State Reinsurance Program Annual Public Forum

July 23, 2025
Meeting Held via Video Conference

Welcome and Introductions:

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE) opened the meeting by identifying the federal regulations under which the meeting is required. Ms. Lane stated that the meeting's purpose is to allow the public to comment on the progress of the 1332 waiver. Ms. Lane then reviewed the meeting's agenda.

Maryland State Reinsurance Program Performance for Plan Year 2025

Ms. Lane began the discussion by reviewing trends in premium rates from 2015-2026. She reported that rates have been rising modestly since the full realization of Maryland's State Reinsurance Program (SRP) in 2021, but that proposed rates for 2026 will rise by an average of 17.1% if adopted as filed. Ms. Lane explained that enhanced premium tax credits (ePTCs) enacted under the American Rescue Plan Act are set to expire at the end of 2025, likely resulting both in higher premiums and lower enrollment in 2026.

Ms. Lane then compared current premium rates to the average lowest cost premiums in the United States. She reported that Maryland's lowest cost plans are lower than nationwide averages and remain lower than before the SRP was implemented.

Next, Ms. Lane estimated the effects of the SRP on premiums by insurance carrier. Without the SRP, premium rates would have increased 35 to 90% in 2025, depending on the carrier, but with the program, have only increased by 4.7% on average.

Ms. Lane then demonstrated the impact of the SRP on enrollment. On-exchange enrollment is up 70%, and combined on- and off-exchange enrollment is up 66%, since the program was enacted in 2019. Ms. Lane emphasized that this growth cannot be attributed entirely to the SRP because of ePTCs.

Next, Ms. Lane estimated the impact of the SRP on enrollment via count of enrollees. Without the program, enrollment would be 19,433 individuals (6%) lower, according to MHBE.

Program Developments Since Last Annual Reinsurance Public Forum

Ms. Lane began by describing the Centers for Medicare & Medicaid Services (CMS)

Marketplace Integrity Final Rule. The Final Rule will make enrollment more burdensome, restrict eligibility, reduce affordability, and ultimately discourage healthier people from enrolling resulting in a more expensive risk pool.

Next, Ms. Lane discussed the Budget Reconciliation Bill H.R. 1 (One Big Beautiful Bill Act or OBBBA), noting it has significant impacts on the MHBE's operations, including provisions removing tax credit eligibility for legal immigrants, adding burdens to enrollment, and codifying elements of the CMS Final Rule. The OBBBA does not address ePTCs, set to expire at the end of 2025. Ms. Lane explained that roughly 190,000 Marylanders will lose some or all financial support for their health insurance, and that premiums are expected to rise by about 70%.

Next, Ms. Lane described recent legislation at the state level in anticipation of the end of ePTCs. House Bill 1082 requires the MHBE to establish a State-Based Individual Subsidy Program to mitigate enrollment losses and stabilize the health insurance market in plan years 2026 and 2027. It includes language suspending the program if Congress extends the ePTCs.

Ms. Lane then explained that Maryland's health insurance affordability programs, including the SRP, the Young Adult Subsidy (YAS), and the new individual subsidy, all use the same funding source: the state provider assessment. This means that, depending on the parameters established for the new individual subsidy, the YAS could be discontinued and folded into the broader program. Since state funds are insufficient to fully replace lost ePTCs, the MHBE's actuarial consultants modeled a range of options for partial replacement.

Next, Ms. Lane shared details of how the OBBBA limits tax credit eligibility for lawfully present immigrants. Beginning January 1, 2026, lawfully present immigrants whose income falls below 100% of the federal poverty level (FPL) and who are ineligible for Medicaid due to the five-year bar are no longer eligible for tax credits. On January 1, 2027, lawfully present refugees, asylees, and victims of human trafficking become ineligible for tax credits. Ms. Lane explained that the estimated cost of replacing tax credits for those affected by the five-year bar is up to $154 million per year and is not modeled in the subsidy designs due to how recently these provisions were made law.

Ms. Lane then discussed the priorities established in H.B. 1082 for subsidy design. The program must mitigate the reduction in federal tax credits and maximize enrollment in the individual market but also consider the state funds necessary to ensure the SRP continues to provide market stability through 2028 and account for uncertainties in state and federal regulation and funding.

Next, Ms. Lane shared details of the population whose eligibility for federal tax credits will end in 2026, breaking them down by age group and by FPL range. She noted that concentrations of affected individuals occur both at the lower end of the income scale and among the older population.

Ms. Lane then laid out the considerations for a state individual subsidy program, including market impacts, program costs, and impact on the SRP and its fund. She pointed out that the state subsidy program will affect the amount of money available via

federal pass-through funding, as well as the overall SRP fund balance. Due to their being funded from the same source, she explained, the amount spent on the SRP determines the amount available for individual subsidies.

Next, Ms. Lane gave an overview of how the SRP is arranged, with four parameters: an attachment point (the dollar value above which an insured individual's claims for the year will trigger the SRP), a coinsurance rate (the portion of the claims costs covered by the state), a cap (the dollar value above which the carrier covers the costs), and a dampening factor (a calculation performed by the Maryland Insurance Administration [MIA] to reduce the likelihood of carriers receiving double payment from the SRP and the federal risk adjustment program). She explained that each of these parameters, especially the attachment point, affect the total value of the SRP, so that increasing the attachment point of the SRP would make more money available for the individual subsidy. The MHBE must balance SRP parameters alongside the individual subsidy to control the scale of premium increases.

Ms. Lane then compared the attachment point in the 2023 SRP to the other states that operate reinsurance programs, showing that Maryland has among the lowest attachment points in the country. This means that the MHBE can raise the attachment point of the SRP while still maintaining the relative generosity of the program..

Next, Ms. Lane described the scenarios modeled by the actuaries, arranged into four "buckets." The first "bucket" has no state replacement of ePTC and includes only one scenario. The second bucket of options would fully replace ePTC with state funds and includes four scenarios: no change to the planned attachment point of $22,000, increasing the attachment point to $30,000, increasing the attachment point to $40,000, and replacing 75% of ePTC for all participants along with a $30,000 attachment point. The third scenario would fully replace ePTC for those up to 200% FPL and provide reduced subsidy on a sliding scale between 201% and 250% FPL with no subsidy for those above 250% FPL. The fourth bucket includes five scenarios, each of which would fully replace ePTC for those up to 200% FPL, provide reduced subsidy on a sliding scale from full replacement to 50% replacement for those between 201% and 250% FPL, and provide 50% replacement for those between 251% and 400% FPL. The five models in the fourth scenario include various attachment point changes, extension of subsidies to those above 400% FPL, and maintaining or ending the YAS. She explained that the MHBE received public comments in support of the two models in the fourth scenario that maintain the YAS, referred to as scenarios A1 and A3. In scenario A1, the attachment point of the SRP remains at the planned $22,000, the YAS stays active, and no subsidy is offered to those over 400% FPL. In scenario A3, raising the attachment point of the SRP to $30,000 while maintaining the YAS makes it possible to extend subsidies to those over 400% FPL.

Ms. Lane then shared the estimates of projected program costs, enrollment decline, and fund balance at the end of 2027 and 2028 compared to both no replacement of ePTC and full replacement of ePTC. Scenarios A1 and A3 both project enrollment decline of approximately 7% in 2026, compared to 25% decline with no replacement of ePTC and no decline with full replacement. Both scenarios project a positive fund balance at the end of 2027 and a fund deficit at the end of 2028. The MHBE Board of Trustees are

reviewing these scenarios but have not yet selected a subsidy design model. Ms. Lane pointed out that, since the design of the individual subsidy depends on the SRP attachment point, the Board will consider both together at a future meeting.

Next, Ms. Lane explained that, in prior years' Reinsurance Public Forum presentations, the MHBE would share projections of SRP fund balance in the remaining years of the waiver period. Since the parameters of the SRP for 2026 have not yet been finalized, the MHBE instead prepared a range of projections based on the subsidy design models previously discussed. Taking no steps to replace ePTC and keeping the previously planned $22,000 attachment point would result in a projected positive SRP fund balance of $4 million at the end of the waiver period. Scenario A1 is projected to leave a balance deficit of $132 million while scenario A3 is expected to leave a smaller deficit of $52 million for the same period.

Ms. Lane then discussed the waiver amendment approved by CMS in January 2025 that allows Marylanders to enroll in coverage on-exchange regardless of immigration status. Given recent developments at the federal level, she noted, it remains unclear how the MHBE will proceed.

Carrier Accountability Reports

Ms. Lane explained that insurance carriers who participate in the SRP are required to submit annual accountability reports to MHBE. Accountability reports contain utilization data and information on efforts to contain costs of reimbursement.

Ms. Lane shared that the effectiveness of cost controls is measured using estimated reduction in claims and utilization. Ms. Lane also shared that population health efforts are included in accountability reports.

Next, Ms. Lane discussed the key population health goals targeted in accountability reports. The issues included diabetes, behavioral health, asthma, pregnancy/childbirth, and heart disease. Ms. Lane encouraged the audience to access the report templates and instructions for the accountability reports and provided a link to this year's version.

Ms. Lane then provided data regarding the number of people whose claims triggered the SRP and the total SRP payments by carrier for plan years (PYs) 2020 through 2023. She noted that adults aged 55 to 64 years are the largest demographic triggering the SRP, counted by both number of people and total payments. Overall, the rates have increased, both for the number of people whose claims triggered the SRP (from about 12,400 to 17,500) and total SRP payments (from $400 million to $570 million) during that period. Regarding PY 2023 Care Management Initiatives, Ms. Lane reported that no carriers had programs to address asthma or pregnancy/childbirth. Both CareFirst and Kaiser Permanente have initiatives to address behavioral health and diabetes and Kaiser Permanente has initiatives to address heart disease. Ms. Lane mentioned that United has Care Management Initiatives, but the carrier does not meet the reporting threshold, due to limited enrollment.

Next, Ms. Lane shared the most frequent Hierarchical Condition Categories (HCCs) among SRP claims. She reported that diabetes, cancer, and pregnancy were among the top HCCs by utilization in all three years and noted that autistic disorder made the top

five in 2023 but was not in the top ten in the previous years. Ms. Lane then presented the HCCs with reported highest cost, which included various cancers, heart failure, hemophilia, and sepsis.

Public Comment

Ms. Lane welcomed any questions and public comments from the audience.

Stephanie Klapper with Maryland Citizens Health Initiative read the following statement.

Our mission is quality, affordable health care for all Marylanders. And I would like to applaud the past success of Maryland's reinsurance program to stabilize rates. And as Maryland copes with destabilization due to the federal reconciliation bill and final rule impacting state-based exchanges, we commend the Maryland General Assembly and Governor Moore for passing legislation to create the Maryland state subsidy program. We also commend MHBE and MIA for modeling how to design the program to stabilize premiums for low-income Marylanders and fully integrating the young adult subsidy program. The reinsurance program is most effective in stabilizing premiums for folks over 400% of the federal poverty level and continuing to prioritize making health coverage affordable for young adults helps get more young and healthy people into the individual market and also help stabilize premiums for those over 400% of the federal poverty level who don't receive as much subsidy support. I also want to just thank MHBE for its role in helping Maryland's Prescription Drug Affordability Board this past legislative session gain the authority to set upper payment limits for high-cost drugs for all Marylanders, which we hope they will start to do in 2026. And as rising prescription drug costs contribute much to the raising of rates in the individual market, we hope that this will also help to stabilize premiums. So, thank you all for the work that you do and for rising up to meet the current challenges.

Comment

Ms. Lane thanked Ms. Klapper for her comment and closed the meeting.

State Reinsurance Program Annual Public Forum

Maryland Health Benefit Exchange
Policy Department

July 23, 2025

MARYLAND HEALTHBENEFIT EXCHANGE

This meeting will be recorded

Introduction

- This forum is required pursuant to 31 CFR §33.120(c) and 45 CFR §155.1320(c)
- MHBE hosts this forum annually
- The purpose is to provide the public an opportunity to give meaningful comment on the progress of the waiver thus far

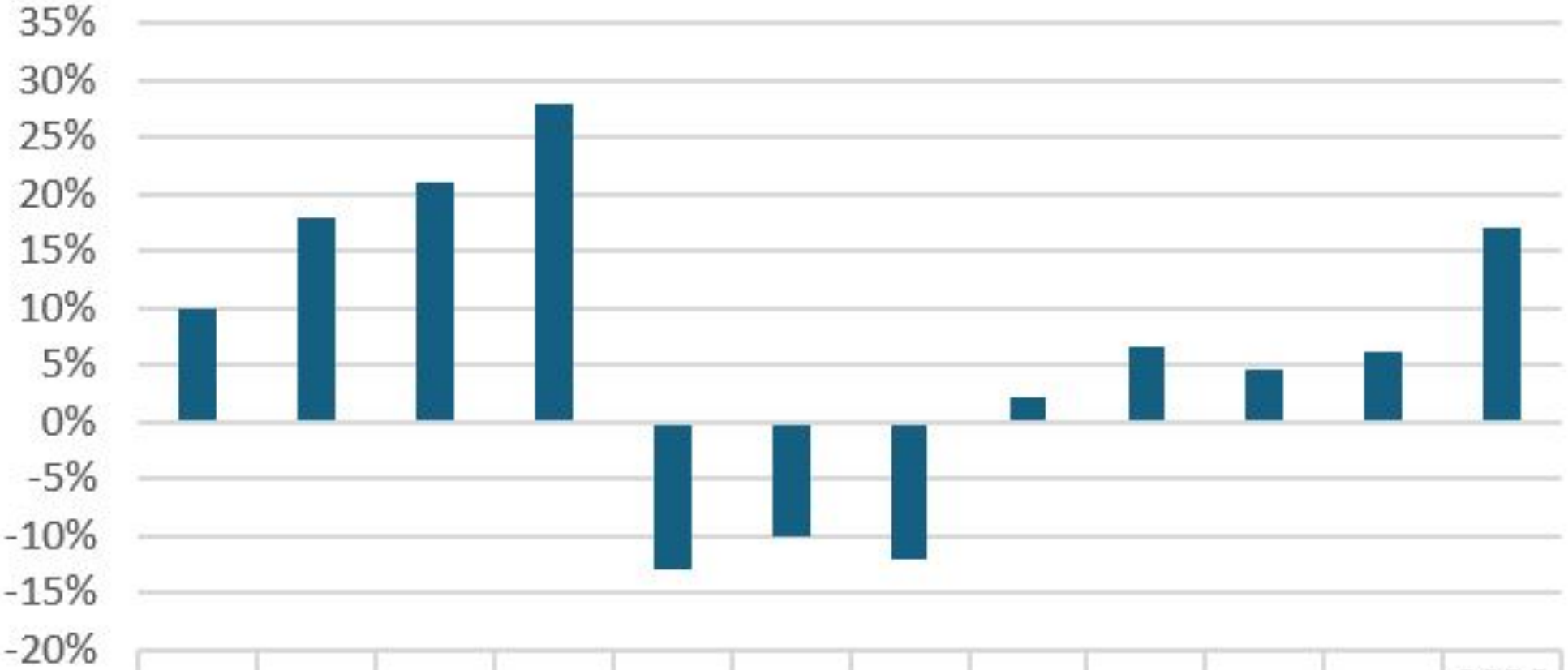
Public Forum Agenda

- Introduction
- 1332 Waiver Presentation
  - Program Performance for Plan Year 2025
  - Program Developments Since Last Annual Reinsurance Public Forum
  - Carrier Accountability Reports
- Public Testimony Period

*Note: If you wish to testify during the public comment period, please sign up on the Google Form in the comment section

Maryland State Reinsurance Program Performance for Plan Year 2025

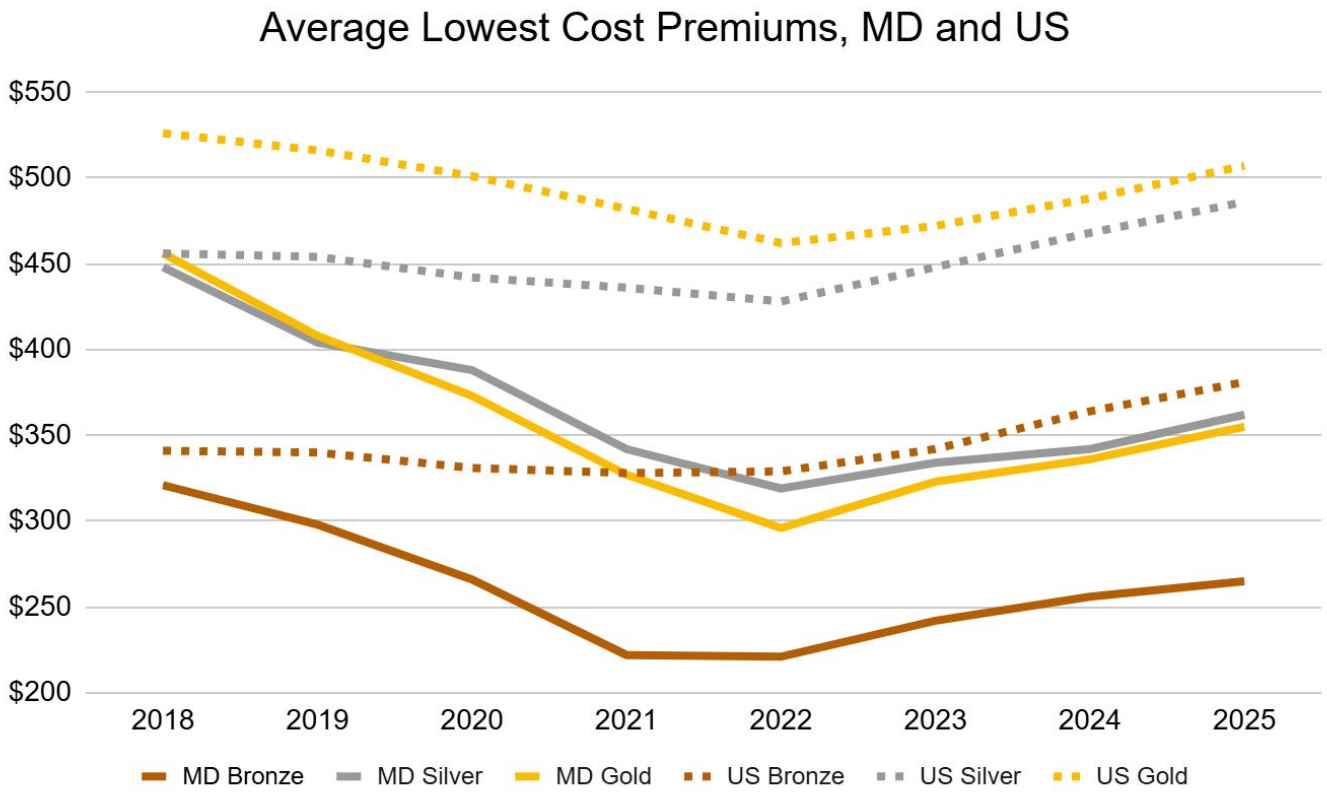
Individual Market Premium Change, 2015 - 2026



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 (proposed)
Rate Change	10%	18%	21%	28%	-13%	-10%	-12%	2.1%	6.6%	4.7%	6.2%	17.1%

Reinsurance Program Impact: Premiums Successfully Reduced

- Premiums are 17% lower than in 2018.
- Maryland's lowest cost plans are about 30% below US averages



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

MARYLAND HEALTHBENEFIT EXCHANGE

Estimated Effect of the Reinsurance Program on 2025 Premiums

Rate Impact of the SRP by Carrier

Carrier (Network)	Enrollment* (on/off MHC)	2025 Rate Change (w/o Reinsurance)**	2025 Rate Change (w/ Reinsurance)*
CareFirst (HMO)	126,167	50.6%	5.1%
CareFirst (PPO)	12,272	89.8%	8.6%
Kaiser Permanente (HMO)	50,959	38.6%	8.5%
Optimum Choice (HMO)	91,134	43.3%	5.5%
Aetna Health, Inc	4,939	35.6%	8.8%
Wellpoint Maryland, Inc	1,090	[48.1%]	New
Total	296,561		4.7%

MARYLAND HEALTHBENEFIT EXCHANGE

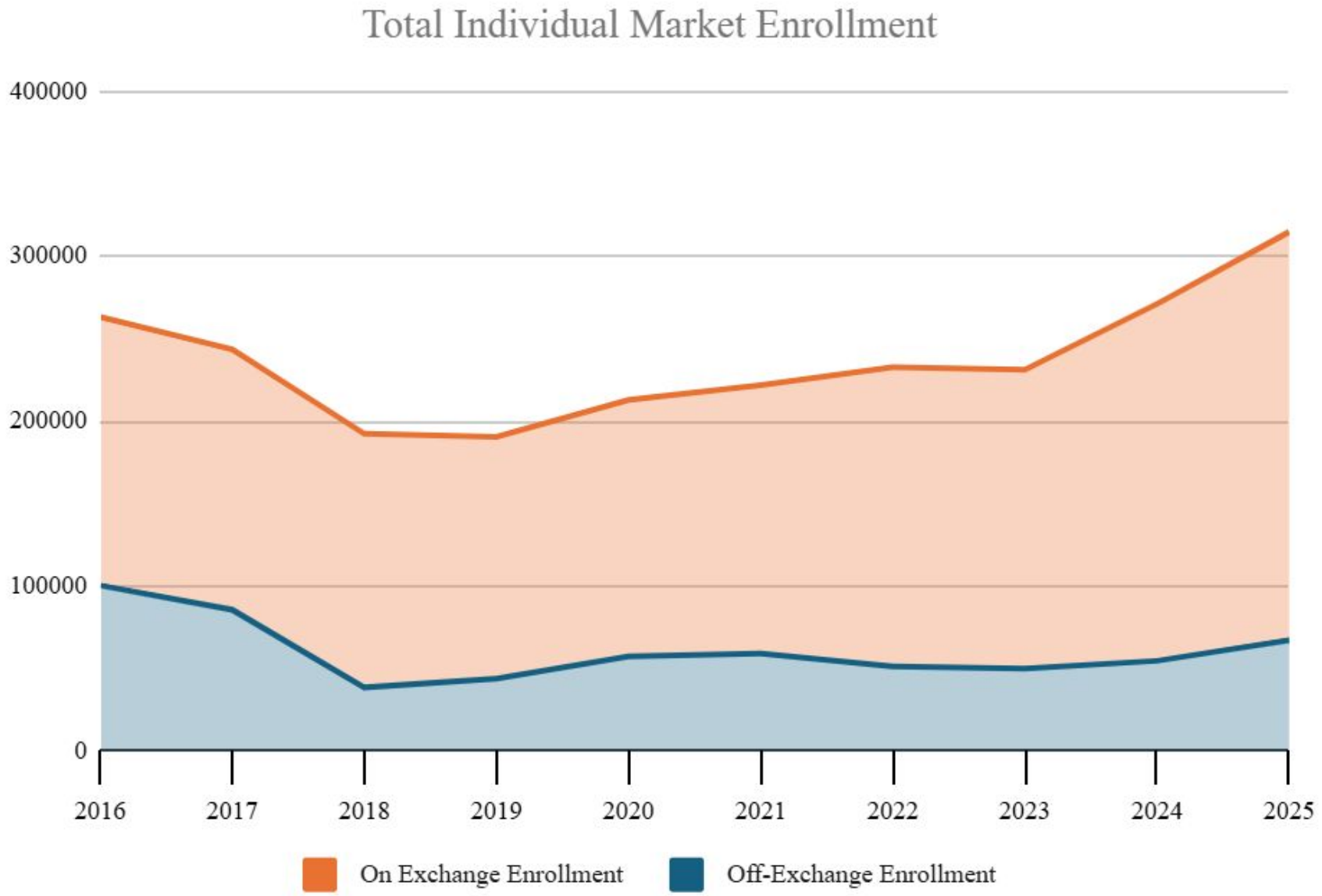
*Data as of 4/30/25 provided by the MIA

**Data provided by the MIA

Total Individual Market Enrollment 2014-2025

Between 2019 and 2025:

- On-Exchange enrollment is up 70%
- Total individual market enrollment (on- and off-Exchange) is up 66%



MARYLAND HEALTHBENEFIT EXCHANGE

Estimated Effect of the Reinsurance Program on 2025 Enrollment

Without the reinsurance program, individual market enrollment would have been an estimated 6 percent lower.

Scenario	Total*
2025 Estimate w/o Reinsurance	304,447
2025 Estimate w/ Reinsurance	323,880
Difference w/o Reinsurance	19,433

*Data from actuarial estimates (July 2025)

Program Developments Since Last Annual Reinsurance Public Forum

CMS Marketplace Program Integrity Final Rule

- The Centers for Medicare & Medicaid Services (CMS) released the **"Marketplace Integrity and Affordability"** Proposed Rule on March 10, 2025.
  - MHBE submitted comment on April 10th

- CMS published the **Final Rule** June 20th:
  - **Updates**: Many provisions now sunset after 2026, or no longer apply to state-based Marketplaces (SBMs).
  - The proposals will make enrollment more burdensome, restrict eligibility, reduce affordability, and ultimately discourage healthier people from enrolling resulting in a more expensive risk pool.

2025 Budget Reconciliation Bill - H.R.1

- **The Budget Reconciliation Bill** - H.R.1 (One Big Beautiful Bill Act or OBBBA)
  - Signed into law July 4, 2025
  - Major Marketplace provisions: remove eligibility for legal immigrants, add additional enrollment burdens, and codify some of the CMS rule provisions.

- Bill **does not address extending enhanced premium tax credits** (ePTC)
  - Schedule to expire at the end of 2025 unless Congress acts
  - Expiration will lead to significant affordability challenges and subsequent enrollment losses

- Both the reconciliation bill and the CMS final rule are likely to lead to significant enrollment losses and cost/operational burdens on the Marketplace to implement

State Subsidy Program (1/3)

- Enhanced federal tax credits, which have reduced net premiums and boosted enrollment since 2021, will expire at the end of 2025 unless Congress acts
- Unless Congress acts, enrollment will decline in 2026 due to reduced affordability:
  - 190,000 MHC consumers will lose some or all financial support
  - Premiums estimated to increase by an average 68% for tax credit-eligible consumers
- HB 1082 requires MHBE to establish a State-Based Individual Subsidy Program to mitigate enrollment losses and stabilize market in PYs 2026-2027
  - Contingency language: if Congress extends enhanced subsides, no state-based subsidy

State Subsidy Program (2/3)

- All three of the state's affordability programs (Reinsurance, Young Adult Subsidy, Individual Subsidy) use the same funding source, the state premium assessment. Young adult subsidy would be discontinued or included in broader individual subsidy.
- State funds are insufficient to fully replace lost enhanced tax credits (would cost $209 million/year gross), so MHBE's actuarial consultants have modeled several partial replacement options.

State Subsidy Program (3/3)

- On July 4, the president signed H.R. 1, which includes provisions limiting eligibility for premium tax credits for lawfully present immigrants
  - Effective Jan. 1, 2026: Lawfully present immigrants <100% FPL and ineligible for Medicaid due to 5-year bar no longer eligible for APTC
  - Effective Jan. 1, 2027: Lawfully present immigrants **no longer eligible** for APTC except for lawful permanent residents ("LPR" a.k.a. green card holders), certain Cuban or Haitian entrants, and Compact of Free Association (COFA) migrants at 100-400% FPL
    - Denies assistance to groups such as refugees, asylees, and victims of human trafficking
- **Estimated cost** to replace APTC for the group losing APTC in 2026 (lawfully present immigrants under <100% FPL and ineligible for Medicaid due to 5-year bar): **up to $154 million per year**
  - This is not included in subsidy parameter modeling

Priorities for Subsidy Design

(As set forth in HB 1082 / Md. Ins. Art., §31-125(D))

- Mitigate reduction in federal tax credits
- Maximize enrollment in the individual market
- Consider state funds necessary to ensure the State Reinsurance Program continues to provide market stability through CY2028
- Account for uncertainties in enrollment in Medicaid, the individual market, and small group market due to changes in state and federal regulation and funding

2025 Federal Poverty Level (FPL) Income Thresholds

Household Size	200% FPL	300% FPL	400% FPL
1 person	$31,300	$46,950	$62,600
4 people	$64,300	$96,450	$128,600

Potentially Impacted Enrollees: Currently APTC Eligible Under ARPA

Projected 2026 Subsidy Replacement Enrollment (APTC Eligible w ARPA)

Age Band/FPL	<150%	150-200%	200-250%	250-300%	300-400%	400+%
0-17	488	555	555	674	3,045	-
18-25	3,023	4,748	3,425	2,352	2,220	142
26-34	6,518	8,121	5,830	4,040	1,534	27
35-44	7,756	7,951	5,271	3,551	3,700	160
45-54	7,382	8,673	6,470	4,677	4,677	335
55-64	8,584	11,595	8,705	7,016	7,962	12,135
65+	8,433	785	440	299	184	9,205
Total	**42,184**	**42,427**	**30,697**	**22,609**	**23,322**	**22,003**

Considerations

1. **Market impacts**
   - Impact on net premiums
   - Impact on enrollment
   - Impact on silver loading

2. **Subsidy program cost**

3. **State Reinsurance Program and Fund impacts**
   - Impact on reinsurance cost
   - Impact on pass through
   - SRP fund balance

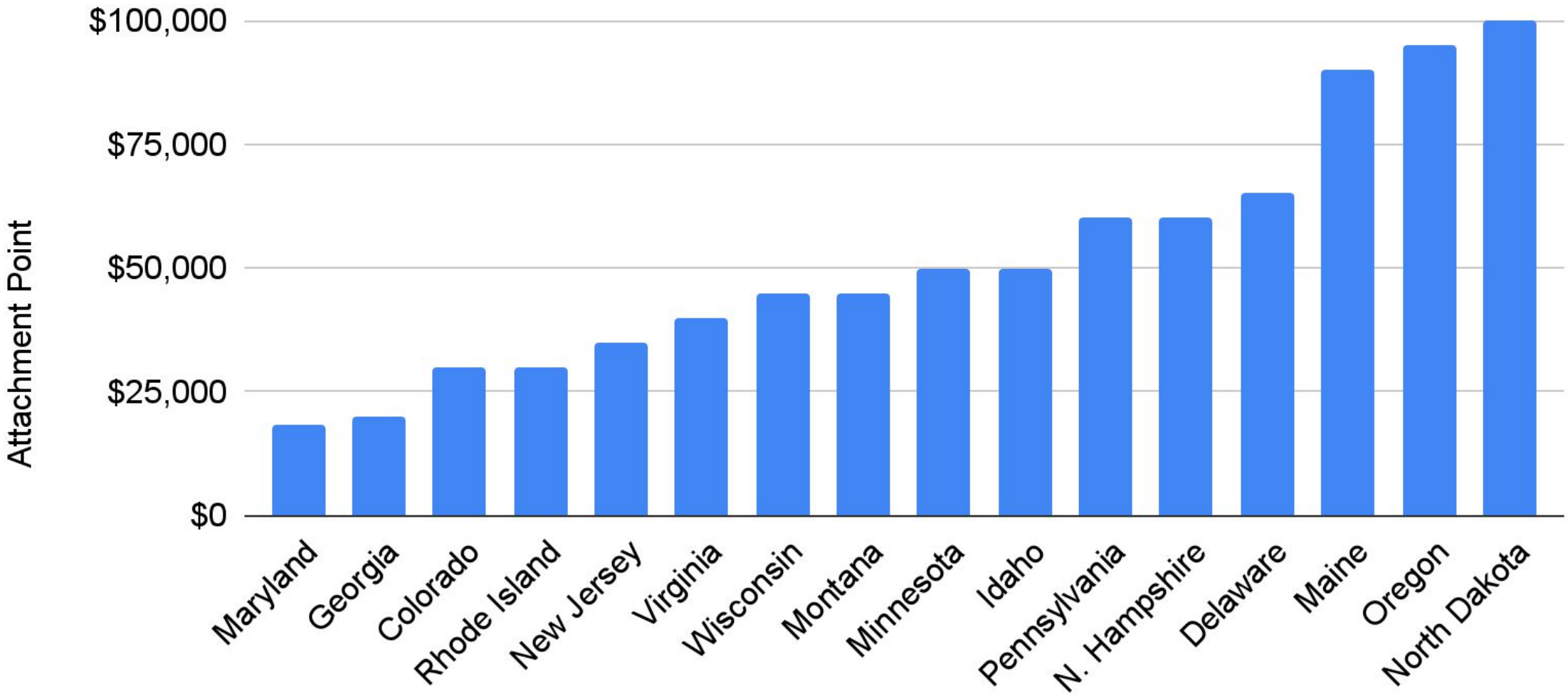
Reinsurance Program Parameters Refresher

The state reinsurance program (SRP) has three key parameters governing the total amount of claims that the program covers in the individual market:

1) Attachment point (AP): annual claim level (for an individual) above which SRP reimbursements start
    - Each $1,000 increase in the AP is projected to increase rates by ~0.6%
    - Increasing from 22k to 30k = ~5% increase
2) Cap: claim level at which SRP reimbursements stop and insurer bears full cost of claims
3) Coinsurance rate: percent of claims covered by SRP between attachment point and cap

Parameters	Final 2019-2022	Final 2023	Final 2024	Final 2025	Estimated 2026 (as of Feb 2025)
Attachment Point	$20,000	$18,500	$20,000	$21,000	$22,000
Coinsurance Rate	80%	80%	80%	80%	80%
Cap	$250,000	$250,000	$250,000	$250,000	$250,000
Dampening Factor	0.760-0.805	0.840	0.850	0.850	TBD

2023 Attachment Points - State Comparison



https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf

Modeled Scenarios

1. **No state subsidy replaces the enhanced APTC (eAPTC)**

2. **State subsidy fully replaces eAPTC and**
   a. No change to planned attachment point ($22k)
   b. Increase attachment point to $30k
   c. Increase attachment point to $40k
   d. Replace 75% of eAPTC for all recipients; attachment point to $30k

3. **Fully replace eAPTC up to 200% FPL, phase out subsidy to 250% FPL, no state subsidy above 250% FPL**

4. **Fully replace eAPTC up to 200% FPL, phase out subsidy to 250% FPL, 50% replacement of eAPTC 250%-400% FPL and**
   a. **[A1]** No change to planned attachment point ($22k) + maintain Young Adult Subsidy
   b. Increase attachment point to $30k
   c. Provide eAPTC to >400% FPL, no change to planned attachment point ($22k)
   d. Provide eAPTC to >400% FPL, increase attachment point to $30k
   e. **[A3]** Provide eAPTC to >400% FPL, increase attachment point to $30k + maintain YAS

*Scenarios 2-4 include covering non-EHB premium for all enrollees with a 0% expected contribution

2026 State-Based Subsidy Parameters – Scenarios for Discussion

	State Subsidy Description	Reinsurance Attachment Point (2026)	2026 Program Cost (M)	2026 Net Cost (M)	2026 Total Ind. Market Enrollment (000s)	Enrollment decline relative to 2025	Net Funding EOY 2027 (M)	Net Funding EOY 2028 (M)
	No replacement	$22k	n/a	n/a	243	25%	$154	$4
	Full replacement	$22k	$209	$144	312	n/a	($140)	($327)
A1	Full to 200, phase to 250, 50% 250-400 + YAS	$22k	$131	$57	302	7%	$40	($132)
A3	Full to 200, phase to 250, 50% >250 + YAS	$30k	$147	$43	301	7%	$68	($52)

Public Comment (1/2)

Shared all options for comment June 6 - July 3, 2025 (with the exception of A3, which was developed in response to feedback)

Commenter	Comment
CareFirst	Prefer 4a *[A1]* and 4c because of the $22,000 attachment point, progressive support across income brackets, and modest impact to enrollment. Don't support raising the attachment point because of the disproportionate impact to carriers.
Kaiser Permanente	Continue the Young Adult Subsidy like in 4a *[A1]* is good for the risk pool but that an increase to the attachment point (to $30,000) and less generous replacement to those over 400% would help balance that fiscal impact. Alternatively, 4d *[A2]* is best for being "fiscally prudent" and equitable while mitigating enrollment declines.
United	Prefer 2c or 4d *[A2]* and support raising AP as much as necessary to fully replace lost eAPTC or replace as much as possible to maximize enrollment and market stability. They believe this tradeoff would have a smaller impact on rates than allowing low income members to lose coverage due to lost eAPTC.

Public Comment (2/2)

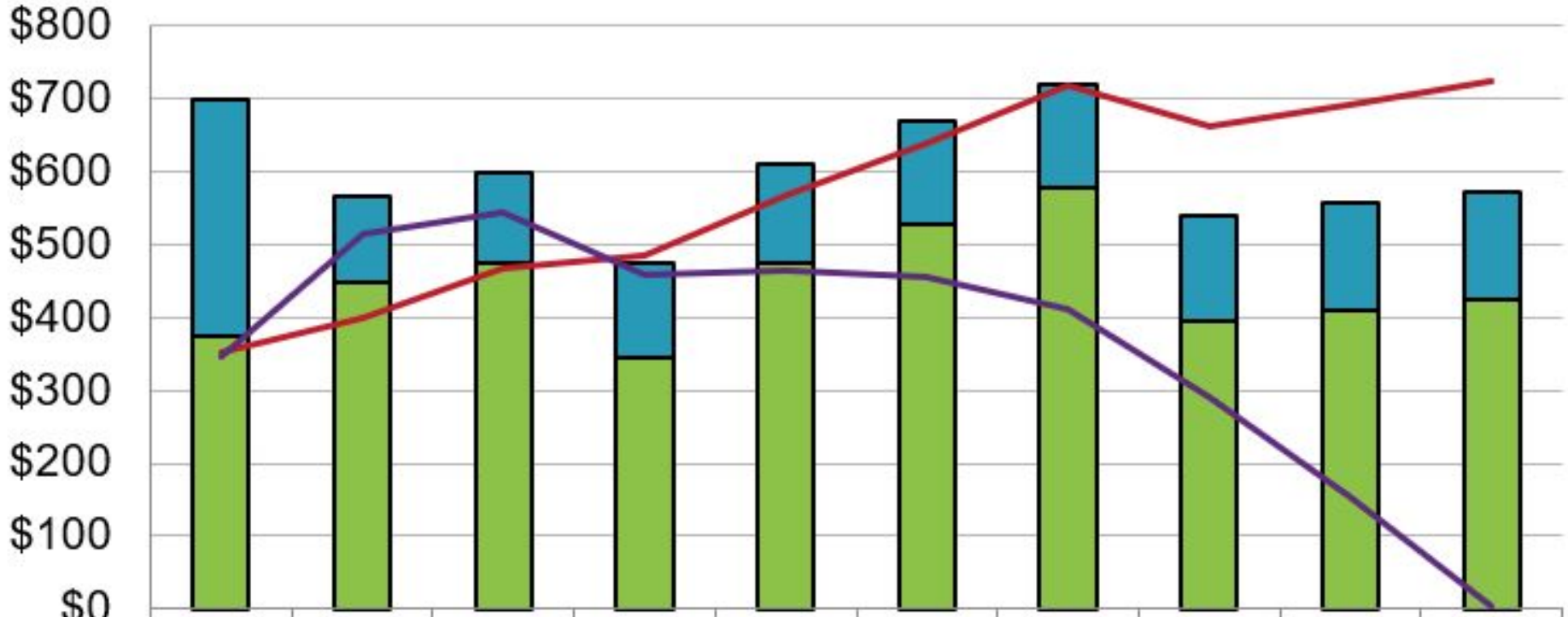
Commenter	Comment
Maryland Citizens' Health Initiative	Incorporate the full Young Adult Subsidy (YAS) to promote market stability and health equity. Work to increase the provider assessment in the future to generate funding.
Health economists: Coleman Drake, PhD (U of Pittsburgh); Mark Meiselbach, PhD & Daniel Polsky, PhD (Johns Hopkins)	Target low-income enrollees (<200%FPL) because it is most cost effective; do not extend YAS; consider supplemental cost-sharing to lowest income enrollees; keep in mind that proposed federal policies will further reduce enrollment, that reinsurance has affordability tradeoffs, and that certain subsidy designs are more effective at generating federal pass-through (especially targeting to low-income)
Individual (Mukta Bain)	Preserve the Young Adult Subsidy because of the impact to the risk pool. Widespread support for the Young Adult Subsidy evident from the passage of bill making it permanent in 2025 Session

2026 SRP Parameters Pending Board Approval

- On February 18, 2025, the Board set estimated 2025 parameters with an attachment point of $22,000
- On July 21, 2025, staff presented on parameter options for the new State Subsidy Program, which will affect the 2026 reinsurance attachment point. The Board will vote on parameters for both programs at a future ad hoc Board meeting

Parameters	Final 2019-2022	Final 2023	Final 2024	Final 2025	Estimated 2026 (as of Feb 2025)
Attachment Point	$20,000	$18,500	$20,000	$21,000	$22,000
Coinsurance Rate	80%	80%	80%	80%	80%
Cap	$250,000	$250,000	$250,000	$250,000	$250,000
Dampening Factor	0.760-0.805	0.840	0.850	0.850	TBD

July 2025 Funding Projections - 2026 Attachment Point of $22k, no eAPTC replacement

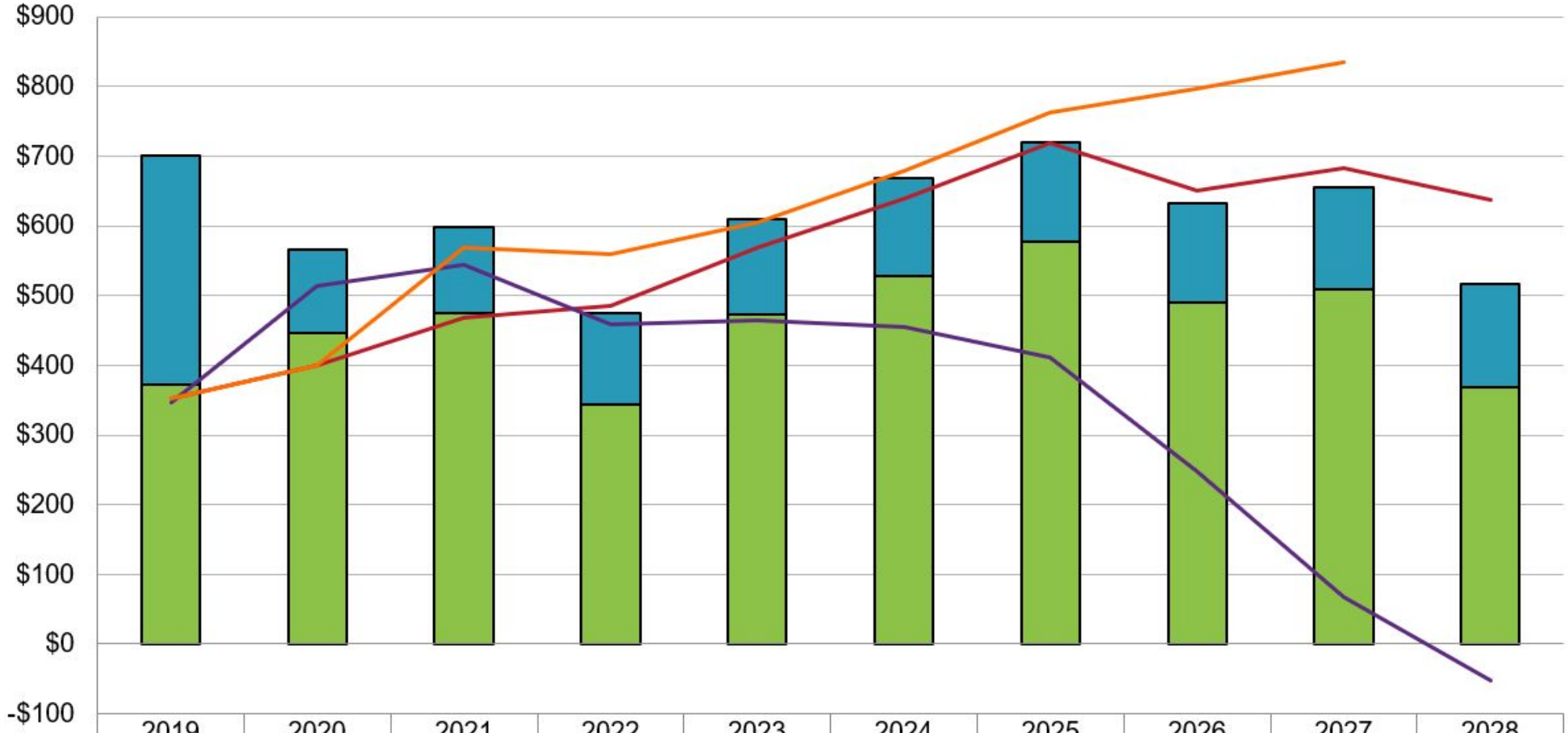


	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$137	$141	$142	$144	$147	$149
Federal Funding	$373	$447	$475	$344	$473	$527	$578	$396	$409	$424
Reinsurance Cost	$353	$400	$468	$485	$568	$639	$719	$662	$692	$723
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$454	$412	$290	$154	$4

July 2025 Funding Projections
2026 Attachment Point of $22k (A1)

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$137	$141	$142	$144	$147	$149
Federal Funding	$373	$447	$475	$344	$473	$527	$578	$576	$596	$368
Reinsurance Cost	$353	$400	$468	$485	$568	$639	$719	$768	$803	$750
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$454	$412	$233	$40	$(132)
Reins. + State Program Cost	$353	$400	$568	$560	$605	$679	$762	$899	$937	

July 2025 Funding Projections
2026 Attachment Point of $30k (A3)



	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$137	$141	$142	$144	$147	$149
Federal Funding	$373	$447	$475	$344	$473	$527	$578	$489	$509	$368
Reinsurance Cost	$353	$400	$468	$485	$568	$639	$719	$650	$683	$638
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$454	$412	$247	$68	$(52)
Reins. + State Program Cost	$353	$400	$568	$560	$605	$679	$762	$797	$834	

Waiver Amendment Update

- In early January 2025, the federal government approved MHBE's waiver amendment request to waive section 1312(f)(3) of the Affordable Care Act for the period January 1, 2026 through December 21, 2028.
  - Pursuant to Maryland's Access to Care Act (SB705/HB728)
  - Would allow all residents to enroll on-Exchange, regardless of immigration status

Calendar Year 2025 SRP Key Dates

February 18, 2025	**MHBE Board**	**Set estimated 2026 SRP parameters.**
Spring 2025	CMS	Publish estimated and final 2025 pass-through funding
May 19, 2025	MIA	2026 Rate Filing Deadline
May 2025	MIA CMS MHBE Policy	Proposed 2026 rates due Shares unadjusted 2024 SRP carrier payment amounts Carriers submit 2024 and emerging 2025 data
June 30, 2025	MHBE Policy	2024 Carrier SRP Accountability Reports due
Early July 2025	MHBE Policy	Finalize recommended 2026 SRP parameters
August 2025	**MHBE Board**	**Set final 2026 SRP parameters and 2026 State Subsidy parameters**
Mid-August – Early September	MIA	2026 rates finalized
September 2025	MHBE	Issuers receive SRP payments for 2024 claims experience

Carrier Accountability Reports

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
- Annual reports have been submitted for plan years (PYs) 2019-2023
  - CareFirst
  - Kaiser Permanente
  - United (2021 and later only)

Report Collects the Following

- 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 effectives, 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
  - Heart Disease
- Reporting instructions and templates are available here

SRP Payments and Enrollment by Carrier

- CareFirst's proportion of enrollees and payments remained steady across all years.
- Adults aged 55-64 years accounted for the largest portion of both SRP enrollment and payments in all years (data not shown).
  - 29.7% of enrollment and 32.1% of payments in PY 2023.

Carrier	# of Enrollees with Claims Reimbursed by the SRP	% of Enrollees with Claims Reimbursed by the SRP	Total SRP Payment	% of Total SRP Payment
PY 2020				
CareFirst	10,179	82%	$333,092,419	83%
Kaiser	2,225	18%	$70,532,659	17%
Total	**12,404**	**100%**	**$403,625,078**	**100%**
PY 2021				
CareFirst	12,192	83%	$394,882,353	84%
Kaiser	2,419	16%	$69,697,447	15%
United	96	1%	$3,078,688	1%
Total	**14,707**	**100%**	**$467,658,488**	**100%**
PY 2022				
CareFirst	12,297	81%	$400,941,568	83%
Kaiser	2,446	16%	$70,794,057	15%
United	392	3%	$12,746,112	3%
Total	**15,135**	**100%**	**$484,481,738**	**100%**
PY 2023				
CareFirst	13,931	79%	$459,419,112	81%
Kaiser	2,639	15%	$74,677,199	13%
United	973	6%	$33,740,167	6%
Total	**17,543**	**100%**	**$567,836,478**	**100%**

Summary of PY 2023 Care Management Initiatives

United had limited enrollment in 2023 and had no care management initiatives meeting the reporting 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.

Target Condition	Carriers and Initiatives	
	CareFirst	Kaiser
Asthma	-	-
Pregnancy	-	-
Behavioral Health	BH and SUD Care Management Behavioral Health Digital Resource	Depression Screening and Engagement Substance Use Screening and Engagement Behavioral Health Post-Hospitalization Follow Up
Diabetes	Diabetes Care Management Diabetes Virtual Program	Diabetes Care Management Diabetes Remote Data Monitoring Glycemic Control
Heart Disease	-	Heart Failure Care Management Hypertension Management Lipid Management
Other	High-Cost Claimant Unit	-

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

PY 2021	PY 2022	PY 2023
Diabetes With or Without Complications	Diabetes With or Without Complications	Cancers
HIV/AIDS	Ongoing Pregnancy without Delivery with No or Minor Complications	Major Depressive Disorder, Severe, and Bipolar Disorders
Cancers	Major Depressive Disorder, Severe, and Bipolar Disorders	(Ongoing) Pregnancy without Delivery with No or Minor Complications
Ongoing Pregnancy without Delivery with No or Minor Complications	Varicella Encephalitis and Encephalomyelitis	Autistic Disorder
Heart Failure	Cancers	Diabetes With or Without Complications

- Diabetes, major depressive/bipolar disorders, and certain pregnancy codes are among the state's public health priorities
- Cancers were also in the top 5 in each year
- Autistic disorder, 4th most frequent in 2023, was not in the top 10 in any previous PY from 2019-2022

Top 5 HCCs among SRP Claims by Total Allowed Claims

PY 2021	PY 2022	PY 2023
Cancers	Cancers	Cancers
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Hemophilia	Ongoing Pregnancy without Delivery with No or Minor Complications	Specified Heart Arrhythmias
End Stage Renal Disease	Hemophilia	Hemophilia
Inflammatory Bowel Disease	Heart Failure	Heart Failure

- HCCs covering various cancers and septicemia were the 1st and 2nd highest cost HCCs among SRP enrollees in all 3 years.
- Hemophilia was in the top 4 in each year
- Septicemia, sepsis, and systemic inflammatory response syndrome/shock were also among the top 5 in each year.

Public Comment

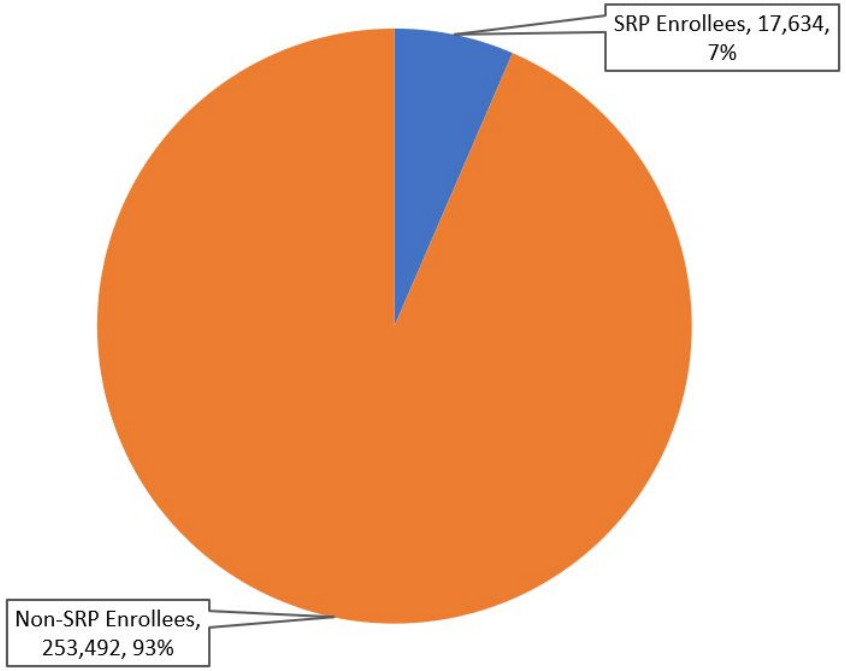
Appendix

2024 Reinsurance Results – Cost, Funding, Enrollment

2024 Program Cost and Federal Funding

	2024 Projection (L&E)	2024 Actuals
Cost	$618M	**$639M**
Federal Funding	n/a	**$527M**

2024 Total Average Individual Market Enrollment

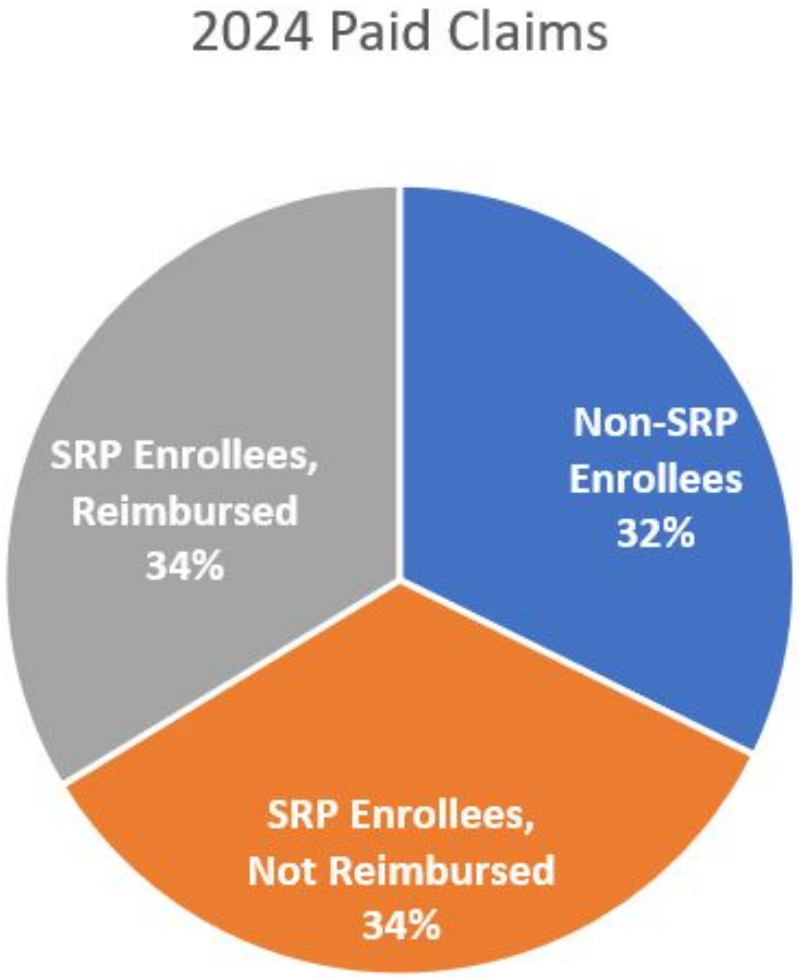


Enrollment calculated by MHBE using member months in CMS SRIS file

MARYLAND HEALTHBENEFIT EXCHANGE

2024 Reinsurance Results – Paid Claims Breakdown

- Total paid claims in 2024 were about $1.9B
- The 93% of enrollees who did not qualify for SRP payments accounted for 32% of paid claims
- The 7% of enrollees who qualified for SRP payments accounted for 68% of paid claims
  - The SRP reimbursed about half of these claims, accounting for 34% of total paid claims
  - Issuers covered the other half, accounting for 34% of total paid claims



Appendix: Summary Data, 2014-2025

Sources: MHBE Annual Reports, MHBE Plan Management, MIA Rate Decisions, Carrier Rate Justifications Data as of the end of open enrollment preceding each benefit year

Benefit Year	Participating carriers (#)	# QHPs Offered	Enrollment	Subsidized/ Unsubsidized (%)	Premium Change (%)	Rate Justification
2014	4	45	81,553	80/20	-	-
2015	5	53	131,974	70/30	10%	Sicker/Older Pool | MHIP Migration | Increased unit cost of care | Increased utilization | Health Insurer Fee
2016	5	53	162,652	70/30	18%	Actual claims experience higher than 2015 rates | Pent-up demand in formerly uninsured entrants | Risk Adjustment payments | Increased cost and utilization trends | Reduction in reinsurance payments
2017	3	23	157,637	78/22	21%	Increased unit cost of care, claims, morbidity of pool | Cessation of the reinsurance program
2018	2	21	153,571	79/21	50%	New members entering risk pool | Current members terminating coverage | Increased churn and trend | Loss of CSR | Individual mandate enforcement not included in rate
2019	2	20	156,963	77/23	-13%	Introduction of the State Reinsurance Program | Medical inflation | Removal of the Individual Mandate
2020	2	23	158,934	76/24	-10%	Ongoing effectiveness of reinsurance program | Trend
2021	3	33	166,038	73/27	-12%	Reinsurance program | New market entrants
2022	3	33	181,206	79/21	2.1%	
2023	3	33	182,166	76/24	6.6%	
2024	4	42	213,895	77/23	4.7%	
2025	5	46	249,603	77/23	6.2%	Claims cost trend

MARYLAND HEALTHBENEFIT EXCHANGE

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.

Age Distribution of and Cost to Replace APTC for Lawfully Present Enrollees with Incomes <100% FPL by Age

Age Band	2026 APTC Per Member Per Year (PMPY)	# Enrollees	Cost to Replace APTC for One Year
0-17	$2,900	34	$98,600
18-25	$3,600	1,331	$4,791,600
26-34	$4,200	2,761	$11,596,200
35-44	$4,800	3,520	$16,896,000
45-54	$6,700	2,848	$19,081,600
55-64	$10,200	2,876	$29,335,200
65+	$11,600	6,211	$72,047,600
TOTAL		19,581	**$153,846,800**

Md. Ins. Art., §31-125

(A) IN THIS SECTION, “PROGRAM” MEANS THE STATE–BASED HEALTH INSURANCE SUBSIDIES PROGRAM.
(B) **THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A STATE–BASED HEALTH INSURANCE SUBSIDIES PROGRAM TO PROVIDE SUBSIDIES TO INDIVIDUALS FOR THE PURCHASE OF HEALTH BENEFIT PLANS IN THE INDIVIDUAL HEALTH INSURANCE MARKET.**
(C) THE PROGRAM REQUIRED UNDER THIS SECTION SHALL BE DESIGNED TO:
(1) MAINTAIN AFFORDABILITY FOR INDIVIDUALS PURCHASING HEALTH BENEFIT PLANS THROUGH THE EXCHANGE; AND
(2) TARGET INDIVIDUALS WHO EXPERIENCE AN INCREASE IN THE APPLICABLE PERCENTAGES ESTABLISHED UNDER 26 U.S.C. § 36B(B)(3)(A)(III) FOR PREMIUMS BASED ON HOUSEHOLD INCOME IN CALENDAR YEARS 2026 AND 2027, AS COMPARED TO THE APPLICABLE PERCENTAGES IN PLACE FOR CALENDAR YEAR 2025.
(D) SUBJECT TO AVAILABLE FUNDS, FOR CALENDAR YEARS 2026 AND 2027, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH SUBSIDY ELIGIBILITY AND PAYMENT PARAMETERS FOR THE PROGRAM THAT:
(1) MITIGATE A REDUCTION IN ADVANCE PREMIUM TAX CREDITS BECAUSE OF CHANGES IN THE APPLICABLE PERCENTAGES DESCRIBED IN SUBSECTION (C)(2) OF THIS SECTION; AND
(2) MAXIMIZE ENROLLMENT IN THE INDIVIDUAL MARKET;
(3) TAKE INTO CONSIDERATION STATE FUNDS NEEDED TO ENSURE THE STATE REINSURANCE PROGRAM CONTINUES TO PROVIDE MARKET STABILITY THROUGH CALENDAR YEAR 2028; AND
(4) TAKE INTO CONSIDERATION UNCERTAINTIES IN ENROLLMENT IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE INDIVIDUAL MARKET, AND THE SMALL GROUP MARKET DUE TO CHANGES IN STATE AND FEDERAL REGULATION AND FUNDING.
(E) IN FISCAL YEARS 2026 THROUGH 2028, THE EXCHANGE MAY DESIGNATE FUNDS FROM THE FUND TO BE USED FOR THE PROGRAM.
(F) THE EXCHANGE SHALL ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

SRP Payments and Enrollment by Carrier (1/2)

Carrier	# of Enrollees with Claims Reimbursed by the SRP	% of Enrollees with Claims Reimbursed by the SRP	Total SRP Payment	% of Total SRP Payment*	% of Total Market Enrollment
PY 2019					
CareFirst	9,095	79%	$267,234,734	76%	53%
Kaiser	2,389	21%	$85,563,864	24%	47%
Total	**11,484**	**100%**	**$352,798,597**	**100%**	**100%**
PY 2020					
CareFirst	10,179	82%	$317,104,612	79%	62%
Kaiser	2,225	18%	$83,002,042	21%	38%
Total	**12,404**	**100%**	**$400,106,654**	**100%**	**100%**
PY 2021					
CareFirst	12,192	83%	$381,657,103	82%	67%
Kaiser	2,419	16%	$81,956,875.77	18%	32%
United	96	1%	$4,044,508.52	1%	1%
Total	**14,707**	**100%**	**$467,658,488**	**100%**	**100%**
PY 2022					
CareFirst	12,297	81%	$386,768,673	80%	64%
Kaiser	2,446	16%	$82,396,335.82	17%	30%
United	392	3%	$15,755,448.35	3%	6%
Total	**15,135**	**100%**	**$484,920,457**	**100%**	**100%**

*May not sum to 100% due to rounding

SRP Payments and Enrollment by Carrier (2/2)

Carrier	# of Enrollees with Claims Reimbursed by the SRP	% of Enrollees with Claims Reimbursed by the SRP	Total SRP Payment	% of Total SRP Payment*	% of Total Market Enrollment
PY 2022					
CareFirst	12,297	81%	$386,768,673	80%	64%
Kaiser	2,446	16%	$82,396,335.82	17%	30%
United	392	3%	$15,755,448.35	3%	6%
Total	**15,135**	**100%**	**$484,920,457**	**100%**	**100%**
PY 2023					
CareFirst	13,931	79%	$459,419,113	81%	60%
Kaiser	2639	15%	$74,677,199	13%	26%
United	980	6%	$33,740,167	6%	14%
Total	**17,550**	**100%**	**$567,836,479**	**100%**	**100%**
PY 2024					
CareFirst	13,898	73%	$479,423,991	75%	51%
Kaiser	2524	13%	$78,403,476	12%	20%
United	2349	12%	$75,860,517	12%	27%
Aetna	143	1%	$5,250,414	1%	1%
Total	**18,914**	**99%***	**$638,938,398**	**100%****	**99%***

MARYLAND HEALTHBENEFIT EXCHANGE

*May not sum to 100% due to rounding

**Carrier-specific amounts may not be final as dampening factor has not yet been applied

Helpful Resources

- State Health and Values Strategies presentation (7/10): Changes to the Marketplaces
- KFF tracker: Health Provisions in the 2025 Federal Budget Reconciliation Bill
  - Includes overview of Medicaid provisions too

July 29, 2025

Michele Eberle, Executive Director
Maryland Health Benefit Exchange
750 E. Pratt St.
Baltimore, MD 21202

Dear Ms. Eberle,

Maryland Citizens' Health Initiative Education Fund, Inc.'s mission is to advocate for quality, affordable health care for all Marylanders. We applaud the reinsurance program in Maryland which has successfully boosted enrollment by reducing premiums by 17% since 2018 and helped make Maryland's lowest cost plans about 30% below U.S. averages. Thanks to the reinsurance program over 19,000 additional Marylanders have been able to afford quality health coverage in 2025 than if the reinsurance program did not exist. We support its continuation.

The federal Budget Reconciliation Bill and "Marketplace Integrity and Affordability" Rule significantly threaten the progress Maryland has made expanding access to health coverage by adding administrative hurdles to Marylanders obtaining and keeping their coverage and by failing to renew the enhanced federal premium tax credits that became available under the Inflation Reduction Act and have helped so many Marylanders access health coverage. We applaud the Maryland General Assembly and Gov. Wes Moore for passing HB 1082 to establish a status subsidy program contingent on the expiration of enhanced federal premium subsidies and on availability of state funds in the reinsurance program. We further thank MHBE and the Maryland Insurance Administration for identifying two potential models for this program which both prioritize helping lower-income Marylanders and young adults afford their health coverage. Fully folding the young adult subsidy into the new state subsidy program will help ensure that young and healthy adults remain in the market, further helping to stabilize premiums while improving equity in access to coverage.

We also thank you for supporting HB 424/SB 357 to expand the authority of Maryland's Prescription Drug Affordability Board to be able to make high-cost prescription drugs more affordable for ALL Marylanders, which will further help to stabilize premiums because of the large share of total spending in the individual market that is comprised of prescription drugs.

Thank you once again for this opportunity to comment, and for doing during these challenging times everything in your power to protect and improve access to quality, affordable health coverage for all Marylanders.

Sincerely,

Stephanie Klapper

Stephanie Klapper, Deputy Director
Maryland Citizens' Health Initiative Education Fund, Inc.

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