2027 Proposed Plan Certification Standards Preview

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October 20, 2025

MARYLAND HEALTHBENEFIT EXCHANGE

Plan Certification Standards Background

- MHBE sets plan certification standards for individual market plans sold through Maryland Health Connection, which encompass plan design, operational, and other requirements. Past examples:
  - Require NCQA Health Equity Accreditation (2024)
  - Dental carriers must have PayNow functionality for Stand-Alone Dental Plans (2023)
  - **Value Plan standards (annually 2020-present)**
- Value Plan design as a policy tool
  - Support affordability/access; simplify plan choice; promote health equity

2027 Proposed Plan Certification Standards Summary

- Require alignment with primary care investment targets under the AHEAD model
- 2027 Value Plan Standards

Timeline

- August - December 2025: Value Plan Workgroup meets
- September and November 2025: Proposed 2027 standards discussed with Standing Advisory Committee
- October 2025: Preliminary Board discussion of proposed 2027 standards
- Fall/Winter 2025 (TBD): 2027 Federal Actuarial Value Calculator released
- January 2025: Board votes on proposed 2027 Plan Certification Standards, followed by formal public comment period
- February 2026: Board votes to finalize 2027 Plan Certification Standards
- January 1, 2027: New plan certification standards in effect for plan year 2027 plans

Primary Care Investment

Primary Care Investment - Background

- Research finds that primary care is the only specialty in which increased supply results in lower mortality and more equitable health outcomes.[1]
- Multi-payer alignment for advanced primary care models provides critical financial incentives for primary care practices to transform the way they deliver care.
  - Primary care clinicians may not focus on each individual patient's payer, and investment is required to build the infrastructure to best manage the population health of communities.
- 2025 MHCC Primary Care Investment Analysis and Recommendations Report - Key Findings: Primary care spending as a percentage of total medical expense (TME) did not increase between 2021-2023, and was also relatively flat on a per member per month basis.[2]

1 National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding The Foundation of Health Care. Washington, DC: The National Academies Press, 2021. https://nap.nationalacademies.org/catalog/25983/implementinghigh-quality-primary-care-rebuilding-the-foundation-of-health.

2 https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcw/pci_rpt.pdf

AHEAD Model

- AHEAD is is a voluntary state-based alternative payment and service delivery model designed by CMS to curb health care cost growth, improve population health, and promote healthier living.
- On November 1, 2024, the Governor signed a State Agreement (Agreement) to participate in AHEAD.
- The Agreement requires that Maryland establish a Total Cost of Care Growth Target for all payers in the State and an All-Payer Primary Care Investment Target.
- Targets for 2027-2030 are to be established by October 2026.
- The Model also includes prospective care management payments and requirements for care transformation, such as integrating behavioral health into primary care services.

Primary Care Investment Proposed Plan Certification Standard - Individual and Small Group

Proposed Plan Certification Standard

- Carriers offering individual or small group plans on-exchange must commit to meeting the primary care investment target set by the Maryland Health Care Commission.
- *To be discussed with stakeholders: Feasibility of requiring carriers to pay for Advanced Primary Care Management services, Behavioral Health Integration services, and Collaborative Care Model services without cost sharing, where permitted by law.*

Rationale: align with AHEAD model requirements and recommendations in MHCC Primary Care investment report; support investment to improve enrollee health; potentially reduce reinsurance program costs

Value Plans

What are Value Plans?

- Plans with standardized cost-sharing determined by MHBE
  - *Benefits* that plans must cover are already determined by State and Federal governments
  - *Cost-sharing* (copays and coinsurance) varies by plan and is semi-regulated through actuarial value standards for metal levels
    - Actuarial Value: measure of plan generosity
    - Metal level: category of plan generosity (Bronze, Silver, Gold, Platinum)
- Carriers must offer one Value Plan at each of the Bronze, Silver, and Gold metal levels

Actuarial Value: Measure of Plan Generosity

- Generosity of qualified health plans must adhere to federal limits for each metal level ("Actuarial Value" or AV).
- AV is represented as the percentage of healthcare costs that an insurer will cover; the remainder is the consumer's responsibility
  - Bronze ~60% AV, Silver ~70%, Gold ~80%, Platinum ~90%
- Annually, the federal government releases the Actuarial Value Calculator (AVC), which must be used to ensure each plan complies with federal limits
  - A plan's AV must fall within the federally specified allowable range of AVs for a given metal level. This is referred to as the "de minimis" range
- 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.**

Value Plan Policy Goals

- Improve health care access and affordability
  - Pre-deductible coverage
  - Copays vs. coinsurance
  - Promote health equity through plan design (2021 Health Equity Workgroup recommendation)
- Promote insurer competition
  - Transparency
  - “Apples-to-apples” plan comparison
- Simplify plan shopping

Value Plan Policy History

- 2019: MHBE convened an Affordability Workgroup that made recommendations to improve affordability and access, including Value Plans
- **2020: Original (non-standardized) Value Plans launch,** including $0 diabetic supplies (insulin and glucometers) in Silver and Gold plans only
- 2021: Health Equity Workgroup recommendations included reducing cost-sharing for high-disparity conditions, such as diabetes
- 2022: Affordability Workgroup recommended standardized Value Plan designs for 2024 and limit on number of plans per metal level for 2025
- **2024: Standardized Value Plans launch**, including $0 diabetic services in all metal levels
- 2025: Minimal changes to standards; new limit of 3 plans per metal level effective
- 2026: Reduced lab copays where possible; technical fixes; changes to meet AV limits

Possible Changes for 2027 Value Plans

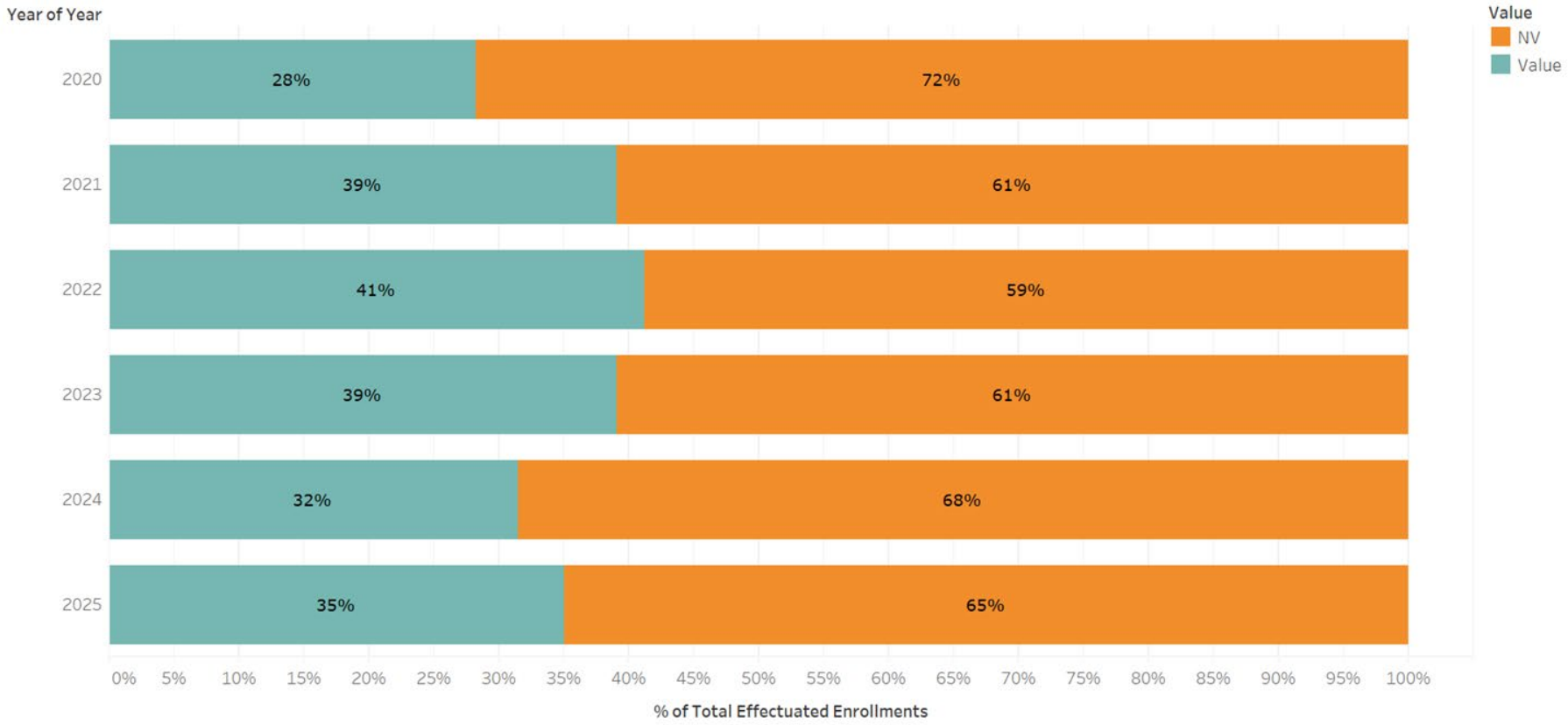
- Maintain 2026 cost-sharing for 2027
  - Workgroup will meet again after CMS releases the actuarial value calculator if cost-sharing needs to be adjusted to meet AV restrictions
- Add diabetes coverage requirement that at least one continuous glucose monitor (CGM) be available at $0 cost sharing
  - Include requirement that carriers develop an “easy-to-understand, transparent, and searchable page on the carrier’s website” that includes specific information on the $0 diabetes benefit as outlined by MHBE (similar to Colorado guidance)
- Change name of Value Plans, informed by results of consumer research

***Workgroup has not yet voted to recommend these changes**. They are subject to change*

Appendix

Value Plan Enrollment Up from PY2024 to 2025

- Value Plan enrollment (blue) increased or held relatively steady 2020-2023, decreased in 2024, and increased in 2025



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Proposed 2027 Value Plan Designs (1/5)

***Blue text indicates service is not subject to the deductible.**

	Proposed 2027 Gold	Proposed 2027 CSR 94%	Proposed 2027 CSR 87%	Proposed 2027 CSR 73%	Proposed 2027 Base Silver	Proposed 2027 Expanded Bronze
Actuarial Value	TBD	TBD	TBD	TBD	TBD	TBD
Medical Deductible	$1,000	$0	$1,000	$4,500	$4,500	$10,150
Drug Deductible	$150	$0	$150	$750	$750	n/a
Medical MOOP	$8,500	$1,950	$2,850	$6,800	$8,500	$10,150
Rx MOOP	$600	$250	$500	$1,300	$1,300	n/a
Combined MOOP	$9,100	$2,200	$3,350	$8,100	$9,800	$10,150
Emergency Room Services	$350	$75	$150	$500	$500	n/a
All Inpatient Hospital Services (inc. MH/SUD)	$450	$150	$350	$550	$550	n/a
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$10	$5	$10	$35	$35	$35
Specialist Visit	$35	$20	$35	$110	$110	$110
Mental/Behavioral Health and Substance Use Disorder Office Visits	$10	$5	$10	$35	$35	$35
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	$10	$5	$10	$35	$35	$0

Deductibles & 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.

Proposed 2027 Value Plan Designs (2/5)

	Proposed 2026 Gold	Proposed 2026 CSR 94%	Proposed 2026 CSR 87%	Proposed 2026 CSR 73%	Proposed 2026 Base Silver	Proposed 2026 Expanded Bronze
Imaging (CT/PET Scans, MRIs)	$400	$125	$350	$600	$600	n/a
Speech Therapy	$10	$5	$10	$35	$35	$35
Occupational and Physical Therapy	$10	$5	$10	$35	$35	$35
Preventive Care/Screening/Immunization	$0	$0	$0	$0	$0	$0
Laboratory Outpatient and Professional Services	$25	$10	$25	$45	$45	$55
X-rays and Diagnostic Imaging	$50	$20	$50	$150	$150	$150
Skilled Nursing Facility	$75	$30	$75	$150	$150	n/a
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$250	$50	$75	$150	$150	n/a
Outpatient Surgery Physician/Surgical Services	$125	$60	$125	$150	$150	n/a
Generic Drugs	$10	$0	$6	$25	$25	$25
Preferred Brand Drugs	$30	$5	$25	$75	$75	n/a
Non-Preferred Brand Drugs	$60	$15	$50	$80	$80	n/a
Specialty Drugs (i.e. high-cost)	$75	$25	$60	$100	$100	n/a

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Proposed 2027 Value Plan Designs (3/5)

		Proposed 2026 Gold	Proposed 2026 CSR 94%	Proposed 2026 CSR 87%	Proposed 2026 CSR 73%	Proposed 2026 Base Silver	Proposed 2026 Expanded Bronze
Additional Standardized Service Categories							
Durable Medical Equipment		20%	10%	20%	30%	30%	n/a
Emergency Transportation/Ambulance		$300	$50	$100	$350	$350	n/a
Habilitation Services		$10	$5	$10	$35	$35	$35
Home Health Care Services		$30	$10	$25	$45	$45	n/a
Hospice Services		$0	$0	$0	$0	$0	$0
Inpatient Physician and Surgical Services		$30	$10	$25	$40	$40	n/a
Outpatient Rehabilitation Services		$10	$5	$10	$35	$35	$35
Urgent Care Centers or Facilities		$40	$15	$30	$75	$75	$75

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Proposed 2027 Value Plan Designs (4/5)

		Proposed 2026 Gold	Proposed 2026 CSR 94%	Proposed 2026 CSR 87%	Proposed 2026 CSR 73%	Proposed 2026 Base Silver	Proposed 2026 Expanded Bronze
Additional Standardized Service Categories							
Pediatric Vision							
	Routine Eye Exam for Children (optometrist)	$0	$0	$0	$0	$0	$0
	Eye exam by an Ophthalmologist	$0	$0	$0	$0	$0	$0
	Basic Lenses	$0	$0	$0	$0	$0	$0
	Frames	$0	$0	$0	$0	$0	$0
	Contacts – elective (i.e. in lieu of lenses and frames)	$0	$0	$0	$0	$0	$0
	Contacts – medically necessary	$0	$0	$0	$0	$0	$0
	Low vision testing	$0	$0	$0	$0	$0	$0
	Low vision aid	$0	$0	$0	$0	$0	$0
Pediatric Dental							
	Class I Preventive & Diagnostic Services	$0	$0	$0	$0	$0	$0
	Class II Basic Services	20%	20%	20%	20%	20%	20%
	Class III Major Services	50%	20%	30%	40%	50%	50%
	Class IV Major Services – Restorative	50%	20%	30%	40%	50%	50%
	Class V Orthodontic Services	50%	50%	50%	50%	50%	50%

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***Blue text indicates service is not subject to the deductible.**

Possible Website Requirement (adapted from Colorado)

- To ensure consumers are adequately aware of the availability of diabetic supplies offered with $0 cost-sharing, individual market carriers … must develop an easy-to-understand, transparent, and searchable page on the carrier's website titled "[*TBD*]" that includes the following information:
  - A clear statement that [Value Plans (name TBD)] provide coverage of diabetic supplies at $0 cost-sharing.
  - A complete list of all diabetic supplies, including the name of the item or supply and the category (e.g., continuous glucose monitors, lancets, test strips) that are covered at $0 cost-sharing under the Colorado Option Standardized Health Benefit Plan.
    - At all times, the list shall include all of the diabetic supplies that are covered for the current plan year.
    - During the annual Open Enrollment Period, the website shall also display the diabetic supplies covered for the upcoming plan year.
- Next to each item or supply, the carrier must clearly indicate whether it is covered under the medical benefit, including durable medical equipment (DME), or prescription drug benefit.
  - If an item or supply is covered as DME, the carrier must include clear instructions for how a consumer may obtain the diabetic supply through the covered DME supplier, including where to find the contact information for their plan's DME supplier.
  - If an item or supply is covered under the prescription drug benefit, the carrier must include clear instructions on how a consumer can access the most recent prescription drug formulary and the carrier's provider directory.

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- Adapted from https://doi.colorado.gov/sites/doi/files/documents/Bulletin-4.130-Colorado-Option-Plan-Coverage-of-Diabetic-Supplies.pdf
- "TBD" because we will be changing the name of Value Plans and will use that language when we have it

Proposed 2027 Value Plan Designs (5/5)

- 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.
    - All carriers must cover, at $0 cost sharing:
      - Test strips and glucometers
      - Preferred brands of insulin
      - At least one continuous glucose monitor (CGM) product (**language TBD**)
      - At least one from each of the following classes of oral hypoglycemics:
        - Biguanides (such as metformin)
        - Thiazolidinediones (such as pioglitazone or rosiglitazone)
        - Sulfonylureas (such as glipizide, glyburide, gliclazide, or glimepiride)
- Insurers must maintain a page on their websites detailing $0 diabetes coverage that adheres to MHBE guidance (see separate guidance)
- 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.