MHBE's actuarial contractors Lewis & Ellis projected total program costs for 2024 of approximately $598 million.[17] Actual program costs for 2024, finalized in July 2025, consisted of approximately $638,938,397.86 in payments to carriers (approximately 6.8% higher than projected in 2024) and $68,356.25 in program administration.[18]

On May 23, 2024, HHS notified the MHBE that the Department of the Treasury's final administrative determination for pass through funding would be $526,747,454 for calendar year 2024.[19] The 2024 health insurance provider assessment of 1% collected $141,228,355 for the state reinsurance fund. Spending and funding numbers for 2024 are presented below in Table 2 and additional detail on spending is provided in Table 3.

[17] In August 2019, the MHBE contracted with Lewis & Ellis, Inc. to provide ongoing actuarial analysis to inform administration of the SRP. Lewis & Ellis updates SRP spending and funding forecasts at least annually, using updated data and assumptions.

[18] Federal pass-through funding may be used to cover program administration costs.

[19] Maryland 2024 Pass-Through Funding Letter. May 23, 2024. https://www.cms.gov/files/document/1332-md-2024-ptf-letters.pdf.

*Table 6: 2024 SRP Payments to Carriers, Federal Funding, Individual Market Enrollment, and Average Premium*

| Total Payments to Carriers | Total Federal Funding | Total Individual Market Enrollment[20] | Average Individual Market Premium PMPM[21] |
|---|---|---|---|
| $638,938,397.86 | $526,747,454 | 271,126 | $467 |

*Table 7: 2024 SRP Cost and Funding Breakdown*

| Spending | Value | Comments |
|---|---|---|
| Total spent on individual claims payment to issuers | **$638,938,397.86** | |
| CareFirst BlueChoice, Inc. | $336,833,863.79 | |
| CareFirst of Maryland, Inc. | $71,042,240.13 | |
| GHMSI | $55,482,484.52 | |
| Kaiser Foundation Health Plan, Mid-Atlantic, Inc. | $84,972,089.97 | |
| Optimum Choice, Inc. | $85,542,731.27 | |
| Aetna Health Inc. | $5,064,988.20 | |
| Amount of funding spent on operation of the reinsurance program | $68,356.25 | CMS EDGE server fee: $8,000<br>Actuarial fees: $60,356.25 |
| Total Spending | $639,006,754.11 | Claims payment to issuers plus operational cost |
| 2024 Federal Funding | $526,747,454 | |
| Federal Funding Carried Over from Previous Years Spent on 2024 Claims | $0.00 | |
| Amount from the state reinsurance fund needed to fully fund the program for the reporting year | $112,259,300.11 | |
| Amount of any unspent balance of Federal pass-through funding for the reporting year | $0.00 | |

[20] 2024 total individual market enrollment calculated by MHBE as the 2024 individual market member-months reported in the 2024 Reinsurance Summary Report provided by CMS to MHBE, divided by 12.
[21] 2024 average individual market premium PMPM was calculated by MHBE using the 2024 total individual market premium and 2024 individual market member-months reported in the 2024 Reinsurance Summary Report provided by CMS to MHBE.

## V. Program Forecast

### *A. Projected Program Spending and Projected Federal Funding*

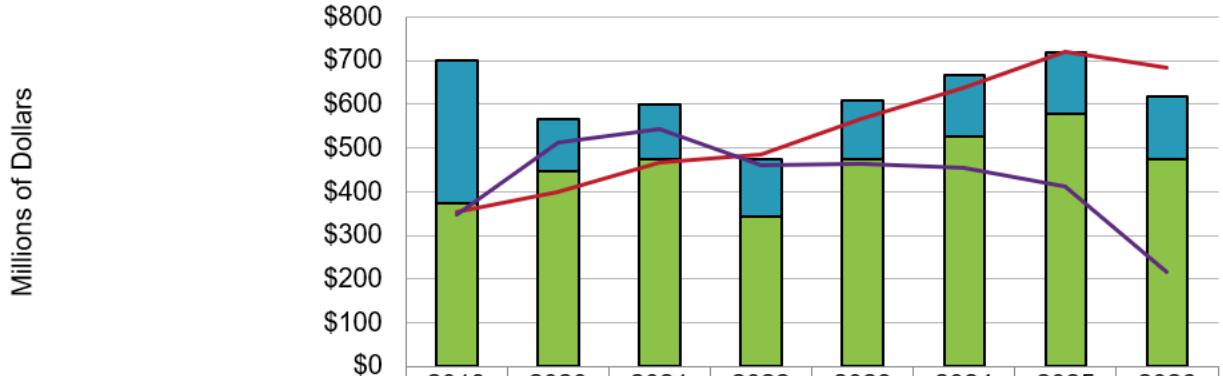
Projections illustrate that the size of the SRP Fund in 2026 and beyond depends on the expiration (or possible extension) of enhanced federal tax credits. Federal funds were sufficient to cover the costs of the SRP for the first three years of the program and in 2023 and 2024, allowing MHBE to save funds from the state-based health insurance provider assessment and any remaining federal funds in the SRP fund. Assuming the ARPA-enhanced tax credits expire, federal pass-through funding is projected to reduce significantly in 2026 and through the end of the waiver period in 2028. In those years, MHBE will need to draw down on reserves to cover program costs as it did in 2022. Extension of the federal subsidies past 2025 would significantly strengthen the financial outlook but is very uncertain.

Due to the HB1082 State-Based Subsidy Program sharing a funding source with the SRP, the SRP fund balance in each year 2026 through 2028 (the end of the current waiver period) will depend on that year's subsidy parameters. On August 18, 2025, the MHBE Board of Trustees voted to finalize 2026 State-Based Subsidy parameters, which include a 100% replacement of lost enhanced federal tax credits for enrollees with incomes up to 200% of the federal poverty level (FPL), a phasing down of the replacement between 200 and 250% FPL from 100% to 50% replacement, and 50% replacement for those 250-400% FPL. Young adults will also continue to receive extra help towards their premiums in 2026. To ensure SRP fund solvency, these parameters also include increasing the SRP attachment point to $24,000 in 2026. This first year of the subsidy is projected to require an initial outlay of $131 million, but because it will retain enrollment of individuals receiving APTC compared to a scenario without the subsidy, Maryland will receive passthrough funding through the SRP for this population, leading to an estimated net cost of $73 million. More details on the PY2026 State-Based Subsidy Parameters can be found in the presentation from the August 18, 2025 meeting of the MHBE Board of Trustees.[22]

Table 4 below presents SRP and State-Based Subsidy spending and funding projections through 2026, the latest year for which the Board has finalized parameters for the SRP and for the State-Based Subsidy program. MHBE will evaluate emerging 2026 experience to inform program design decisions in summer 2026 for plan year 2027.

[22] https://www.marylandhbe.com/wp-content/uploads/2025/08/2026-State-Subsidy-and-Reinsurance-Parameters-8-18-25.pdf

*Table 8: Projected SRP Fund Spending and Funding Considering Final 2026 State-Based Subsidy Parameters and Enhanced Federal Premium Subsidies Expiring at the End of 2025, 2019-2026 (in millions)**




| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|
| State Funding | $327 | $119 | $124 | $131 | $137 | $141 | $142 | $144 |
| Federal Funding | $373 | $447 | $475 | $344 | $473 | $527 | $578 | $474 |
| Reinsurance Cost | $353 | $400 | $468 | $485 | $568 | $639 | $719 | $683 |
| Fund Balance End-of-Year | $347 | $513 | $544 | $459 | $465 | $454 | $412 | $217 |

*Projections assume that enhanced federal funding under ARPA will expire at the end of 2025. State-Based Subsidy costs are factored into the End-of-Year Fund Balance.

MHBE asked Lewis & Ellis to model scenarios that include some level of state subsidy in 2026 through 2028 to mitigate enrollment losses as much as possible, although HB1082 requires a subsidy only in 2026-2027 and further legislation would be required to extend MHBE's authority for the subsidy program in 2028. Slides 22 and 23 of the August 18, 2025 MHBE Board of Trustees presentation show sample subsidy parameters for 2027 and 2028 that maintain a positive end-of-year SRP fund balance.[23] In general, projections indicate that accelerated attachment point increases and a reduction in the State-Based Subsidy will likely be necessary for 2027 and 2028 in order to operate within available funds. However, projections confirm that the best strategy to mitigate enrollment loss is to offer the greatest market support in 2026 and phase out the support in following years, as opposed to a design that offers less support in 2026 but maintains the same level of support across program years.

i. Program Expenditures

Program costs continue to grow in 2024 and 2025 due to increasing enrollment in the individual market and medical trend. In 2026 and beyond, costs are projected to decline due to an expected decrease in enrollment after the expiration of enhanced federal tax credits at the end of 2025.

[23] https://www.marylandhbe.com/wp-content/uploads/2025/08/2026-State-Subsidy-and-Reinsurance-Parameters-8-18-25.pdf

Any reduction in cost due to the accelerated increase in the SRP attachment point in PY2026 (and anticipated for 2027-2028 as well) will, as intended, be largely offset by the new State-Based Subsidy program. Maryland has historically maintained a low attachment point, even reducing it to $18,500 for 2023 from $20,000 in prior years.[24] Costs continued to rise in 2024, despite a return to a $20,000 attachment point, and are projected to rise again in 2025 despite an increase to a $21,000 attachment point, before falling in 2026

2025's HB1082 does not earmark a specific amount from the SRP fund to be spent on a new State-Based Subsidy program, but based on the final PY2026 parameters, MHBE projects that the new program will cost an initial $131 million with an estimated net cost of $73 million after factoring in an increase in federal passthrough funding as noted previously. Additionally, during the 2021 legislative session, a significant amount of funding was withdrawn from the state reinsurance fund or earmarked for future withdrawals to support other state initiatives. Note that these initiatives may only be funded through the state funding generated by the state-based health insurance provider assessment; federal pass-through funding may not be used for programs other than the SRP. The state reinsurance program funding dedicated to other state initiatives includes $100M in FY 21 and $50M (reduced from a previously planned $100M) in FY 22 to support the Medicaid program, a total of $80M across five fiscal years 2022-2026 (plan years 2022-2025) to support the state young adult subsidy program, $15M per year in FY 23-25 to support health equity resource zone grants, $8M per year for FY 23 and FY 24 for the Community Health Resources Commission (CHRC), and $1.9M in FY 22 for the Senior Prescription Drug Affordability Program, for a total reduction in state funding of $247.9M through FY 26.

ii. Program Funding

The American Rescue Plan Act increased federal premium subsidies for 2021 and 2022, and the Inflation Reduction Act passed in August 2022 extended the enhanced federal premium subsidies through 2025. This extension increased federal pass-through funding in 2023-2025 relative to a scenario in which the enhanced subsidies had not been extended. From 2021 to 2022, we saw a 27% reduction in federal funding, down from approximately $475M in 2021 to $344M in 2022, primarily due to the impact of a third carrier entering the individual market statewide, which lowered premium tax credit spending by the federal government and affected the blend of carrier assumptions regarding the impact of the SRP on rates. In 2023, federal funding increased to approximately $473M, 7.8% more than projected, and in 2024, federal funding increased to about $527M (an increase of 11.4% from 2023 and 11.1% higher than projected), due to the impact of ARPA. In 2025, federal funding increased still more, to $578M (9.6% higher than in 2024 and 5% higher than projected). However, we expect to see federal funding decline steeply in 2026 if the enhanced federal premium subsidies are not extended.

[24] The impact of the reduced attachment point was offset by a $50 million reduction in state reinsurance funds that had been slated to be transferred to Medicaid but instead remained in the state reinsurance fund.

The projected state reinsurance funding generated by the state-based health insurance provider assessment increased slightly in 2024 compared to 2023. The assessment totaled approximately $141.2 million in 2024, slightly less than the $146 million that was projected but more than the $137 million collected in 2023. The assessment is projected to collect approximately $141.5 million in 2025. The federal terms and conditions of the State Innovation Waiver, in the section titled “Legislation Authorizing and Appropriating Funds to the reinsurance program,” state that “the MHBE must ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in the MHBE's waiver application.” The 2019 and 2020-2028 health insurance provider assessment ensures that Maryland has consistent funding to support the SRP and allows Maryland to access the federal pass-through funding that undergirds the SRP. Any unspent federal funds or state reinsurance funds can be rolled forward to support the SRP in future years.

*Table 5: SRP Financial Overview, Plan Years 2019-2026 (millions)*

| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|---|
| SRP Cost | $353 | $400 | $468 | $485 | $568 | $639 | $719 | $683 |
| MA Budget Transfer | | | $100 | $50 | | | | |
| Young Adult Subsidy | | | | $15 | $13.5 | $24.5 | $26 | |
| Health Equity Grants | | | | | $15 | $15 | $15 | |
| Community Health Resources Commission | | | | $8 | $8 | | | |
| Senior Prescription Drug Affordability Program | | | | $1.9 | | | | |
| Federal Funding | $374 | $447 | $475 | $344 | $473 | $527 | $578 | $474 |
| State Funding | $327 | $118 | $124 | $131 | $137 | $141 | $142 | $144 |
| Approx. End of Year Balance – Fed. | $20 | $67 | $75 | $0 | $0 | $0 | $0 | $0 |
| Approx. End of Year Balance - State Reinsurance Fund | $327 | $445 | $469 | $459 | $465 | $454 | $412 | $217 |

*End of year balances may not sum due to rounding and nominal administrative costs are not shown. Additionally, the financial overview presented assumes that the enhanced APTCs established by the American Rescue Plan Act expire at the end of 2025.*

## VI. Carrier Accountability Reporting

MHBE regulations require all carriers participating in the SRP to submit an annual report that describes carrier activities to manage the costs and utilization of the enrollees whose claims were reimbursed by the SRP, as well as efforts to contain costs so enrollees do not exceed the reinsurance threshold.[25] The third year of data under this requirement was collected in 2024, for plan year 2023. A report summarizing key findings, as well as the carriers' data submissions, are available on the MHBE website.[26] Background and highlights from plan year 2023 are summarized below. MHBE is in the process of collecting the sixth year of reports, for plan year 2024.

### *A. Reporting Overview*

MHBE collected data from carriers on the following items:

- The initiatives and programs the carrier administers to manage costs and utilization of enrollees whose claims are reimbursable under the SRP;
- The total population of enrollees whose claims are reimbursable under the SRP, the allocation of these enrollees across each of the initiatives and programs 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, and actions the carrier will take to improve on the effectiveness;
- Estimated savings to the SRP and estimated rate impact due to these programs and initiatives, and the methodology used to make these estimates; and
- Population health initiatives and outcomes for individual market enrollment.[27]

MHBE asked carriers to report on targeted initiatives addressing diabetes, behavioral health, asthma, heart disease, and pregnancy/childbirth, as well as health outcomes addressing these conditions. These conditions were chosen to align with state population health goals and because they can have preventable costs. In order to protect patient privacy, carriers were asked to report on initiatives that served 300 or more total individual market enrollees.

### *B. Key Findings*

The table below lists the most prevalent and costly Hierarchical Condition Categories (HCCs) among the claims reimbursed by the SRP, according to data reported by the carriers. HCCs are groupings of related diagnoses that are used by the federal risk

[25] COMAR 14.35.17.03(C)
[26] https://www.marylandhbe.com/policy/reinsurance-program/
[27] Reporting instructions are available here and a corresponding reporting template is available here.

adjustment program and are a way to classify diagnosis codes into meaningful categories. Table 6 presents, in descending order, the most frequently occurring and the highest cost HCCs among SRP claims across both carriers. MHBE notes that the top HCCs reimbursed by the SRP include conditions of state population health interest—diabetes, asthma, behavioral health, heart disease, and pregnancy.

Diabetes (with or without complications) was the most frequent HCC in PYs 2021 and 2022, while various forms of cancers were the most frequent in PY 2023 as well as the highest cost HCC in all three years. HIV/AIDS was the second most frequent HCC in PY 2021 but was not among the top five most frequent in the two subsequent years, a marked change from PYs 2019 and 2020, when it was the second most frequent HCC (HCCs for PY 2019 and 2020 not shown here). Ongoing pregnancy without delivery with no or minor complications and major depressive disorder (severe) and bipolar disorders were the second and third most frequently billed HCCs in PY 2022, then switched positions in the PY 2023 ranking. The HCC covering septicemia and related conditions was the second highest cost HCC for the fourth straight year (PY 2020 not shown), while hemophilia was the third most costly HCC in PY 2021 and the fourth most costly HCC in PY 2022. Heart failure was the only other HCC among the top five most costly in more than one year. Diabetes was the third most costly HCC in PY 2023 after not ranking among the top 10 in either of the previous years. The MHBE notes that the top HCCs reimbursed by the SRP include the conditions of state population health interest—diabetes, asthma, behavioral health, heart disease, and pregnancy. These are highlighted in light blue in the table.

*Table 6: Top Hierarchical Condition Categories by Count and Cost, PY 2021-2023 SRP**

| Most Frequent | | | Highest Cost | | |
|---|---|---|---|---|---|
| **2021*#** | **2022** | **2023** | **2021*#** | **2022** | **2023** |
| Diabetes With or Without Complications | Diabetes With or Without Complications | Cancers | Cancers | Cancers | Cancers |
| HIV/AIDS | Ongoing Pregnancy without Delivery with No or Minor Complications | Major Depressive Disorder, Severe, and bipolar disorders | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock |
| Cancers | Major Depressive Disorder, Severe, and Bipolar Disorders | Ongoing Pregnancy without Delivery with No or Minor Complications | Hemophilia | Ongoing Pregnancy without Delivery with No or Minor Complications | Diabetes, With or Without Complications |
| Ongoing Pregnancy without Delivery with No or Minor Complications | Varicella Encephalitis and Encephalomyelitis | Autistic Disorder | End Stage Renal Disease | Hemophilia | Specified Heart Arrhythmias |
| Heart Failure | Cancers | Diabetes, With or Without Complications | Inflammatory Bowel Disease | Heart Failure | Heart Failure |

*: The name of HCC 130, "Congestive Heart Failure", was changed to "Heart Failure" in PY 2021, though both names describe the same set of conditions.

#: PY 2021 is the first year HCC 212, "(Ongoing) Pregnancy without Delivery with No or Minor Complications," was used. In previous years, pregnancy HCCs described completed pregnancies, ectopic pregnancies, and miscarriages, all of which are also included in PY 2021. It is possible HCC 212 was among the most common reported by carriers in PY 2021 because it could have been billed more times over the course of a pregnancy than the other pregnancy HCCs from PY 2021 and previous years.

**Blue highlighted cells indicate conditions of state population health interest.*

In 2023, Kaiser Permanente and CareFirst both had care management initiatives targeting diabetes and behavioral health, and Kaiser Permanente had initiatives targeting heart disease:

- CareFirst:
    - Diabetes Care Management (PYs 2019-2023)
    - Diabetes Virtual Care Program (PYs 2020-2023)
    - Behavioral Health and Substance Use Disorder Care Management Programs (PYs 2019-2023)
    - Behavioral Health Digital Solution (PY 2023)
    - High-Cost Claimant Unit (PY 2022-2023)
- Kaiser Permanente
    - Heart Failure Care Management (PY 2023)
    - Hypertension Management (PY 2023)
    - Lipid Management (PY 2023)
    - Diabetes Care Management Program (PYs 2019-2020, 2023)
    - Diabetes Remote Data Monitoring (PY 2023)
    - Glycemic Control (PY 2023)
    - Depression Screening and Engagement (PY 2023)
    - Substance Use Screening and Engagement (PY2023)
    - Behavioral Health Post-Hospitalization Follow Up (PY 2023)

UnitedHealthcare was new to the market in 2021 and had limited enrollment in 2022 and 2023, therefore none of their care management initiatives met the threshold of 300 or more enrollees. However, United continued to operate 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, including for those conditions listed here.

No carriers reported care management initiatives targeting asthma or pregnancy.

**Appendix: Projections**
**(Plan Years 2023-2026)**

| | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|
| **Without Reinsurance** | | | | |
| Total Non-Group Enrollment | 220,160 | 252,274 | 304,447 | 259,016 |
| APTC Enrollment | 158,266 | 180,474 | 218,547 | 142,344 |
| Total Non-Group Premium PMPM | $ 697 | $ 737 | $ 775 | $ 781 |
| APTC PMPM | $ 574 | $ 585 | $ 606 | $ 692 |
| Total Premiums | $ 1,841,428,528 | $ 2,231,510,593 | $ 2,831,113,982 | $ 2,426,964,352 |
| Total APTCs | $ 1,089,546,761 | $ 1,267,948,048 | $ 1,589,935,697 | $ 1,181,614,095 |
| **Reinsurance Information** | | | | |
| Attachment Point | $ 18,500 | $ 20,000 | $ 21,000 | $ 24,000 |
| Reinsurance Cost | $ 567,836,479 | $ 638,938,395 | $ 718,689,263 | $ 682,658,429 |
| State Reinsurance Fee | 1.00% | 1.00% | 1.00% | 1.00% |
| State Reinsurance Fee Funding | $ 136,947,734 | $ 141,228,355 | $ 141,500,000 | $ 144,117,750 |
| Increase in SLCSP Premium without Reinsurance | 48.3% | 49.3% | 49.5% | 48.2% |
| **With Reinsurance** | | | | |
| Total Non-Group Enrollment | 234,213 | 269,736 | 323,880 | 275,549 |
| APTC Enrollment | 142,074 | 161,437 | 193,842 | 138,212 |
| Total Non-Group Premium PMPM | 461 | $ 484 | $ 508 | $ 514 |
| APTC PMPM | $ 377 | $ 383 | $ 398 | $ 428 |
| Total Premiums | $ 1,296,812,257 | $ 1,567,545,846 | $ 1,976,310,492 | $ 1,697,950,657 |
| Total APTCs | $ 642,418,267 | $ 741,269,464 | $ 926,775,465 | $ 710,065,767 |
| **Savings** | | | | |
| Estimated Federal Pass Through | $ 473,027,855 | $ 526,747,454 | $ 577,750,590 | $ 473,979,372 |
| Estimated Pass Through % of Reinsurance Costs | 83% | 82% | 80% | 69% |
| **Funding Available** | | | | |
| Starting Balance | $ 459,209,731 | $ 464,848,840 | $ 454,386,254 | $ 411,947,581 |
| Program Cash Flows | $ 42,139,110 | $ 29,037,414 | $ 561,327 | $ (64,561,307) |
| State Adjustment | $ (36,500,000) | $ (39,500,000) | $ (43,000,000) | $ (130,578,672) |
| Net Funding EOY | $ 464,848,840 | $ 454,386,254 | $ 411,947,581 | $ 216,807,602 |