



LARRY HOGAN  
GOVERNOR

STATE OF MARYLAND  
OFFICE OF THE GOVERNOR

May 18, 2018

The Hon. Alex M. Azar, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

The Hon. Steven T. Mnuchin, Secretary  
U.S. Department of the Treasury  
1500 Pennsylvania Avenue, NW  
Washington, DC 20220

Dear Secretary Azar and Secretary Mnuchin:

The State of Maryland respectfully asks for your assistance in creating a solution to the increasingly destabilized individual health insurance market in our state by approving our application for a Section 1332 State Innovation Waiver. As detailed in this application, Maryland is requesting that Section 1312(c)(1) of the Affordable Care Act (ACA) be waived for a period of five years beginning in the 2019 plan year to implement a state reinsurance program. This waiver will not affect any other provision of the ACA and adheres to the general guardrails established by Section 1332.

Without significant assistance, for example, in the form of a sizeable reinsurance program, a key part of the State's recent success in reducing the rate of uninsured Marylanders may be seriously compromised. Maryland has one of the best healthcare delivery systems in the country, and only six percent of our citizens do not have health insurance. However, we have experienced a significant contraction in the number of carriers offering policies in our individual health insurance market. From its peak in benefit years 2015 and 2016, the number of carriers offering plans on the state insurance exchange has decreased from five to two. Since the implementation of the Affordable Care Act, rates on the individual market in Maryland have risen by an outrageous and unsustainable 166 percent, and are set to increase by over 200 percent without action. Unless decisive and corrective action is taken, we anticipate that these rates will continue to rise to unaffordable levels for the approximately 250,000 Marylanders who rely on this form of access to health care.

As demonstrated in the comprehensive analysis attached in the application, we believe your assistance at the federal level, including federal pass-through funds, will allow more predictability in the health insurance market and allow Maryland's State Reinsurance Program to lower premium rates market-wide. Ensuring that health care is as accessible and affordable as possible for our citizens is a goal I am confident that we share. Combined with State resources, your expedited approval and federal contribution would assist us in stabilizing the individual market so that we can preserve our recent gains in health care delivery and deliver system-wide health savings.

Thank you for your consideration.

Sincerely,



Larry Hogan  
Governor

cc: Seema Verma, Administrator, Centers for Medicare and Medicaid Services

**Congress of the United States**  
Washington, DC 20510

May 17, 2018

The Honorable Steven Mnuchin  
Secretary of the Treasury  
Department of the Treasury  
1500 Pennsylvania Avenue, NW  
Washington, DC 20220

The Honorable Alex Azar  
Secretary of Health and Human Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201


Dear Secretary Mnuchin and Secretary Azar,


We write to request that the U.S. Department of the Treasury and the U.S. Department of Health and Human Services grant Maryland's application for a Section 1332 State Innovation Waiver as soon as possible. We urge that this process include careful and thorough consideration of key stakeholder's input such as the Maryland Medical Society.

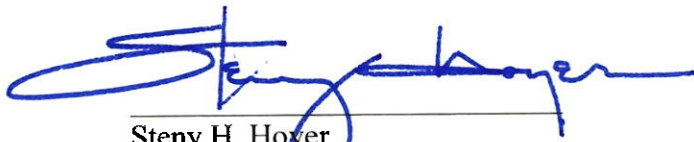
Earlier this year, the Maryland General Assembly voted to establish a state-based reinsurance program, the Maryland State Reinsurance Program. The Governor and both Democratic and Republican leaders strongly support this effort to address premium costs and access to affordable healthcare in our state. The Maryland Insurance Administration estimates that the State Reinsurance Program would lower premium rates market-wide by as much as 30 percent and would lead to a reduction in federal payments of advance premium tax credits. By contrast, without federal approval, rates for many individual market plans could increase substantially.

The matter is urgent because the Maryland Insurance Administration must finalize the approval of the individual market rates by September 1, 2018. Accordingly, on behalf of our constituents, we urge you to complete your consideration of Maryland's waiver application as soon as possible.

Sincerely,

  
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Benjamin L. Cardin  
United States Senator

  
\_\_\_\_\_  
Chris Van Hollen  
United States Senator



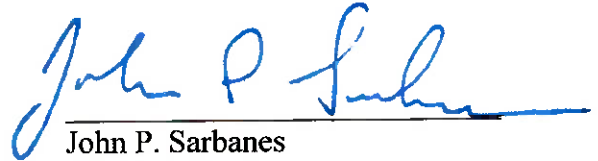
Steny H. Hoyer  
Member of Congress



Elijah E. Cummings  
Member of Congress



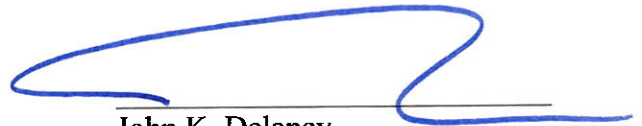
C.A. Dutch Ruppersberger  
Member of Congress



John P. Sarbanes  
Member of Congress



Andy Harris, M.D.  
Member of Congress



John K. Delaney  
Member of Congress



Jamie Raskin  
Member of Congress



Anthony G. Brown  
Member of Congress





# **Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program**

**Maryland Health Benefit Exchange  
*Submitted May 31, 2018***

**Updated on August 15, 2018 to include:**

- **Addendum to the Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program. *Submitted August 4, 2018.***
- **Maryland Response to Application Reviewer Questions from Federal Public Comment Period. *Submitted August 10, 2018.***

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## **Executive Overview**

### ***Waiver Request***

On behalf of the state of Maryland, the Maryland Health Benefit Exchange (MHBE) respectfully submits this 1332 state innovation waiver application to the United States Department of the Treasury and the United States Department of Health and Human Services. Maryland is requesting to waive Section 1312(c)(1) of the Affordable Care Act (ACA) for a period of five years to implement a state reinsurance program. The waiver would cover plan years 2019 through 2023. The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, which will decrease premiums and federal payment of advance premium tax credits (APTCs). The waiver will not affect any other ACA provisions.

### ***Rationale and Goals of the Reinsurance Program***

While Maryland has made great strides in improving access to health care coverage, its non group health insurance market is experiencing some challenges that are jeopardizing affordability and viability. Over recent years, a number of carriers have exited the non group health insurance market, creating less competition in the market and leaving fewer choices for consumers. Only two carriers remain, and only one offers coverage statewide. At the same time, premiums have risen dramatically and are expected to continue to increase without further stabilization efforts. The proposed reinsurance program would help stabilize the market by offsetting the rate impact of high cost claims.

### ***Impact and Operation of the Reinsurance Program***

House Bill 1795 was signed into law on April 5, 2018, establishing the Maryland reinsurance program, which will be operated by the MHBE. Total program costs for 2019 are expected to be approximately \$462 million. House Bill 1782, signed into law on April 10, 2018, creates a 2.75 percent assessment on certain health insurance plans and state regulated Medicaid managed care organizations to help fund the reinsurance program; the assessment fee is estimated to collect \$365 million in 2019. Through this waiver application, Maryland is seeking federal pass-through funding through net APTC savings to fund the remainder of the program costs.

The reinsurance program will operate as a traditional, claims-based reinsurance program that will reimburse qualifying health insurers for a percentage of an enrollee's claims between an attachment point and cap. Maryland is proposing a cap of \$250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders. The MHBE will establish the payment parameters each year. It is estimated that the reinsurance program will reduce average premiums by approximately 30 percent in 2019 from what they would be absent the waiver. Operationally, the MHBE can administer the program with existing resources if the federal government is able to accommodate certain modifications to the existing EDGE server infrastructure, thereby leveraging existing resources and reducing downstream administrative burden. If such federal flexibility is not available, the MHBE can administer the program with additional resources

costing \$434,000 in fiscal year 2019. These potential approaches are detailed in *Section VI. Additional Information under Administrative Burden.*

### **Compliance with Section 1332**

Waiver of Section 1312(c)(1) will not affect the comprehensiveness of coverage in Maryland's insurance markets. The reinsurance program will reduce premiums by approximately 30 percent in 2019 from what they would be absent the waiver, making insurance more affordable. In turn, enrollment in the non group market is expected to increase by 5.8 percent in 2019. The decreased premiums will decrease federal spending on APTCs. The actuarial analysis estimates that federal savings will be \$304 million, \$319 million, and \$157 million in 2019, 2020, and 2021, respectively.

## I. Maryland 1332 Waiver Request

Since the enactment of the Affordable Care Act (ACA), the state of Maryland has made great strides in improving access to health care coverage, with the uninsured rate decreasing from 10.2 percent in 2013 to 6.1 percent in 2016.<sup>1</sup> As of February 1, 2018, 145,109 residents were enrolled in qualified health plans (QHPs) offered through the Maryland Health Benefit Exchange (MHBE), and over 315,000 were enrolled in the ACA Medicaid expansion. With these coverage expansions, hospital uncompensated care has also decreased from 7.2 percent of gross patient revenue in state fiscal year 2013 to 4.6 percent in 2016. This in turn reduced the all-payer costs for uncompensated care built into hospital rates under Maryland's hospital rate-setting system.<sup>23</sup>

Prior to the ACA, Maryland's non group health insurance market was underwritten, meaning that insurance carriers could deny coverage to individuals based on health status. At that time, the state operated a high-risk pool—the Maryland Health Insurance Program—that offered coverage to certain individuals who could not otherwise qualify for non group market coverage due to pre-existing health conditions. With the ACA reforms, this program was phased out, and participants could transition into QHPs. To mitigate the premium impact of the uncertainty of the health status of new entrants into the non group market and the transition of high-risk pool enrollees, the ACA created several premium stabilization programs, including the:

- Permanent risk adjustment program
- Temporary risk corridors program
- Temporary reinsurance program

Both of the temporary programs have expired under the terms of the ACA. Maryland also supplemented the federal transitional reinsurance program for plan years 2015 and 2016 by increasing the coinsurance rate. Despite these initial premium stabilization programs, Maryland's non group health insurance market—as in other states—is experiencing some challenges that are jeopardizing its affordability and viability.

Over the past several years, a number of carriers have exited the non group health insurance market, creating less competition in the market and leaving fewer choices for consumers. Carrier participation decreased from a high of five in the 2015 and 2016 plan years to only two in 2018. Of the two remaining carriers, only one is statewide, and 13 of Maryland's 24 counties have only one carrier. At the same time, premiums have risen dramatically. Average rates increased by as much as 53.6 percent between 2017 and 2018 alone.<sup>4</sup> Without further stabilization efforts,

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<sup>1</sup> U.S. Census Bureau. Current Population Survey. Retrieved from <https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html>

<sup>2</sup> Maryland Health Services Cost Review Commission (2016, October). *Report to the Governor: Fiscal Year 2016*. Retrieved from <http://www.hscrc.state.md.us/Documents/pdr/ar/Gov-Report-FY2016-102516.pdf>.

<sup>3</sup> Maryland Health Services Cost Review Commission. (2017, April 12). *Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2016*. Retrieved from <http://www.hscrc.state.md.us/Documents/pdr/ar/HSCRC-Disclosure-Report-FY-2016.pdf>.

<sup>4</sup> Maryland Insurance Administration. (2017, October 25). *Maryland Insurance Administration Approves Amended 2018 Premium Rates for Silver On-Exchange Plans Sold in the Individual Market*. Retrieved from <http://www.mdinsurance.state.md.us/Pages/newscenter/NewsDetails.aspx?NR=2017172>

premiums are expected to continue to increase at an unsustainable rate, raising concerns about the future viability of the market, a loss of access to coverage for consumers, and potential downstream implications for Maryland’s hospital all-payer model.

Therefore, Maryland is requesting to waive Section 1312(c)(1) of the ACA to implement a state reinsurance program. Section 1312(c)(1) states that a “health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the non group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.” The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate. A lower index rate would in turn decrease premiums and decrease the premium subsidy amount that the federal government would have paid for eligible consumers. Maryland is requesting a five-year waiver for plan years 2019 through 2023 to implement a state-operated reinsurance program to stabilize the non group market by making premiums more affordable.

Table 1 below summarizes the potential impact of the waiver program on premiums, enrollment, and net federal savings in 2019, as estimated by the Wakely Consulting Group. It is estimated that the program will reduce average premiums by 30 percent from what they would be absent the waiver, increase non-group market enrollment by 5.8 percent, and generate \$304 million in federal savings.

**Table 1. Potential Impact of the Maryland Reinsurance Waiver on 2019 Premiums, Enrollment, and Federal Deficit**

	<b>Premium Impact</b>	<b>Non-Group Enrollment</b>	<b>Federal Savings</b>
Effects of Reinsurance	-30.0%	+5.8%	\$304 million

## **II. Compliance with Section 1332 Guardrails**

The actuarial analysis estimated that the proposed waiver program meets all four of the required Section 1332 guardrails in 2019, as well as each subsequent year of the required 10-year window. See Attachment 5 for the full analyses.

### ***Comprehensive Coverage Requirement (1332(b)(1)(A))***

The first guardrail for 1332 waivers is that health care benefits must be at least as comprehensive as they would have been without the waiver. The proposed program will have no impact on covered benefits and will not change the essential health benefit benchmark plan or actuarial value requirements. All ACA-compliant plans in the state are required to provide essential health benefits.<sup>5</sup> The program will have no impact on the scope of benefits in other health insurance markets in the state.

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<sup>5</sup> Ins. Art. § 31-115(b)(1), Ann. Code of MD.



### ***Affordability Requirement (1332(b)(1)(B))***

The second guardrail is that health care coverage must be as least as affordable as it would have been without the waiver. The proposed program will decrease average premiums by an estimated 30 percent in 2019 from what they would be absent the waiver, and premiums will be lower than or equal to what they otherwise would have been during each subsequent year of the waiver. Cost sharing protections against excessive out-of-pocket spending will remain the same and within federal requirements, so the waiver will not have an impact on affordability in terms of cost sharing. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, the Children's Health Insurance Program (CHIP), small or large group market insurance, or other types of coverage. Employer contributions and employee wages are not expected to be affected by the waiver. The waiver will not affect the calculation of small business tax credits offered under the Small Business Health Options (SHOP) program.

### ***Scope of Coverage Requirement (1332(b)(1)(C))***

The third guardrail is that the state must cover at least a comparable number of people as it would have covered without the waiver. As noted above, the proposed program will reduce average non group market premiums in 2019. This lower cost will in turn allow a greater number of consumers to newly purchase or maintain coverage in the non group market than without the waiver. Enrollment is expected to increase by approximately 5.8 percent in 2019. In subsequent years, enrollment is projected to be greater than or equal to what it would have been absent the waiver. Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, small or large group market insurance, or other types of coverage, will have the same access to coverage.

### ***Federal Deficit Requirement (1332(b)(1)(D))***

The fourth guardrail is that the waiver program cannot increase the federal deficit. The proposed reinsurance program will reduce non group market premiums in Maryland in 2019, including premiums for the second lowest cost silver plan. As the federal advanced premium tax credit (APTC) is based on the second lowest cost silver plan, the federal government will pay less for APTCs in Maryland than it would have paid without the waiver. The actuarial analysis estimates that the aggregate amount of APTCs will be less than or equal to what the federal government would have paid absent the waiver for each year of the required 10-year budget window. Federal savings are estimated to be \$304 million, \$319 million, and \$1577 million in 2019, 2020, and 2021, respectively.

## **III. Description of the 1332 Waiver Proposal**

### ***Enabling Legislation***

The Maryland General Assembly passed two bills during the 2018 legislative session related to the establishment of the reinsurance program (see Attachment 1 for full copies of the enabling legislation). The Maryland General Assembly passed HB 1795, *Maryland Health Benefit Exchange-Establishment of a Reinsurance Program*, on March 26, 2018, and Governor Larry

Hogan signed the legislation on April 5, 2018. The bill directs the MHBE, in consultation with the Maryland Insurance Administration (MIA), to establish a state reinsurance program for carriers that offer non group market health insurance coverage in Maryland. The goal of the program is to mitigate the impact of high-risk individuals on premium rates in the non group market. The bill authorizes the MHBE to develop payment parameters for the reinsurance program beginning with the 2019 plan year, including the attachment point, coinsurance rate, and reinsurance cap. The bill authorizes funds for the program from (1) federal pass-through funds under an approved 1332 waiver, (2) any funds designated by the federal government to provide reinsurance to non group market carriers, and (3) any funds designated by the state. Finally, the bill requires the MHBE to apply for a federal 1332 waiver to carry out the program, and implementation is contingent upon federal approval of this waiver. The bill grants the MHBE the authority to adopt regulations to implement the program. On April 16, 2018, the MHBE Board of Trustees voted to approve a state reinsurance program for 2019 with an attachment point that will be determined based on funding availability and consideration of stakeholder feedback, a coinsurance rate of 80 percent, and a cap of \$250,000. See Attachment 2 for the accompanying MHBE Board Resolution.

The second bill, HB 1782, *Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018)*, was passed on April 5, 2018 and signed by Governor Hogan on April 10, 2018. It creates a health plan assessment for the 2019 plan year to help fund the reinsurance program. Section 9010 of the ACA created a federal health insurance provider fee for covered entities engaged in the business of providing health insurance. The fee is based on the entity's net premiums for the year and was intended to help fund exchanges. The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019.<sup>6</sup> HB 1782 applies a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state, and essentially allows the state to collect certain funds that the federal government would have collected under Section 9010.

## **Program Features**

Maryland is proposing to use a traditional, claims-based reinsurance program that would help pay claims associated with high-cost participants. The program will reimburse non group market carriers for a percentage of the costs (coinsurance rate) for participants with annual claims costs exceeding a specified threshold (attachment point) and up to specified ceiling (reinsurance cap). Based on estimated funding and costs of the program, Maryland is proposing a reinsurance program with a cap of \$250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders. This will allow active stakeholder engagement and reflect the latest data available so that estimated reinsurance payments match the funding available. If the 2019 experience is more expensive than predicted, the MHBE may adjust these payment parameters. On the other hand, if the 2019 experience is less expensive than predicted, the MHBE may reserve the funds for future years. The program's authorizing legislation grants the MHBE the authority to establish the payment parameters each year.

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<sup>6</sup> H.R. 195, 115th Cong. § 4003 (2017) (enacted).

## **Funding Mechanism**

Total program costs for 2019 are expected to be about \$462 million. Through this waiver application, Maryland requests federal pass-through funding through net APTC savings. The remaining program costs will be funded through the state health insurance assessment described above, which is estimated to collect \$365 million.

## **IV. Waiver Implementation Timeline**

The MHBE will implement and operate the reinsurance program. The MHBE will receive the federal pass-through and state funds, collect and review reinsurance claims from carriers (should EDGE server modifications not be feasible), and make payments to carriers for eligible claims. The MHBE already has experience with this process, as it implemented a state supplemental reinsurance program that wrapped around the federal transitional reinsurance program for the 2015 and 2016 plan years. The MHBE proposes the following draft implementation timeline for the initial years of the program. The MHBE respectfully requests a federal approval date of no later than August 22, 2018, in order for the state to approve final rates, certify QHPs, and load this information to the Maryland Health Connection website in time for renewal operations and open enrollment for the 2019 plan year.

**Table 2. Draft Implementation Timeline**

<b>Date</b>	<b>Milestone</b>
March 1, 2018	Non-group market carrier form filing deadline with the MIA for the 2019 plan year.
April 5, 2018	Reinsurance program is signed into law.
April 16, 2018	MHBE Board votes on parameters for the waiver application.
April 20, 2018	Waiver application is released for public comment. Although there are no federally-recognized tribes in the state, state-recognized tribes are encouraged to participate.
April 26, 2018	Public hearing is held on the Eastern Shore.
May 1, 2018	Non-group market carrier rate filing deadline with the MIA for the 2019 plan year.
May 3, 2018	Public hearing is held in Central Maryland.
May 7, 2018	Public hearing is held in Western Maryland.
May 10, 2018	Public hearing is held in Southern Maryland.
May 20, 2018	State public comment period closes.
May 21, 2018	MHBE Board votes to incorporate public comment feedback into waiver application.
May 31, 2018	Incorporate public comment and submit waiver application to the federal government.
July 16, 2018	Application deemed complete by the federal government. Federal approval and public comment period begins.
July 2018	MHBE begins state regulations promulgation process.
August 16, 2018	Federal 30-day comment period closes.
August 22, 2018	Desired federal approval date.
September 1, 2018	MIA approves rates for the 2019 plan year.
September 1, 2018	Reinsurance program payment parameters for the 2019 plan year will be finalized.
October 1, 2018	MHBE certifies QHPs for the 2019 plan year.
November 1, 2018	Open enrollment begins.
January 1, 2019	State regulations to operate the program become effective.

<b>Date</b>	<b>Milestone</b>
March 1, 2019	Non-group market carrier form filing deadline with the MIA for the 2020 plan year.
March 15, 2019	Premium assessment collection by the MIA.
April 15, 2019	MHBE submits quarterly report to the federal government.
May 1, 2019	Non-group market carrier rate filing deadline with the MIA for the 2020 plan year.
June 2019	MHBE holds required 6-month public forum.
July 1, 2019	Reinsurance program payment parameters for the 2020 plan year will be finalized.
July 15, 2019	MHBE submits quarterly report to the federal government.
August 2019	MIA approves rates for the 2020 plan year.
October 1, 2019	MHBE certifies QHPs for the 2020 plan year.
October 15, 2019	MHBE submits quarterly report to the federal government.
December 31, 2019	Premium assessment funds transferred to Maryland Health Benefit Exchange no later than the indicated date.
January 15, 2020	MHBE submits quarterly report to the federal government.
March 1, 2020	Non-group market carrier form filing deadline with the MIA for the 2021 plan year.
April 1, 2020	MHBE submits first annual report to the federal government.
April 15, 2020	MHBE submits quarterly report to the federal government.
May 1, 2020	Non-group market carrier rate filing deadline with the MIA for the 2021 plan year. Carriers submit 2019 claims to MHBE for reimbursement.
June 2020	MHBE holds required annual public forum.
July 1, 2020	Reinsurance program payment parameters for the 2021 plan year will be finalized.
July 15, 2020	MHBE submits quarterly report to the federal government.
August 2020	MIA approves rates for the 2021 plan year.
October 1, 2020	MHBE certifies QHPs for the 2021 plan year.
October 15, 2020	MHBE submits quarterly report to the federal government.
December 31, 2020	MHBE reimburses carriers for eligible 2019 claims.

## **V. Actuarial and Economic Analysis**

The State of Maryland Department of Legislative Services (DLS), through Bolton Partners, retained the Wakely Consulting Group, LLC (Wakely). Through a Memorandum of Understanding with DLS, the MHBE has engaged with Wakely to address the actuarial analysis, actuarial certifications, economic analysis, data, and assumptions requirements for a 1332 waiver. Wakely collected 2016, 2017, and emerging 2018 data directly from Maryland insurers to develop the base data for the analyses. See Attachment 5 for Wakely’s full report.

## **VI. Additional Information**

### ***Administrative Burden***

This waiver program may pose a minor administrative burden to the federal government and to the state. Within the federal government, staff from the Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) will have the increased burden of:

- Reviewing and approving the waiver application
- Determining and transferring pass-through funds to the state
- Reviewing state reports, including the required quarterly and annual reports
- Periodically evaluating the program
- Reviewing any documented complaints related to the waiver that may arise
- Modifying the EDGE server infrastructure to leverage for the program

The waiver will not affect the calculation or payment of APTCs.

Within Maryland, the waiver program will have no administrative impact on employers or consumers, and consumers will continue to shop for and purchase plans through the same vehicles as available now. The program will have a small administrative impact on non group market insurance carriers in terms of identifying and submitting documentation of reinsurance claims for reimbursement. These carriers, however, have previously implemented these processes under the federal transitional and Maryland supplemental reinsurance programs, and the financial benefit of reinsurance payments will far outweigh these administrative costs.

To implement a program with the greatest administrative efficiency, the MHBE respectfully requests consideration on whether the existing EDGE server infrastructure, utilized in the administration of the risk adjustment program and transitional reinsurance program, may be leveraged to implement the State Reinsurance Program with modifications. The MHBE has received feedback from the issuers participating in the non group market that leveraging the EDGE server would increase program efficiency and reduce downstream administrative burden. Should the request to leverage the EDGE server be approved, the implementation, and ongoing, costs of modifications to the EDGE server may be drawn from the total pass-through funding amount received from waiver approval. If approved, the MHBE will supply the necessary reinsurance parameters to the federal government annually, through written communication, on a timeline to be determined with federal partners.

Alternatively, if the primary method should not be available, the waiver program will have a minor impact on state agency burden. The MHBE will be responsible for administering the program, including administering funds, reviewing and collecting claims information from carriers, paying carriers for eligible claims, ongoing program monitoring, and complying with federal reporting and public comment requirements. The MHBE previously administered a state supplemental reinsurance program for the 2015 and 2016 plan years and can leverage and build upon these pre-existing resources. The MHBE anticipates some additional staff costs for administering the program, including hiring a program manager and IT consultant time. These costs are estimated to be approximately \$434,000 in state fiscal year 2019, \$582,000 in 2020, and \$599,000 in 2021. The MIA may also have minor increased burden related to reviewing and

approving carrier rate filings and state health insurance premium tax collection, but this can be absorbed by current staff resources.

### ***Impact on Other ACA Provisions***

The program will have no impact on other provisions of the ACA.

### ***Impact on Access to Out-of-State Services***

Maryland shares borders with Virginia; West Virginia; Washington, D.C.; Pennsylvania; and Delaware. Of the two carriers in Maryland's non group insurance market, one offers coverage statewide, and the other offers coverage in 11 of 24 counties. Both carriers' networks contain providers in border states. This waiver will not affect provider networks or access to services out-of-state.

### ***Compliance, Fraud, Waste, and Abuse***

The MIA is responsible for regulating and monitoring the solvency of non group market insurance carriers and performing market conduct analysis, examinations, and investigations. The MHBE is responsible for certifying non group market QHPs for participation on the exchange. The MIA and MHBE will continue these existing processes under the waiver program.

The MHBE has a robust compliance program and will administer the reinsurance program in accordance with its existing compliance and auditing procedures. The Maryland Office of Legislative Audits conducts a financial audit of the MHBE every three years, and per ACA requirements, the MHBE contracts with an independent, external auditor each year to audit financial and program activities. As a state-based exchange, the MHBE is also subject to audits by the U.S. Government Accountability Office, CMS, and the Internal Revenue Service. The MHBE also maintains internal and external stakeholder hotlines for reporting of fraud, waste, and abuse concerns.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

## **VII. State Reporting Requirements and Targets**

The MHBE will comply with the quarterly and annual waiver reporting requirements as defined in 45 CFR §155.1324. States must submit quarterly reports in accordance with the terms and conditions specified in the waiver. These reports must include, but are not limited to reports of any ongoing operational challenges and plans for/results of associated corrective actions. Unless otherwise specified in the waiver approval, the MHBE will submit its first quarterly report in April 2019. While there is no change to the provision of the ten Essential Health Benefits under this waiver application, Maryland will report on any modifications from federal or state law on an annual basis.

States must also submit an annual report that documents the following:

- The progress of the waiver



- Data on compliance with the four Section 1332 guardrails, similar to the data presented in Attachment 5
- A summary of the required annual post-award public forum, including all public comments received on the progress of the waiver and action taken in response to such concerns or comments
- Other information as required by the terms and conditions of the waiver
- The premium for the second lowest cost silver plan under the waiver and an estimate of what the premium would have been without the waiver for a representative consumer in each rating area

The annual report is due no later than 90 days after the end of each waiver year, or as otherwise specified in the terms and conditions. The MHBE will submit its first annual report by April 1, 2020, unless otherwise specified. The MHBE is committed to ensuring that the quarterly and annual reports will conform to the measures and formats to be specified by CMS.

## **VIII. Public Comments and Tribal Consultations**

### ***Public Comments***

The MHBE opened the 30-day public comment process for this waiver application on April 20, 2018, by posting notice of the opportunity to comment on the agency's website at [marylandhbe.com/policy-legislation/public-comment/1332-waiver](http://marylandhbe.com/policy-legislation/public-comment/1332-waiver). In addition, the MHBE sent out a press release and an email notification to its stakeholder distribution list, which includes over 200,000 email addresses for Maryland Health Connection enrollees who opted in to receive messaging; individuals who opted in to receive messaging through MarylandHealthConnection.gov and MarylandHBE.com; contact lists of community stakeholders, including faith-based organizations, application counselor sponsoring entities, consumer assistance organizations, producers, SHOP stakeholders, plan management stakeholders, and other community and individual stakeholders; members of the media; Maryland elected officials; MHBE Board members; state executive leadership; and MHBE staff members.

The public comment period closed on May 20, 2018. The MHBE received a total of 21 written comments from a variety of stakeholders, including consumers, professional/trade organizations, insurance carriers, advocacy organizations, and a legislator. The press release, email notification and public comments are included as Attachment 3.

### ***Public Hearings***

The MHBE conducted four public hearings across the state to obtain stakeholder input:

1. On the Eastern Shore, the MHBE conducted a public hearing on April 26, 2018 in the Chesapeake Room at the Talbot County Department of Parks and Recreation located at 10028 Ocean Gateway, Easton, MD 21601.

2. Within central Maryland, the MHBE conducted a public hearing on May 3, 2018 in the Training Room at the Maryland Health Benefit Exchange, located at 750 E Pratt Street in Baltimore, Maryland 21202.
3. Within Western Maryland, the MHBE conducted a public hearing on May 7, 2018, at the Frederick County Health Department, located at 350 Montevue Ln., Frederick, MD 21702.
4. Within Southern Maryland, the MHBE conducted a public hearing on May 10, 2018 at the Charles County Health Department, located at 4545 Crain Highway, White Plains, MD 20695.

During each hearing, the MHBE provided an overview of the proposed waiver program and public comment process and then opened the meeting to questions from the public, followed by an opportunity for members of the public to offer testimony. All attendees were encouraged to ask questions and to voice their opinions. A total of 67 members of the public attended the four hearings, and 11 members entered testimony into the public record. Audio recordings of each meeting are available at [marylandhbe.com/policy-legislation/public-comment/1332-waiver](http://marylandhbe.com/policy-legislation/public-comment/1332-waiver). See Attachment 4 for the details of each hearing.

### ***Summary of Public Comments***

During the four public hearings, stakeholders asked a number of questions about the proposed reinsurance program. Frequently asked question included:

- Will the waiver impact out-of-pocket costs?
- Will the waiver impact consumer choices?
- How much will the waiver lower premiums?
- If the waiver is a short-term premium stabilization plan, what is the long-term plan?
- What will happen if the waiver is not approved?

Stakeholders also offered verbal testimony during the hearings and submitted written comments to the MHBE, which included the following themes:

- **Support of the state initiative to stabilize the non-group market.** All written comments and verbal testimony expressed universal support to establish the reinsurance program.
- **Equal impact on consumers.** Several stakeholder groups, including one of the two carriers in the non group market, the state's medical society, a consumer advocacy organization, and other local professional organizations, requested that the program be structured in such a way that premium relief is experienced by as many consumers as possible. These stakeholders cautioned that a reinsurance program with payments that favor issuers with less managed provider networks and utilization controls might be viewed as a disincentive for new market entrants. Further, the respondents cautioned that

unequal premium relief might be perceived by Marylanders as “unfair” if not equitably experienced as a “market-wide” impact.

- **Coordination with the federal risk adjustment program.** Many stakeholders, an issuer, consumer advocates, the state medical society, a Maryland state senator, and other advocacy groups, expressed concern on potential issuer payments under the state reinsurance program and the federal risk adjustment program that would be duplicative of the same risk. The respondents cautioned that this could result in market distortions that would change profitability from low-risk members to high-risk members, whose claims might receive duplicate payments under both programs. The respondents expressed concern that this would create a disincentive to broaden the risk pool to attract healthier consumers.

The other of the two issuers in the non group market cautioned against such an approach stating that, at the federal level, the programs were intended to address different issues. While the risk adjustment program is intended to equalize the risk burden borne by any single issuer, the reinsurance program was designed to mitigate the costs of a “very small percentage of high cost enrollees in order to reduce premiums for all.” This issuer also cautioned that any action to coordinate payments between risk adjustment and reinsurance might affect approval of the 1332 waiver application.

Both issuers have requested an actuarial study to determine the degree of overlap between the two programs, if any.

- **Amend 1332 Waiver Application Language.** An issuer, the state medical society, and the state hospital association requested that the 1332 waiver application include their concerns regarding duplicative risk adjustment and reinsurance payments and incentives to manage the care of high-risk enrollees. While these respondents did not suggest that the specific methodology be included in the application, they requested that the state indicate its intent to account for duplicative payments in the final application.
- **Establishing a reinsuring program that will attract new entrants.** An issuer, the state medical society, and a consumer advocacy organization expressed that the reinsurance program could be leveraged to create a market environment that is favorable for new entrants. They cautioned that the program should not be constructed in a manner that would support certain care delivery models over others. Specifically, “the design of Maryland’s reinsurance program [should] not unintentionally competitively disadvantage [an issuer] or other carrier” (a consumer advocacy organization).
- **Incentives for utilization/care management and quality improvement.** The state hospital association, an issuer, the state medical society, a consumer advocacy organization, and a Maryland state legislator expressed that the reinsurance program should be explored as a tool to increase quality and reward effective utilization/care management. Additionally, the respondents suggested that the program could be used to further the goals of other state initiatives, such as the hospital All-Payer Model and the state’s Medicare waiver.
- **Reduction in out-of-pocket costs.** Although not specific to the 1332 waiver application, many stakeholders including consumers, the state medical society, and the state hospital association, expressed that the state should seek to reduce out-of-pocket costs.

Consumers frequently noted that, while reduced premiums would help, they would not reduce out-of-pocket costs paid at the point of service. Consumers frequently described high deductibles as a barrier to care, and that even with premium relief, the value of having health insurance coverage is being able to defray costs when you need to access services.

- **Expansion of public programs.** Although not specific to the 1332 waiver application, four respondents (two consumers, a consumer advocacy organization, and a policy advocacy organization) expressed support for the expansion of public programs as a long-term solution for non group market stability. While this support was expressed through different recommendations, they all follow a common theme of the desire to expand the role of public programs in reducing the cost of care, either through the creation of public option through a Medicaid Buy-in program (a consumer advocacy organization), a single-payer system (a policy advocacy organization), an expansion of the existing subsidy structure (consumer), or a more active role in reducing out-of-pocket costs at the point of service (consumer).
- **Participation in CRISP (Maryland's Health Information Exchange).** Although not specific to the 1332 waiver application, the state's medical society recommended that the reinsurance program should require robust issuer participation in CRISP.
- **Stand-Alone Dental Plans (SADPs).** Although not specific to the 1332 waiver application, the Alliance of Dental Plans, while in support of the waiver, acknowledged that they would not directly benefit from the program. They requested that the state explore potential mechanisms for how the reinsurance program could benefit SADPs.

## ***Response to Public Comments***

In testimony before the MHBE Board of Trustees and public hearings, stakeholders requested that the MHBE take action on the potential duplicative payment transfers issuers might receive from the risk adjustment and reinsurance programs. Both issuers participating in the non group market have advocated that the MHBE commission the Wakely Consulting Group to investigate, and forecast, the magnitude of duplicative payments that would occur, if any, under the State Reinsurance Program.

In response to these public comments, the MHBE has commissioned additional actuarial analyses to determine the potential for duplicate payments under the proposed state reinsurance program and the federal risk adjustment program. The actuarial report is expected on June 30, 2018. MHBE will share the results of the completed study with application reviewers upon completion. Further, on May 21, 2018, the MHBE Board of Trustees voted to consider regulatory action based on the results of this study. The Board also voted to explore the inclusion of financial incentives in the State Reinsurance Program for issuers to manage high risk and high cost enrollees after active engagement with stakeholders in the regulatory process. See Attachment 2 for the accompanying Board Resolution.

## **Attachments**

1. Enabling Legislation
2. MHBE Board Resolutions
3. Public Comment
4. Public Hearing Process
5. Actuarial and Economic Analysis

## ***Attachment 1. Enabling Legislation***

- For HB 1795, Maryland Health Benefit Exchange-Establishment of a Reinsurance Program, see [http://mgaleg.maryland.gov/2018RS/chapters\\_noln/Ch\\_6\\_hb1795T.pdf](http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_6_hb1795T.pdf)
- For HB 1782, Health Insurance-Individual Market Stabilization (Maryland Health Care Access Act of 2018), see [http://mgaleg.maryland.gov/2018RS/chapters\\_noln/Ch\\_37\\_hb1782E.pdf](http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_37_hb1782E.pdf)



## Chapter 6

## (House Bill 1795)

AN ACT concerning

**Maryland Health Benefit Exchange – Establishment of a Reinsurance Program**

FOR the purpose of repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the prohibition on the Exchange's assuming responsibility for the program corridors for health benefit plans in certain exchanges established under certain provisions of the Affordable Care Act; repealing the requirement that the Exchange operate or oversee the operation of a transitional reinsurance program in accordance with certain regulations for certain coverage years; repealing the requirement that the Exchange operate or oversee the operation of a certain risk adjustment program; repealing the requirement that the Exchange, beginning in a certain year, strongly consider using a certain model for a certain purpose; altering the purposes of the Maryland Health Benefit Exchange Fund; altering the contents of the ~~Maryland Health Benefit Exchange~~ Fund; providing that certain funds may be used only for the purposes of the State Reinsurance Program; requiring, rather than authorizing, the Exchange, in consultation with the Maryland Insurance Commission and as approved by the Maryland Health Benefit Exchange Board, to establish and implement a State Reinsurance Program to provide reinsurance to certain carriers and that meets certain requirements and is consistent with certain laws; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; requiring the Exchange, in consultation with the Commissioner and as approved by the Board and based on available funds, to establish certain parameters for reinsurance in certain years; authorizing the Exchange, in consultation with the Commissioner and as approved by the Board, to alter the parameters under certain circumstances; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made ~~from certain sources by using certain funds; requiring that, beginning on a certain date and under certain circumstances, certain State funding~~ the implementation of the Program for the reinsurance of the individual market ~~through the Program~~ be contingent on the ~~Centers for Medicare and Medicaid Services'~~ U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury approving a waiver application under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; ~~authorizing~~ requiring the Exchange ~~and the Maryland Insurance~~, in consultation with the Commissioner and as approved by the Board, to submit a waiver and seek certain funding under certain provisions of federal law as soon as practicable but not later than a certain date; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; making this Act an emergency measure; and generally relating to the establishment of a reinsurance program by the Maryland Health Benefit Exchange.

## BY repealing

Article – Insurance  
 Section 31–117  
 Annotated Code of Maryland  
 (2017 Replacement Volume)

BY repealing and reenacting, with amendments,

Article – Insurance  
Section 31–107  
Annotated Code of Maryland  
(2017 Replacement Volume)

## BY adding to

Article – Insurance  
 Section 31–117 and 31–117.1  
 Annotated Code of Maryland  
 (2017 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 31–117 of Article – Insurance of the Annotated Code of Maryland be repealed.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Article – Insurance**

31–107.

(a) There is a Maryland Health Benefit Exchange Fund.

(b) (1) The purpose of the Fund is to:

(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under ~~§ 31–117~~ of this title.

(2) The operation and administration of the Exchange and the State Reinsurance Program may include functions delegated by the Exchange to a third party under law or by contract.

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6–103.2 of this article;

[(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;]

[(4) (3) income from investments made on behalf of the Fund;

[(5) (4) interest on deposits or investments of money in the Fund;

[(6) (5) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

[(7) (6) money donated to the Fund;

[(8) (7) money awarded to the Fund through grants; [and]

(8) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(9) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

(10) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

[(9) (11) any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only:

(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and

(2) for the establishment and operation of the State Reinsurance Program [authorized under § 31-117 of this title].

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the State Reinsurance Program.

(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.

(3) Funds received from the distribution of the premium tax under § 6-103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.

[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.]

**(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF FUNDING THE STATE REINSURANCE PROGRAM:**

**(I) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;**

**(II) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND**

**(III) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.**

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

31–117.

**(A) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A STATE REINSURANCE PROGRAM;**

**(1) TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;**

**(2) THAT MEETS THE REQUIREMENTS OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT; AND**

**(3) THAT IS CONSISTENT WITH STATE AND FEDERAL LAW.**

**(B) THE STATE REINSURANCE PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH–RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.**

**(C) (1) BASED ON AVAILABLE FUNDS, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH REINSURANCE PAYMENT PARAMETERS FOR CALENDAR YEAR 2019 AND EACH SUBSEQUENT CALENDAR YEAR THAT INCLUDE:**

- (I) AN ATTACHMENT POINT;
- (II) A COINSURANCE RATE; AND
- (III) A COINSURANCE CAP.

(2) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, MAY ALTER THE PARAMETERS ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION AS NECESSARY TO SECURE FEDERAL APPROVAL FOR A WAIVER SUBMITTED IN ACCORDANCE WITH § 31-117.1(A) OF THIS TITLE.

~~(c)~~ (D) BEGINNING JANUARY 1, 2019, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE STATE REINSURANCE PROGRAM MAY BE MADE FROM BY USING:

- ~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~
- ~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

(1) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(2) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

(3) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

~~(D)~~ (E) BEGINNING JANUARY 1, 2019, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING THE IMPLEMENTATION OF A STATE REINSURANCE PROGRAM FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE STATE REINSURANCE PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES' APPROVING A WAIVER APPROVAL FROM THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND THE U.S. SECRETARY OF THE TREASURY OF A STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT.

~~(E)~~ (F) THE ON OR BEFORE JANUARY 1, 2019, THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.



31-117.1.

(A) ~~THE AS SOON AS PRACTICABLE BUT NOT LATER THAN JULY 1, 2018, THE EXCHANGE AND THE COMMISSIONER MAY, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL SUBMIT A WAIVER STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ESTABLISH A PROGRAM FOR REINSURANCE AND SEEK FEDERAL PASS-THROUGH FUNDING UNDER § 26B OF THE INTERNAL REVENUE CODE AND § 1402 OF THE AFFORDABLE CARE ACT.~~

(B) ON OR BEFORE DECEMBER 31, 2018, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2018 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 5, 2018.

## Chapter 37

## (House Bill 1782)

AN ACT concerning

**Health Insurance – ~~Health Care Access Program – Establishment~~ Individual  
Market Stabilization  
(Maryland Health Care Access Act of 2018)**

FOR the purpose of ~~requiring the State Health Services Cost Review Commission, for a certain fiscal year, to assess on each hospital a certain fee for a certain purpose; prohibiting the State Health Services Cost Review Commission from raising certain hospital rates as part of a certain update factor to offset the fee; prohibiting the fee from exceeding a certain percentage of certain revenue; requiring each hospital to remit the fee to the Maryland Health Benefit Exchange Fund; requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; requiring the assessment to be in addition to certain taxes and certain penalties or actions; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to pay, in a certain calendar year, a certain additional assessment for a certain purpose; providing for the distribution of the assessments; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; requiring that certain funds be used in a certain manner; repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the authority of the Exchange to establish a State Reinsurance Program; requiring the Exchange to establish a Health Care Access Program to provide reinsurance to certain carriers; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made from certain sources; requiring that, beginning on a certain date and under certain circumstances, certain State funding for the reinsurance of the individual market through the Program be contingent on the Centers for Medicare and Medicaid Services approving a waiver under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; authorizing the Exchange and the Maryland Insurance Commissioner to submit a waiver under a certain provision of federal law in accordance with the recommendations of the Maryland Health Insurance Coverage Protection Commission; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; requiring, beginning on a certain date, an individual to maintain certain coverage for certain individuals; requiring that an individual pay a certain penalty under certain circumstances; requiring that the penalty be in addition to a certain State income tax and included with a certain income tax return; requiring that certain individuals be jointly liable for the penalty under certain circumstances; establishing the amount of the penalty; exempting an individual who qualifies for a~~

~~certain exemption under federal law from being assessed the penalty; requiring an individual to indicate certain information on a certain income tax return; requiring the Comptroller to distribute certain revenues from the penalty to a certain fund for certain purposes; defining certain terms; repealing certain provisions of law rendered obsolete by certain provisions of this Act; requiring the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group market stability; requiring the Maryland Health Insurance Coverage Protection Commission to engage an independent actuarial firm to assist in its study; requiring the Maryland Health Insurance Coverage Protection Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly requiring certain health insurers, nonprofit health service plans, health maintenance organizations, ~~and~~ dental plan organizations, fraternal benefit organizations, managed care organizations, and certain other persons to be subject to a certain assessment in a certain year; establishing the purpose and providing for the distribution of the assessment; establishing that certain provisions of law that apply to certain small employer health benefit plans apply to health benefit plans offered by certain entities; altering the definition of “short-term limited duration insurance” as it relates to certain provisions of law governing individual health benefit plans; altering the membership of the Maryland Health Insurance Coverage Protection Commission; requiring the Commission to study and make recommendations for individual and group health insurance market stability; requiring the Commission to engage an independent actuarial firm to assist in a certain study; requiring the Commission to include its findings and recommendations from a certain study in a certain report; making this Act an emergency measure; and generally relating to health insurance.~~

~~BY repealing and reenacting, with amendments,  
Article – Health – General  
Section 19–214(d)  
Annotated Code of Maryland  
(2015 Replacement Volume and 2017 Supplement)~~

BY adding to  
Article – Insurance  
Section 6–102.1, ~~6–102.2, 31–117, and 31–117.1~~  
Annotated Code of Maryland  
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,  
Article – Insurance  
Section ~~31–107~~ 15–1202 and 15–1301(s)  
Annotated Code of Maryland  
(2017 Replacement Volume)

~~BY repealing~~

~~Article — Insurance  
Section 31 — 117  
Annotated Code of Maryland  
(2017 Replacement Volume)~~

~~BY adding to  
Article — Tax — General  
Section 10 — 102.2  
Annotated Code of Maryland  
(2016 Replacement Volume and 2017 Supplement)~~

BY repealing and reenacting, without amendments,  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(b) and (g)

BY repealing and reenacting, with amendments,  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(c)(6)(viii) and (ix), (h), and (i)

BY adding to  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(c)(6)(x) and ~~(xi)~~ and (h)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,  
That the Laws of Maryland read as follows:

~~Article — Health — General~~

~~19 — 214.~~

~~(d) (1) Each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.~~

~~(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.~~

~~2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15 — 701 of this article.~~

~~(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.~~

~~(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.~~

~~(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.~~

~~(4) (i) IN ADDITION TO THE RATES IMPOSED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND SUBJECT TO SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH, FOR FISCAL YEAR 2019, THE COMMISSION SHALL ASSESS A UNIFORM, BROAD BASED AND REASONABLE FEE ON EACH HOSPITAL FOR THE PURPOSE OF SUPPORTING THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~(II) THE COMMISSION MAY NOT RAISE HOSPITAL RATES AS PART OF THE ANNUAL UPDATE FACTOR FOR FISCAL YEAR 2019 TO OFFSET THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.~~

~~(III) THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH MAY NOT EXCEED 0.5% OF EACH HOSPITAL'S NET PATIENT REVENUE.~~

~~(IV) EACH HOSPITAL SHALL REMIT THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THE INSURANCE ARTICLE.~~

#### Article - Insurance

##### 6-102.1.

~~(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED:~~

~~(2) "CARRIER" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(3) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(B) (1) BEGINNING JANUARY 1, 2019, A CARRIER SHALL PAY AN ASSESSMENT OF 3% ON THE CARRIER'S NEW AND RENEWAL GROSS DIRECT PREMIUMS IF THE CARRIER FAILS TO OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IN ACCORDANCE WITH TITLE 15, SUBTITLE 13 OF THIS ARTICLE.~~

~~(2) THE ASSESSMENT PAYABLE BY A CARRIER UNDER THIS SECTION SHALL BE BASED ON THE CARRIER'S PREMIUMS IN ANY MARKET SEGMENT:~~

~~(I) ALLOCABLE TO THE STATE; AND~~

~~(II) WRITTEN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.~~

~~(C) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2019, THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117 OF THIS ARTICLE.~~

~~(D) THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE IN ADDITION TO:~~

~~(1) TAXES OWED BY THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) ANY PENALTIES IMPOSED OR ACTIONS TAKEN BY THE COMMISSIONER IN RESPONSE TO THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

~~6-102.2.~~

(A) THIS SECTION APPLIES TO:

(1) A HEALTH AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, A DENTAL PLAN ORGANIZATION, A FRATERNAL BENEFIT ORGANIZATION, AND ANY OTHER PERSON SUBJECT TO REGULATION BY THE STATE THAT PROVIDES A HEALTH BENEFIT PLAN REGULATED PRODUCT THAT:

(I) IS SUBJECT TO THE FEE UNDER § 9010 OF THE AFFORDABLE CARE ACT; AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE; AND

(2) A MANAGED CARE ORGANIZATION AUTHORIZED UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.

**(B) THE PURPOSE OF THIS SECTION IS TO RECOUP THE AGGREGATE AMOUNT OF THE HEALTH INSURANCE PROVIDER FEE THAT OTHERWISE WOULD HAVE BEEN ASSESSED UNDER § 9010 OF THE AFFORDABLE CARE ACT THAT IS ATTRIBUTABLE TO STATE HEALTH RISK FOR CALENDAR YEAR 2019 AS A BRIDGE TO STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.**

**(C) (1) IN CALENDAR YEAR 2019, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 2.75% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR CALENDAR YEAR 2018.**

**(2) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE DISTRIBUTED BY THE COMMISSIONER TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE.**

15-1202.

**(a) This subtitle applies only to a health benefit plan that:**

**(1) covers eligible employees of small employers in the State; and**

**(2) is issued or renewed on or after July 1, 1994, if:**

**(i) any part of the premium or benefits is paid by or on behalf of the small employer;**

**(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;**

**(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or**

**(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.**

**(b) A carrier is subject to the requirements of § 15-1403 of this title in connection with health benefit plans issued under this subtitle.**

**(C) THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN OFFERED BY AN ASSOCIATION, A PROFESSIONAL ~~EMPLOYEE~~ EMPLOYER ORGANIZATION, OR ANY**

OTHER ENTITY, INCLUDING A PLAN ISSUED UNDER THE LAWS OF ANOTHER STATE, IF THE HEALTH BENEFIT PLAN COVERS ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS AND MEETS THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION.

15-1301.

(s) "Short-term limited duration insurance" [has the meaning stated in 45 C.F.R. § 144.103] MEANS HEALTH INSURANCE COVERAGE PROVIDED UNDER A POLICY OR CONTRACT WITH A CARRIER AND THAT:

(1) HAS A POLICY TERM THAT IS LESS THAN 3 MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE POLICY OR CONTRACT;

(2) MAY NOT BE EXTENDED OR RENEWED;

(3) APPLIES THE SAME UNDERWRITING STANDARDS TO ALL APPLICANTS REGARDLESS OF WHETHER THEY HAVE PREVIOUSLY BEEN COVERED BY SHORT-TERM LIMITED DURATION INSURANCE; AND

(4) CONTAINS THE NOTICE REQUIRED BY FEDERAL LAW PROMINENTLY DISPLAYED IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT.

~~31-107.~~

~~(a) There is a Maryland Health Benefit Exchange Fund.~~

~~(b) (1) The purpose of the Fund is to:~~

~~(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and~~

~~(ii) provide funding for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(2) The operation and administration of the Exchange and the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM may include functions delegated by the Exchange to a third party under law or by contract.~~

~~(c) The Exchange shall administer the Fund.~~

~~(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.~~



~~(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.~~

~~(e) The Fund consists of:~~

~~(1) any user fees or other assessments collected by the Exchange;~~

~~(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6-103.2 of this article;~~

~~(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;~~

~~(4) ASSESSMENTS COLLECTED BY THE COMMISSIONER UNDER §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(5) ASSESSMENTS REMITTED IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(6) PENALTIES COLLECTED BY THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~[(4)] (7) income from investments made on behalf of the Fund;~~

~~[(5)] (8) interest on deposits or investments of money in the Fund;~~

~~[(6)] (9) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;~~

~~[(7)] (10) money donated to the Fund;~~

~~[(8)] (11) money awarded to the Fund through grants; and~~

~~[(9)] (12) any other money from any other source accepted for the benefit of the Fund.~~

~~(f) The Fund may be used only:~~

~~(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and~~

~~(2) for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM.~~

~~(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.~~

~~(3) Funds received from the distribution of the premium tax under § 6-103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.~~

~~[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.]~~

~~(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) ASSESSMENTS DISTRIBUTED TO THE FUND IN ACCORDANCE WITH §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(II) ASSESSMENTS REMITTED TO THE FUND IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(III) PENALTIES DISTRIBUTED TO THE FUND IN ACCORDANCE WITH § 10-102.2 OF THE TAX GENERAL ARTICLE; AND~~

~~(IV) ANY FUNDS THAT THE STATE RECEIVES FROM THE FEDERAL GOVERNMENT UNDER ANY FEDERALLY SPONSORED OR DEVELOPED PROGRAM TO PROMOTE OR ENHANCE STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.~~

~~(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:~~

~~(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or~~

~~(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.~~

~~(2) Notwithstanding § 7-304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6-103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the~~

~~premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.~~

~~(3) If operating expenses of the Exchange may be charged to either State or non-State fund sources, the non-State funds shall be charged before State funds are charged.~~

~~(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.~~

~~(2) Any investment earnings of the Fund shall be credited to the Fund.~~

~~(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.~~

~~(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.~~

~~§ 31-117.~~

~~(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state-specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.~~

~~(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.~~

~~(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.~~

~~(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high-risk individuals.~~

~~(3) (i) The Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, may establish a State Reinsurance Program to take effect on or after January 1, 2014.~~

~~(ii) The purpose of the State Reinsurance Program is to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the Exchange.~~

~~(iii) The Exchange shall use funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, to fund the State Reinsurance Program.~~

~~(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:~~

~~(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;~~

~~(ii) increase the incentive for carriers to enhance the quality and cost-effectiveness of their enrollees' health care services; and~~

~~(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high-risk individuals.~~

~~(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.]~~

~~31-117.~~

~~(A) THE EXCHANGE SHALL ESTABLISH A HEALTH CARE ACCESS PROGRAM TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.~~

~~(B) THE HEALTH CARE ACCESS PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH-RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.~~

~~(C) BEGINNING JANUARY 1, 2020, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM MAY BE MADE FROM:~~

~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~

~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

~~(D) BEGINNING JANUARY 1, 2020, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(E) THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~31-117.1.~~

~~(A) THE EXCHANGE AND THE COMMISSIONER MAY SUBMIT A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION ESTABLISHED UNDER CHAPTER 17 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2017.~~

~~(B) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2019 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~Article Tax General~~

~~10-102.2.~~

~~(A) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE AND A NONRESIDENT DEPENDENT.~~

~~(B) BEGINNING JANUARY 1, 2019, AN INDIVIDUAL SHALL MAINTAIN FOR THE INDIVIDUAL, AND FOR EACH DEPENDENT OF THE INDIVIDUAL, MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN § 15-1301 OF THE INSURANCE ARTICLE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, AN INDIVIDUAL SHALL PAY A PENALTY IN THE AMOUNT DETERMINED UNDER SUBSECTION (D) OF THIS SECTION IF THE INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR 3 OR MORE MONTHS OF THE TAXABLE YEAR.~~

~~(2) ANY PENALTY IMPOSED UNDER THIS SUBSECTION FOR ANY MONTH IN WHICH AN INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE:~~

~~(i) IN ADDITION TO THE STATE INCOME TAX UNDER § 10-105(A) OF THIS SUBTITLE; AND~~

~~(ii) INCLUDED WITH THE STATE INCOME TAX RETURN FOR THE INDIVIDUAL UNDER SUBTITLE 8 OF THIS TITLE FOR THE TAXABLE YEAR THAT~~

~~INCLUDES THE MONTHS IN WHICH COVERAGE WAS NOT MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.~~

~~(3) IF AN INDIVIDUAL WHO IS SUBJECT TO A PENALTY UNDER THIS SECTION FILES A JOINT STATE INCOME TAX RETURN UNDER § 10-807 OF THIS TITLE, THE INDIVIDUAL AND THE INDIVIDUAL'S SPOUSE SHALL BE JOINTLY LIABLE FOR THE PENALTY.~~

~~(D) THE AMOUNT OF THE PENALTY IMPOSED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE EQUAL TO THE GREATER OF:~~

~~(1) 2.5% OF THE SUM OF THE INDIVIDUAL'S FEDERAL MODIFIED ADJUSTED GROSS INCOME, AS DEFINED IN 42 U.S.C. § 1395R, AND THE FEDERAL MODIFIED ADJUSTED GROSS INCOME OF ALL INDIVIDUALS CLAIMED ON THE INDIVIDUAL'S INCOME TAX RETURN; OR~~

~~(2) THE FOLLOWING FLAT RATES PER INDIVIDUAL, ADJUSTED ANNUALLY FOR INFLATION:~~

~~(I) \$695 PER ADULT; AND~~

~~(II) \$347.50 PER CHILD UNDER 18 YEARS OLD.~~

~~(E) AN INDIVIDUAL MAY NOT BE ASSESSED A PENALTY UNDER SUBSECTION (C) OF THIS SECTION IF THE INDIVIDUAL QUALIFIES FOR AN EXEMPTION UNDER 26 U.S.C. § 5000A(E).~~

~~(F) AN INDIVIDUAL SHALL INDICATE ON THE INCOME TAX RETURN FOR THE INDIVIDUAL, IN THE FORM REQUIRED BY THE COMPTROLLER, WHETHER MINIMUM ESSENTIAL COVERAGE WAS MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR:~~

~~(1) THE INDIVIDUAL;~~

~~(2) THE INDIVIDUAL'S SPOUSE IN THE CASE OF A MARRIED COUPLE;~~

~~AND~~

~~(3) EACH DEPENDENT CHILD OF THE INDIVIDUAL, IF ANY.~~

~~(G) NOTWITHSTANDING § 2-609 OF THIS ARTICLE, AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) (1) The Maryland Health Insurance Coverage Protection Commission, established under Chapter 17 of the Acts of the General Assembly of 2017, shall study and make recommendations for individual and group health insurance market stability, including:~~

~~(i) the components of a waiver under § 1332 of the Affordable Care Act to ensure market stability;~~

~~(ii) whether to pursue a standard plan design that limits cost sharing;~~

~~(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;~~

~~(iv) whether to pursue a Basic Health Program; and~~

~~(v) whether to pursue a Medicaid buy-in program for the individual market.~~

~~(2) The Maryland Health Insurance Coverage Protection Commission shall engage an independent actuarial firm to assist in its study under this subsection.~~

~~(b) On or before October 1, 2018, the Maryland Health Insurance Coverage Protection Commission shall issue a report on its findings and recommendations, including any legislative proposals, under subsection (a) of this section to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange shall adopt the regulations required under § 31-117 of the Insurance Article, as enacted by Section 1 of this Act, on or before January 1, 2019.~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Chapter 17 of the Acts of 2017**

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(c) The Commission consists of the following members:

(6) the following members:

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; [and]

(ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor; AND

(X) ONE REPRESENTATIVE OF A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN THE INDIVIDUAL MARKET, APPOINTED BY THE GOVERNOR; AND

~~(XI) ONE REPRESENTATIVE OF THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, TO BE APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE.~~

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model;

(ii) assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model; and

(iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All-Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage;



(iii) an examination of measures that may prevent or mitigate the adverse effects of changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

**(H) (1) THE COMMISSION SHALL STUDY AND MAKE RECOMMENDATIONS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE MARKET STABILITY, INCLUDING:**

**(I) THE COMPONENTS OF ONE OR MORE WAIVERS UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ENSURE MARKET STABILITY THAT MAY BE SUBMITTED BY THE STATE;**

**(II) WHETHER TO PURSUE A STANDARD PLAN DESIGN THAT LIMITS COST SHARING;**

**(III) WHETHER TO MERGE THE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS IN THE STATE FOR RATING PURPOSES;**

**(IV) WHETHER TO PURSUE A BASIC HEALTH PROGRAM;**

**(V) WHETHER TO PURSUE A MEDICAID BUY–IN PROGRAM FOR THE INDIVIDUAL MARKET;**

**(VI) WHETHER TO PROVIDE SUBSIDIES THAT SUPPLEMENT PREMIUM TAX CREDITS OR COST–SHARING REDUCTIONS DESCRIBED IN § 1402(C) OF THE AFFORDABLE CARE ACT; AND**

**(VII) WHETHER TO ADOPT A STATE–BASED INDIVIDUAL HEALTH INSURANCE MANDATE AND HOW TO USE PAYMENTS COLLECTED FROM INDIVIDUALS WHO DO NOT MAINTAIN MINIMUM ESSENTIAL COVERAGE, INCLUDING USE OF THE PAYMENTS TO ASSIST INDIVIDUALS IN PURCHASING HEALTH INSURANCE.**

**(2) THE COMMISSION SHALL ENGAGE AN INDEPENDENT ACTUARIAL FIRM TO ASSIST IN ITS STUDY UNDER THIS SUBSECTION.**

**(3) THE COMMISSION SHALL INCLUDE ITS FINDINGS AND RECOMMENDATIONS FROM THE STUDY REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (J) OF THIS SECTION.**

**[(h)] (I)** The Commission may:

(1) hold public meetings across the State to carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

**[(i)] (J)** On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION ~~4~~ 3. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

**Approved by the Governor, April 10, 2018.**

***Attachment 2. MHBE Board Resolutions***



## RESOLUTION OF THE MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES

**SUBJECT:** ON THE 2019 STATE REINSURANCE PROGRAM AND SUBMISSION OF A 1332 STATE INNOVATION WAIVER APPLICATION

WHEREAS, Maryland Health Connection is the state-based insurance marketplace for Maryland residents to explore and compare health coverage options, determine eligibility for tax subsidies and credits, and enroll in private health insurance plans on the individual market; and

WHEREAS, Maryland Health Connection connects eligible consumers with financial assistance to help make coverage more affordable; and

WHEREAS, Maryland Health Connection consumers who do not receive financial assistance must shoulder the full cost of health insurance premiums; and

WHEREAS, premiums in the individual market have risen to unsustainable levels for many Marylanders without financial assistance; and

WHEREAS, the Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of Maryland state government, and is responsible for the operation of Maryland Health Connection; and

WHEREAS, the MHBE is required by House Bill 1795 (Maryland Health Benefit Exchange - Establishment of a Reinsurance Program) to submit a State Innovation Waiver to establish a State Reinsurance Program, under Section 1332 of the Affordable Care Act, to help stabilize premiums in the individual market; and

WHEREAS, the MHBE Board of Trustees must approve an attachment point, coinsurance rate, and cap for the State Reinsurance Program; and

WHEREAS, the MHBE Board of Trustees must approve an application for a State Innovation Waiver for the State Reinsurance Program,

NOW THEREFORE, BE IT RESOLVED THAT, the MHBE Board of Trustees approves of a State Reinsurance Program for 2019 with an attachment point that will be determined based on funding availability and stakeholder engagement, a coinsurance rate of 80%, and a cap of \$250,000; and



BE IT FURTHER RESOLVED THAT, the MHBE Board of Trustees approves MHBE to submit a State Innovation Waiver application, to the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury, for a State Reinsurance Program not inconsistent with the parameters indicated within this resolution.

A handwritten signature in blue ink, appearing to read "Robert R. Neall", written over a horizontal line.

Robert R. Neall  
Chair, Board of Trustees

May 25, 2018

DATE

Approved by the MHBE Board of Trustees on April 16, 2018.



## RESOLUTION OF THE MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES

**SUBJECT:** MARYLAND HEALTH BENEFIT EXCHANGE BOARD OF TRUSTEES  
ACTION ON PUBLIC COMMENT AND TESTIMONY ON THE 1332  
STATE INNOVATION WAIVER APPLICATION

WHEREAS, the Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of Maryland state government, and is responsible for the operation of Maryland Health Connection; and

WHEREAS, the MHBE, to help stabilize premiums in the individual market, is applying to the U.S. Secretaries of Health and Human Services and the Treasury for a State Innovation Waiver to establish a State Reinsurance Program, under Section 1332 of the Affordable Care Act; and

WHEREAS, the MHBE has consulted with the Maryland Commissioner of Insurance and held four public hearings across Maryland to receive testimony from the public and a public comment period of thirty days from April 20, 2018 to May 20, 2018 for the State Innovation Waiver Application; and

WHEREAS, the MHBE has received unanimous public comment and testimony in support of the goal of the State Innovation Waiver; and

WHEREAS, the MHBE has received testimony from a diverse set of stakeholders that State Reinsurance Program payments to issuers should not be duplicative with payments received under the existing Federal Risk Adjustment Program; and

WHEREAS, the MHBE has commissioned a study from Wakely Consulting Group on potential duplicative payments under both the State Reinsurance Program and the Federal Risk Adjustment Program, and

WHEREAS, the MHBE has received testimony from a diverse set of stakeholders that the State Reinsurance Program should include financial incentives for issuers who demonstrate effectiveness and efficiency in care management of high risk and high claims enrollees; and

WHEREAS, the MHBE must, under HB 1795, submit a State Innovation Waiver Application no later than July 1, 2018; and



WHEREAS, the MHBE Board of Trustees must approve an application for a State Innovation Waiver for the State Reinsurance Program,

NOW THEREFORE, BE IT RESOLVED THAT, the MHBE Board of Trustees may take regulatory action based on the results of the study being performed by Wakely Consulting Group on potential duplicative payments under the State Reinsurance Program and the Federal Risk Adjustment Program; and

BE IT FURTHER RESOLVED THAT, the MHBE Board of Trustees approves MHBE to submit a State Innovation Waiver application, to the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury, for a State Reinsurance Program that may include financial incentives for issuers to manage high risk and high cost enrollees after active engagement with stakeholders in regulatory action.

WE HEREBY CERTIFY that the foregoing Resolution was adopted on the 21st day of May, 2018, by the Board of Trustees of the Maryland Health Benefit Exchange.

A handwritten signature in black ink, appearing to read "Robert R. Neall".

Robert R. Neall  
Chair, Board of Trustees

A handwritten signature in black ink, appearing to read "S. Anthony McCann".

S. Anthony McCann  
Vice-chair, Board of Trustees

May 21, 2018  
DATE

Approved by the MHBE Board of Trustees on May 21, 2018.

***Attachment 3. Public Comment Process***



- [Montgomery County](#)
- [Prince George's County](#)
- [Southern Region](#)
- [Upper Eastern Shore Region](#)
- [Application Counselor Sponsoring Entities](#)
- [Carriers & SHOP Administrator](#)
  - [Carriers](#)
  - [SHOP Administrator](#)

# State Innovation Waiver Application – Maryland

[Home](#) › [Policy & Legislation](#) › [Public Comment](#) › State Innovation Waiver Application – Maryland

Under Section 1332 of the Affordable Care Act, states may apply for State Innovation Waivers to waive certain federal requirements with the goal of improving their health insurance markets. During the 2018 legislative session, the Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program. Governor Larry Hogan signed House Bill 1795 on April 5, 2018.

House Bill 1795, as an emergency measure, directs the Maryland Health Benefit Exchange to submit a State Innovation Waiver to the U.S. Secretaries of Health and Human Services and the Treasury to establish a State Reinsurance Program.

The purpose of the State Reinsurance Program is to mitigate the premium impact of high cost enrollees on carriers that participate in the individual market. The State Reinsurance Program will reduce rates from what they would have been without the program, creating some relief for Marylanders who have experienced high rate increases on their health insurance premiums.

For more information on State Innovation Waivers, visit the [CMS Section 1332: State Innovation Waivers](#) website.

## **APPLICATION:**

Please see the draft application at the link below:

[DRAFT Maryland 1332 State Innovation Waiver Application](#)

## **PUBLIC COMMENT AND HEARINGS:**

States are required to post State Innovation Waiver Applications for public comment for a minimum of 30 days. All comments should be submitted to the Maryland Health Benefit Exchange at [mhbe.publiccomments@maryland.gov](mailto:mhbe.publiccomments@maryland.gov). The comment period is from April 20 to May 20, 2018.

As a requirement of the State Innovation Waiver application process, the Maryland Health Benefit Exchange, in conjunction with the Maryland Insurance Administration, held four public hearings around the state.

Below are links to the agenda and the presentation at those hearings:

[1332 Waiver Public Hearing Agenda](#)

[Presentation on “Maryland State Innovation Waiver Application: State Reinsurance Program, April 20-May 20, 2018”](#)

Below is additional information from the four hearings:

1. **April 26, Talbot County Department of Parks and Recreation (Chesapeake Room), Easton, MD**
  - [Attendee Sign-In Sheet](#)
  - [Minutes](#)
  - [Audio of Public Hearing #1](#)

**2. May 3, Office of the Maryland Health Benefit Exchange, Baltimore, MD**[Attendee Sign-In Sheet](#)[Minutes](#)[Audio of Public Hearing #2](#)**3. May 7, Frederick County Local Health Department, Frederick, MD**[Attendee Sign-In Sheet](#)[Minutes](#)[Audio of Public Hearing #3](#)**4. May 10, Charles County Local Health Department, White Plains, MD**[Attendee Sign-In Sheet](#)[Minutes](#)[Audio of Public Hearing #4](#)[Section 1332 State Innovation Waiver Application – Public Comments](#)**RESOURCES**

Please see the below resource for important information.

Enacting Legislation:

[HB 1795 – Establishment of a State Reinsurance Program](#)[SB 387 – Maryland Health Access Act of 2018](#)

Authorizing Resolution:

[MHBE Board Resolution on the State Reinsurance Program and Submission of a State Innovation Waiver Application – April 16, 2018](#)[Section 1332 Waiver -Public Comment – Board Presentation – May 21, 2018](#)[Resolution 1332 State Innovation Waiver Application – May 21, 2018](#)**FAQs**[Click here to view answers to Frequently Asked Questions about the 1332 waiver application process](#)

MEDIA RELEASE

## FOUR PUBLIC HEARINGS ANNOUNCED FOR STATE REINSURANCE PROPOSAL

BALTIMORE (APRIL 20, 2018) – The Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration (MIA), will hold a series of hearings to receive public comment to shape Maryland’s application to the federal government for a reinsurance program. The purpose of the program is to hold down consumer cost and bring greater certainty to Maryland’s individual market for health insurance for 2019 and 2020.

Governor Larry Hogan and the Maryland General Assembly approved legislation to create a reinsurance program for the individual health insurance market beginning in 2019. The state plans to raise about \$365 million through a 2.75% premium surcharge on insurance carriers. Maryland may receive additional “pass through” dollars from the federal government. Total funding for the program is projected at \$462 million. If approved, the reinsurance program will hold down premium increases for plans purchased in the individual health insurance market both on and off Maryland Health Connection, the state-based marketplace.

The MHBE Board of Trustees voted on Monday to authorize MHBE to apply to the Centers for Medicare and Medicaid Services (CMS) to request approval for an “innovation waiver” to create the reinsurance program under Section 1332 of the Affordable Care Act. States are required to post applications for public comment for a minimum of 30 days. Maryland-recognized tribes are encouraged to provide comment during the 30-day period.

Maryland’s draft of its 1332 State Innovation Waiver Application for a State Reinsurance Program can be viewed at [MarylandHBE.com](http://MarylandHBE.com).

Four public hearings will be held on:

- **Thursday, April 26, 5 p.m. to 6 p.m., at the Talbot County Department of Parks and Recreation (Chesapeake Room),** 10028 Ocean Gateway, Easton, MD 21601
- **Thursday, May 3, 4 p.m. to 5 p.m., at the office of the Maryland Health Benefit Exchange,** 750 E. Pratt St., 6th Floor, Baltimore, MD 21205
- **Monday, May 7, 3 p.m. to 4 p.m., at the Frederick County Local Health Department,** 350 Montevue Lane, Frederick, MD 21702
- **Thursday, May 10, 5 p.m. to 7 p.m., at the Charles County Local Health Department,** 4545 Crain Highway, White Plains, MD 20695

###

**About the Maryland Health Benefit Exchange:** The Maryland Health Benefit Exchange, a public corporation and independent unit of state government, administers Maryland Health Connection. Including more than 1 million people enrolled in Medicaid, MHBE enrolls one of every six Marylanders in health coverage.

**About Maryland Health Connection:** Maryland Health Connection is the state's official health insurance marketplace for individuals and families to compare and enroll in health insurance. Maryland Health Connection is the only place where Marylanders can access tax credits to make coverage more affordable. People who have lost coverage and meet the criteria for a special enrollment can also enroll throughout the year at [MarylandHealthConnection.gov](http://MarylandHealthConnection.gov) or on the [Enroll MHC](#) mobile app.

#### **Media Contact**

Betsy Plunkett, Director of Marketing  
410-547-6324, [betsy.plunkett@maryland.gov](mailto:betsy.plunkett@maryland.gov)

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MEDIA RELEASE

### FOUR PUBLIC HEARINGS ANNOUNCED FOR STATE REINSURANCE PROPOSAL

BALTIMORE (APRIL 20, 2018) – The Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration (MIA), will hold a series of hearings to receive public comment to shape Maryland's application to the federal government for a reinsurance program. The purpose of the program is to hold down consumer cost and bring greater certainty to Maryland's individual market for health insurance for 2019 and 2020.

## Email Notification of Public Comment and Hearing Process

Governor Larry Hogan and the Maryland General Assembly approved legislation to create a reinsurance program for the individual health insurance market beginning in 2019. The state plans to raise about \$365 million through a 2.75% premium surcharge on insurance carriers. Maryland may receive additional “pass through” dollars from the federal government. Total funding for the program is projected at \$462 million. If approved, the reinsurance program will hold down premium increases for plans purchased in the individual health insurance market both on and off Maryland Health Connection, the state-based marketplace.

The MHBE Board of Trustees voted on Monday to authorize MHBE to apply to the Centers for Medicare and Medicaid Services (CMS) to request approval for an “innovation waiver” to create the reinsurance program under Section 1332 of the Affordable Care Act. States are required to post applications for public comment for a minimum of 30 days. Maryland-recognized tribes are encouraged to provide comment during the 30-day period.

Maryland’s draft of its 1332 State Innovation Waiver Application for a State Reinsurance Program can be viewed at [MarylandHBE.com](http://MarylandHBE.com).

Four public hearings will be held on:

- **Thursday, April 26, 5 p.m. to 6 p.m., at the Talbot County Department of Parks and Recreation**  
(Chesapeake Room), 10028 Ocean Gateway, Easton, MD 21601
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- **Thursday, May 10, 5 p.m. to 7 p.m., at the Charles County Local Health Department**, 4545  
Crain Highway, White Plains, MD 20695

###

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### Media Contact

Betsy Plunkett, Director of Marketing  
410-547-6324, [betsy.plunkett@maryland.gov](mailto:betsy.plunkett@maryland.gov)



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Section 1332 State  
Innovation Waiver  
Application – Public  
Comments

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**Maryland 1332 Waiver Hearing #1**

**Eastern Maryland**

**April 26, 2018**

**Talbot County Department of Parks and  
Recreation**

**10028 Ocean Gateway  
Easton, MD 21601**

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### **Welcome & Introductions**

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate John Mautz and a staff member from the office of Senator Adelaide Eckardt.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### **1332 Waiver Presentation**

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program’s attachment point is not yet finalized since it depends on the available funding.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in enrollment in 2019.

Next, Mr. Cardenas laid out the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including three additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### **Q&A/Discussion**

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether, in the event that the reinsurance program does not meet its savings targets, consumers will have to make up the difference. Mr. Cardenas replied in the negative.

An attendee asked whether the reinsurance program would affect only on-exchange policies. Mr. Cardenas replied that the program would involve all individual market policies, both on- and off-exchange.

An attendee asked whether the 30 percent reduction in average premium is expected in the first year, or averaged over two years. Mr. Cardenas replied that the program is expected to realize the 30 percent reduction in the first year and maintain that level into the second year.

An attendee asked whether the reinsurance program would cover Medigap policies. Mr. Cardenas replied in the negative, noting that the waiver only has jurisdiction over individual market policies governed by the Affordable Care Act.

An attendee asked the likelihood that the waiver program would continue into 2020. Mr. Cardenas replied that the waiver application covers a five-year period, meaning that the program would run from 2019 through 2023, with the opportunity for extensions beyond 2023.

An attendee asked what the MHBE expects to happen with premium prices in 2021 and beyond. Mr. Cardenas replied that, while they do not know exactly what is going to happen at that point, they hope for continued savings. He added that the chief strategy for market health in that extended period is to attract additional insurance carriers into the market and a healthier risk pool.

An attendee, noting that some portion of the funding for this program would come from a fee on insurance companies, asked whether that fee would negatively impact premiums in the group market. Mr. Cardenas replied that, since the fee was already calculated into the rates, the affect on group premium would be neutral.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record.

James Burdick offered the following testimony:

*“As a doctor, I’d like to see everybody get health care. And, actually, I meant what I said about Maryland. Congratulations to the work that’s been done and other good things that are happening in Maryland compared to other states, so this isn’t a criticism. But, long run, as I said, stepping back, a national health program, improved Medicare for all, single payer system would get rid of the admittedly confusing, or at least complicated, details and also save money, cover everybody, and improve quality. It’s really true. Senator Pinsky has introduced a bill in the Senate and there is some enthusiasm for a state single-payer bill. I’d like to see a national program, ideally, but I just want to provide that perspective on the complexity and the potential lack of insurance or uncertain insurance for so many Marylanders still, in spite of the great work that you have been doing.”*

### **Closing**

Ms. Eberle closed the hearing and thanked everyone who attended.

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## **Participants**

### *Maryland Health Benefit Exchange*

Tony McCann, Member, Board of Trustees

Michele Eberle, Executive Director

Andrew Ratner, Chief of Staff

John-Pierre Cardenas, Director of Policy and Plan Management

Kris Vallecillo, Senior Health Policy Analyst

### *Maryland Insurance Administration*

Todd Switzer, Chief Actuary

Brad Boban, Senior Actuary

Joseph Fitzpatrick, Assistance Chief Examiner

### *Maryland Department of Health*

Robert Neall, Secretary

Nikki Laska, Director, Communications

### *Maryland General Assembly*

Delegate Johnny Mautz

Melissa Einhorn, Office of Senator Addie Eckhardt

### *Members of the Public*

Kathy Ruben

Elizabeth Carson

Larry Carson

Matt Celentano

Laurie Kuiper

Dan Mosebach

Chester King

Billy D. Weber

Karen Millison

Jim Burdick

Paul Davin

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**Maryland 1332 Waiver Hearing #2**

**Central Maryland**

**May 3, 2018**

**Maryland Health Benefit Exchange**

**750 E. Pratt Street, 6<sup>th</sup> Floor**

**Baltimore, MD 21205**

### **Welcome & Introductions**

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself. She explained the process and purpose of the 1332 waiver hearings and provided a brief overview of the current state of the marketplace and the proposed state reinsurance program.

She acknowledged the presence of staff from the MHBE and the Maryland Insurance Administration (MIA) and introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### **1332 Waiver Presentation**

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018.

Mr. Cardenas emphasized the importance of stakeholder input on the proposed reinsurance program and gave a brief summary of the proposed reinsurance program, including funding sources. He explained that the reinsurance program's attachment point has not been finalized because it is dependent on the available funding.

Mr. Cardenas then described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By waiving Section 1312(c)(1) of the Affordable Care Act, carriers are allowed to factor the reinsurance program into their premium rates, resulting in a reduction of those premiums. The MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with the guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that the estimations presented are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including two additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### **Q&A/Discussion**

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

There were no questions.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Three individuals offered testimony.

John Kunkel, Chief Financial Officer, Kaiser Permanente, offered the following testimony:

*"I am proud to represent Kaiser today. We are the only insurer that participates in both the exchanges and the Medicaid program, so we are very much impacted by the 1332 waiver. I would reiterate what JP said at the outset. This is something very cool. Kaiser Permanente supports this waiver. What is important to us is that it is done in a very thoughtful and balanced way, and so I will focus my brief comments today around how we believe that should work. And for us it is all about impacting all Marylanders equally regardless of who your insurance carrier is. As the board is aware, Kaiser is concerned that the program could advantage one health plan over the other. We want to make sure that this rate relief that was referenced is spread across everyone and that no carrier has the ability to be paid twice, a double dip concept for both the risk adjustment program as well as this reinsurance program that will hopefully be created for 2019. The issue of double payments is something that has been written about widely by experts, such as the American Academy of Actuaries and Milliman.*

*We have asked the staff of MHBE to seek an estimate from Wakely who is uniquely positioned to look at this because they have the data for the carriers in Maryland. We understand that that work is forthcoming, and we are very appreciative of that. We think that will be important and very instructive to understand the dynamics and ensure that we create the right program for Maryland. So why would this matter to a consumer? During the presentation, it was referenced that this could bring rates down by 30 percent. What is important to Kaiser is that this brings everyone's rates down 30 percent or at least as well as you can model that. We are afraid that the minority will see a disproportionate level of rate decrease and the majority, including the 75,000 members that utilize Kaiser Permanente's care delivery system today will see less than a balanced shift. We would also urge the MHBE to include language in the draft Section 1332 waiver that would indicate the state's intent to implement this type of program.*

*We believe CMS would not hesitate to approve a waiver with this language. And finally, we believe that a program that treats all carriers equally will increase the chances of additional carriers coming to the state. Today, we only have two carriers: Kaiser Permanente and CareFirst, and Kaiser Permanente is not statewide. Our delivery system does not cover all of Maryland. A balanced program that treats carriers equally, particularly those who are incentivized around controlling costs would make Maryland more attractive to additional competitors. In conclusion, Kaiser Permanente believes three important things. One, the program should not allow duplicate payments to be made to any health plan. Two, the program should benefit all Marylanders as equally as possible and not disproportionately those enrolled in just one type of plan. And finally, that this is a solvable problem that we have the data and we have the time to design a program that would accomplish the goals that I have laid out today. So, thank you for your consideration."*



Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

*"I am President of the Board of Consumer Health First, a statewide consumer advocacy organization, and I am here today to deliver our strong support for the 1332 waiver for all of the reasons that JP so eloquently stated. Obviously, all of us know that consumers who do not qualify for financial assistance have borne the brunt of the eye-popping premium increases over the last four years of the Affordable Care Act, and from the data that was provided by the MIA to the General Assembly of this year, we know that premiums in the individual market for consumers who do not qualify for financial assistance range from 26-73 percent of their after tax income. I would submit to you that if any of us in the group market were required to pay anything close to that then we would respectfully decline that coverage from our employers, and so to us this is a crisis deserving of some solution. Although I must say that we see the reinsurance program together with a very thorough rate review, which we are going to be working with the MIA to ensure happens, is one way to modestly impact the rates, but long-term we believe that there is going to have to be other solutions. One of the solutions that we advocate is a Medicaid buy-in.*

*We understand that there is still a lot of work to do before the reinsurance program is launched. You've made many of the decisions about some of the technical aspects of this program already. Regarding the cap on the reinsurance payments, it is much lower than the cap was at the federal level, the federal reinsurance program, and it is much lower than, at least what we understand, what other states have done. We understand that is being done primarily because you want deeper coverage, and so we would certainly support that. We are concerned for slightly different reasons but along the same lines of concern that Kaiser has already expressed, that this reinsurance program will not equitably impact all consumers. It is not so much that we are concerned about what happens to Kaiser, with all due respect. But, there is a difference between the PPO market and the HMO market. In the PPO market, we know that the risk adjustment program that has been put in place at the federal level, all of those monies go to the PPO product, and the monies raised for that program are from the HMO market. Those HMO premiums are in effect increased in order to subsidize the PPO product because the PPO product has higher risks.*

*We know that theoretically there are many who have argued that when you have a reinsurance program and it is combined with a risk adjustment program that nothing further needs to be done, but we are concerned that that is not the truth. And, that it is particularly not going to be the case given the level and the scale of this particular program. So, our ask is that during this time period between now and the end of the year that you take the claims data from 2017 and do a simulation of what exactly would have happened if there had been in effect the risk adjustment program, which of course we know will be in place, and you know what those payouts will be for the 2017 plan year in June and then simulate what the reinsurance payments would have been in 2017 to be sure that the attachment points and whether or not there should be any true up between the risk adjustment program and the reinsurance program so that the percentage decrease in premiums that we expect on average is the same for HMO products and PPO*

*products. I think that we are well aware of the fact that there can be plan differences, there can be differences between Kaiser and CareFirst, but at the end of the day, if we are looking at a 30 percent reduction in rate increase, that should be the same whether or not you are enrolled in an HMO or a PPO. Otherwise, we believe that that is an unfair subsidy again on the part of HMO members.*

*We also understand that, to us anyways, there is the potential, and I wouldn't say that it is absolute, but it is a potential, that consumers would see this in an inequitable way if their premium decreases were not similar for the HMO and PPO products. This could also lead to some market distortions and would lead some carriers, in particular Kaiser Permanente, to rethink their commitment to this market. After all, Kaiser Permanente is not required by law to remain in the individual market. It is another reason why we have seen other carriers depart; they are a business, and they get to decide if they want to stay in this line of business or not. That is not true for CareFirst. CareFirst is the state's only non-profit health service plan, and under the provisions of Section 14-106 (d)(1)(ii) of the Insurance Article, they are required to offer products in the individual market and thus, may not exit. It is not in consumers' interest to have only CareFirst HMO and PPO products. It is in our interest to have more carriers. I am doubtful about the number of other carriers coming in, but at least we should try to hang on to those that are already here. And, obviously some consumers have elected to join Kaiser Permanente and believe that it best meets the needs of them and their families.*

*Finally, we would ask that we take this opportunity with the development of a state reinsurance program where essentially carriers are going to be given a pretty significant amount of money to help out with their travails in this market to put in place meaningful health improvement programs. There is no requirement in Maryland, that I know of, that the Exchange has placed on carriers in the individual market or any other market to demonstrate they are in fact well aware of the healthcare conditions that are driving up premiums and that they have developed meaningful interventions to control those costs going forward. I believe that is in consumers' interests for two reasons. One is that if they are effective, they will lead to a lower rate of increase, which is in consumers' interests, and second of all, if they are effective, it should mean that consumers who have these chronic conditions lead healthier, more productive lives, which is in all of our interests as well as theirs. Again, I would like to close by thanking you for moving forward with this effort, to the Secretary for being here to listen, and we look forward to working with you to try to bring as much benefit to the market as possible to all consumers. Thank you."*

Jeff Ratnow, consumer, offered the following testimony:

*"I am a consumer on the Exchange. I am going to give you my personal story. In 2015, I was fired, and I decided that now was the time to start my business. I started my business. My parents said to me, 'What are you going to do for health insurance?' because health insurance was always provided by my company, and I didn't really think about that. I was so grateful that Obamacare was in effect, and I went to a broker on Eastern Avenue in Highlandtown. He said, 'You're all set. You qualify for Medicaid,' so through the Affordable Care Act, because I was making no money, I got to build my business. As soon as I made \$75,000, I got my bill of \$650 a month, \$3,500 premium [deductible]. That isn't bad. That is kind of reasonable. That is a good deal. The next year, I grew my*

*business a little bit more, and the reward is \$1,200 a month, about the same premium [deductible]. Okay, still alright, but now, it is getting tight at home. I have two kids and a wife, a wife with a pre-existing condition. I found out that I do because I had a sleep apnea test 20 years ago that has been flagged since then, so we are essentially uninsurable without the public markets.*

*So, those of you who buy on the market, I am sure you watched with bated breath when the Republicans tried to kill Obamacare. I had nightmares. When John McCain voted against it, it was better than any Ravens SuperBowl ever. It was literally preserving my chance to live the American dream and build my business because without that, I knew I would have to give up and go get a job. So, the next year, my premium then went up to \$1,350 a month with a \$13,000 deductible. We go skiing, and now we have to make choices. My son breaks his arm. I didn't know if he broke his arm. We kind of waited it out a little bit. Urgent care is about \$300, and they are just going to put him in a splint. What do I do here? My friend is an ER doctor, so we went and saw him. He said, 'I think you need to get it taken care of.' Anyway, it changes how you take care of your family because the monetary pressures are so big.*

*This year, I probably have an exposure of about \$30,000, which is going to be about 30 percent of my net income. That is more than housing and is more than any other expense, and when I read that the state of Maryland was thinking about doing this, I thanked God that I live in a progressive state that really cares about the people. This will help me grow my small business. I will be able to instead pull money out of my business and right into a health savings account and my health insurance. I could look at hiring people. I could look into creating a better life for other folks as well, which I learned through the Goldman Sachs 10,000 Small Businesses Program how to do that. My constraints have been financial, and now this, hopefully if it works out the way that it is written, it will provide stabilization and insulate us from the craziness going on 40 miles south of here. And really create a state where people really want to move to and live in. Thank you."*

### **Closing**

Ms. Eberle recognized Jeff Ratnow and thanked him for sharing his story. Ms. Eberle closed the hearing and thanked everyone who attended.

### **Participants**

*Maryland Health Benefit Exchange*  
Ben Steffen, Member, Board of Trustees  
Dana Weckesser, Member, Board of Trustees  
Michele Eberle, Executive Director  
Andrew Ratner, Chief of Staff  
John-Pierre Cardenas, Director of Policy and Plan Management  
Kris Vallecillo, Senior Health Policy Analyst  
Betsy Plunkett, Marketing Director

*Maryland Insurance Administration*  
Todd Switzer, Chief Actuary  
Cathy Grason, Chief of Staff  
Brad Boban, Senior Actuary  
Bob Morrow, Associate Commissioner  
Joseph Fitzpatrick, Market Conduct Examiner

*Maryland Department of Health*  
Robert Neall, Secretary  
Laura Goodman, Division Chief

---

*Members of the Public*

Rich Albertoni

Zena Alhija

Jen Brock-Cancellieri

Scott Brown

Jackie Cahill

Kim Cammarata

Matt Celentano

Tim Curtis

Xue Dai

Linda Dietsch

Morgan Eichensehr

Calvin Holmes

Laura Hooper

Stephanie Klapper

Laurie Kuiper

Jon Kunkle

Diane Lawrence

Mark Longerbeam

Natasha Murphy

Maansi Raswant

Jeff Ratnow

Dourakine Rosarion

Kathy Ruben

Beth Sammis

Delora Sanchez

Jared Sussman

Bill Wehrle

Wayne Wilson

Bryant Woodford

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**Maryland 1332 Waiver Hearing #3**

**Western Maryland**

**May 7, 2018**

**Frederick County Health Department**

**350 Montevue Lane**

**Frederick, MD 21702**

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### **Welcome & Introductions**

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate Carol Krimm and Robert Neall, the Secretary of the Maryland Department of Health and Chair of the MHBE Board.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### **1332 Waiver Presentation**

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program’s attachment point has not been finalized because it depends on available funding. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increase that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier. An attendee asked if the expected premium decrease factors in subsidies, and Mr. Cardenas responded that that the estimate of the premium decrease is based on premiums without a subsidy.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including one additional hearing later in the week. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### **Q&A/Discussion**

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee commented that the reinsurance program will lower premiums, but asked if it will increase the number of plan options available through the exchange because the attendee is

currently paying \$600 per month for a bronze plan with a \$7,000 deductible. Mr. Cardenas responded that affordability is very important to the MHBE and that the reinsurance program will create a more favorable environment for insurers, which will hopefully encourage more insurers to participate in the exchange. Todd Switzer, Chief Actuary of the MIA, noted that the reinsurance program will have a greater impact on premium prices than one might think. For example, if a carrier files for a 50 percent rate increase, then the estimated 30 percent decrease from the reinsurance program would not result in a 20 percent rate increase but only a 5 percent rate increase because of how premiums are calculated. Mr. Switzer also asked if the attendee was referring to the fact that CareFirst recently decided to offer only one option for each metal level and that the number of Affordable Care Act (ACA) plans has decreased. The attendee responded that BlueCrossBlueShield is widely accepted, so it is difficult to look at another plan and determine the network; the only plan she can afford has a \$7,000 deductible. The attendee reported that it is sometimes cheaper to self-pay rather than use insurance. Mr. Switzer thanked the attendee for her comments.

An attendee asked whether the MHBE was concerned that the option of federal pass-through funding for the reinsurance program could disappear given the changes the current administration has made to weaken the ACA. Mr. Cardenas responded that the section 1332 waiver is protected by statute and that there are currently no proposed regulations that would threaten the waiver. Furthermore, the administration is encouraging states to apply for waivers to implement state based reinsurance programs.

An attendee then asked if the waiver is working in other states. Mr. Cardenas responded that the states that are focusing their 1332 waiver solely on a reinsurance program have had success with their programs; states with multiple programs have had more difficulty. For example, Minnesota has a reinsurance program and basic health plan that both draw from the same pot of money.

An attendee asked if the reinsurance program is still a short-term solution and if there is a long-term plan. Mr. Cardenas confirmed that the reinsurance program is intended to be a short-term solution to control premium costs. Ms. Eberle noted that the waiver application is for five years, though the funding is for two and a half years. New state funding will need to be secured at that point.

An attendee expressed concern about limited carrier participation in the exchange. Ms. Eberle responded that the MHBE is reaching out to carriers and have heard that carriers are interested in the reinsurance program as a way to control the costs of high-risk enrollees. Bob Morrow, Associate Commissioner of the MIA, added that the MIA is constantly reaching out to carriers to encourage participation in the exchange and that it is a top priority. Ms. Eberle noted that a carrier must build its network before entering the marketplace, which can take well over a year.

An attendee asked whether wellness programs, which have been proven to lower healthcare costs, will be part of the reinsurance program. Ms. Eberle responded that public testimony is always helpful and will become part of the application. A section of the 1332 waiver addresses issuer incentives for containing costs and utilization, and the MHBE is interested in that issue.

Regarding carrier participation, Mr. Switzer added that there were seven carriers in the individual market and now there are two; all carriers have been invited to participate. The \$365 million in state funding combined with the federal pass-through funding is expected to last for two years,

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reducing premiums by 30 percent. This gives Maryland time to look for a long-term solution and the ultimate goal of attracting a more robust and healthier pool to stabilize the market.

An attendee expressed concern that the reinsurance program is a patch until the next step is figured out. She also expressed support of a previous comment regarding well care, stating it has been statistically proven to reduce the cost of healthcare. She commented that the reinsurance program looks like the beginning of a single-payer system; other countries have shown that a single-payer system reduces administrative overhead. She asked where the conversation is heading since the reinsurance program is only a short-term solution. She also commented that the estimated savings for the future tend to be optimistic and she expressed concern that there will continue to be a downward spiral. She commented that insurance companies are for-profit and are not interested in reducing healthcare costs; she reiterated that a single-payer system for Maryland may be a better long-term solution and that it has been shown to work. Mr. Cardenas thanked the attendee for her insight, and noted that SB 387 included a series of studies for the Maryland Health Insurance Coverage Protection Commission, such as Medicaid buy-in and an individual mandate. He encouraged attendees to supply comments. Mr. Morrow noted that these public hearings are not the right place to advocate for a single-payer system because the MIA and MHBE are implementing the rules that are passed. They may provide information to legislators, but they are not involved in the policy making process. He explained that this group is trying to implement the reinsurance program and receive federal approval of the Section 1332 waiver that the legislature authorized. The attendee commented that this group would be uniquely qualified to be the administrators of the single-payer system. Mr. Morrow responded that if single-payer legislation was passed that directed the MIA or MHBE to implement a single-payer system, then they would do so.

Regarding wellness programs, Mr. Switzer added that some carriers have such programs, and the MIA is seeking more information regarding the effectiveness of these programs and trying to bolster them. He noted that the MIA will be looking at whether there is a better way to distribute the premium tax credit. Mr. Morrow added that every carrier in the individual and group markets has some wellness program or component in their plans and that could be improved on.

An attendee commented that she is confused by the distribution of the tax credit because she is self-employed. Sometimes it makes more sense for her to file separately from her husband, but that in turn caused her to lose her subsidy, which she feels is not helpful or productive for someone in her situation. Mr. Cardenas responded that the ACA requires married couples to file jointly in order to be eligible for a tax subsidy. If a married couple files separately, then they are ineligible for a subsidy. A future Section 1332 waiver could fix that problem, but that would be further in the future. Ms. Eberle added that the MHBE can connect the attendee to a navigator or a broker to receive assistance with this problem.

An attendee asked if the MHBE and other medical groups are working towards a federal single-payer system because as long as insurance companies are involved, then it will always be for-profit and will not benefit consumers. Ms. Eberle responded that this is not the charge of the MHBE, which was created to roll out health coverage and provide a marketplace for individual insurance through the ACA. Any activity at the federal level must be done through federal policy, and she recommended contacting the federal delegation for Maryland. The attendee commented that the MHBE staff are the experts who should tell the federal government what they want. Ms. Eberle responded that the state legislators would need to direct the MHBE to take that action, as



they are a state agency implementing the rules. She noted that the MHBE can connect the attendee to the people to speak to.

An attendee asked if Maryland will act as the reinsurer if the waiver is approved. Mr. Cardenas responded in the affirmative. The attendee asked if Maryland was considering transferring the risk into the traditional reinsurance market after the program is established. He commented that this is a subsidy not a reinsurance plan, and asked if Maryland considered transferring the risk to the traditional reinsurance instead of taking the risk on their own. Mr. Morrow clarified that the attendee meant that Maryland could purchase a reinsurance plan to cover their obligations; he responded that Maryland has not considered this option but could do so in the future.

An attendee asked if the reinsurance program will be in place in time to affect 2019 rates since open enrollment starts on November 1, 2018. The attendee expressed concern that rates could change halfway through open enrollment. Mr. Cardenas responded that the Centers for Medicare & Medicaid Services (CMS) encouraged Maryland to apply for a waiver starting in 2019, to get relief to as many Marylanders as soon as possible. The MIA and MHBE stand ready to implement adjusted rates after the reinsurance program is established. The recommended approval date for the waiver is the end of July, and previous states have had their waivers approved quickly. For example, Oregon's waiver was approved in 99 days, so a quick approval is possible. The MHBE is trying to submit the application as quickly as possible. Mr. Morrow added that they recognize that time is of the essence and everyone is working very hard to get the waiver done quickly.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Gene M. Ransom, III, CEO of MedChi, offered the following testimony:

*"First of all, I'm Gene Ransom. I'm CEO of MedChi, which is the Maryland State Medical Society, and on behalf of our members, we'd like to strongly support the application but we have three issues that we think need to be addressed before it moves forward. First and foremost, I'd say most important, we would like that language be included in the draft 1332 waiver that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments. We think this is really important. This plan should be designed to stabilize the entire market for everybody and benefit all Maryland consumers equally. We don't want a situation where certain patients of my members are benefited more than others, and we think this is, from a fairness point of view, really important—that everybody be treated equally. We don't want a situation where the state is essentially picking winners and losers in the market. We also think, if you make this adjustment, it will be another incentive to solve the problem we've heard about where there are not carriers in the market and, if we're clear that we're treating everybody fairly and equally, we might attract more folks into the market. My members and MedChi have complained about the concentration in the health insurance market for years. Our rating is off the charts. We're one of the most heavily concentrated markets and it creates all kinds of problems. It creates problems on the cost side for patients. It creates problems for my physician members when they're negotiating contracts with the insurers, and this is an opportunity to either make it worse by subsidizing one carrier more than the others*

*or make it better by subsidizing everybody equally, creating a fair and equal playing field.*

*The second issue that we think needs to be addressed is that specific payment incentives should be included in the reinsurance program that are aligned with the state's broader policy goals related to quality, cost effectiveness, and innovation. I also think that this would be an opportunity to address the wellness issues that came up before that Delegate Krimm and others have brought up. We also believe, specifically in that section, that the carriers should be required to participate and work collaboratively with CRISP, the other HIE, the HIE that's not here. We think that's really important. The population health tools and the work of the health information exchange can create a lot of opportunities for savings and better quality and better outcomes. We have one of the most highly recognized HIE's, again, health information exchange—the same acronym. I don't know why they do that. They should have given you guys different names. CRISP is recognized as one of the best-run HIEs in the country. There needs to be alignment. I don't think this is something that is a major problem. I think you might be able to do this even possibly with a resolution, maybe after the fact if it's a problem including in the application for approval reasons, but we just need to incentivize the carriers, particularly the dominant carrier, to participate with the information exchange so we can have better information and better outcomes.*

*The third thing, and I'm not saying you guys haven't done this, I just think that it's so important and it's such a high priority. We really just think that it's important for you to look at the newly approved—newly soon-to-be-approved hospital all payer Medicare waiver and make sure that this is properly aligned with the Medicare waiver. The Medicare waiver is really important to Maryland. MedChi has been working proactively with the state to get that approved, and we hopefully will have that approved in the matter of a few weeks or months maybe. We just think it's really important that that unique model that keeps our hospitals funded appropriately is aligned with this. And, again, I'm not saying it isn't, I'm just saying let's make a point to not screw that one up by accident. Let's look at it and combine the two.*

*So, in closing, I just want to reiterate that we really appreciate the work of Governor Hogan, of Commissioner Redmer, Secretary Neall who's in the back, and the Democrats in the General Assembly who really worked together in a bipartisan fashion to come up with this solution. We think it makes sense, and I think these three tweaks are positive changes that can be achieved before the application deadline. Thank you."*

David Hexter, MD, Emergency Physician and Physician in Chief at Mid-Atlantic Permanente, offered the following testimony:

*"Good afternoon, my name is David Hexter. I am an Emergency Physician and Physician-in-Chief at Mid-Atlantic Permanente. We care for the patients of Kaiser Permanente in the Baltimore area in general and the Baltimore area as well. Kaiser Permanente is one of only two carriers—we mentioned this several times—that is still on the exchange, and we're also the only one that cares for Medicaid patients. We first of all want to express our support for the section 1332 waiver reinsurance program and really applaud the state legislature, the Hogan administration, and Exchange for working to*

*move forward with this waiver application. And we believe that a reinsurance program like this if it's implemented fairly will go a long way to stabilizing the market and improve affordability, many of the problems of which you've heard today. But we think it must be, we believe it must be implemented fairly because the reinsurance program that Maryland develops should stabilize the entire insurance market and not just part of it. My fellow Permanente physicians are concerned that the reinsurance program as it is currently proposed will give an advantage to one health plan over another. We want to make sure that the rate relief that is provided by the program is spread across all Marylanders, not just those that enroll in one company's products. So unless a specific adjustment is made, the proposed program would allow carriers that are paid substantial amounts under the current federal risk adjustment program to be paid twice for accepting those higher-risk members under the reinsurance program. But why does this matter to consumers and patients? Well, if an adjustment is not included in the program, then the relief is going to be concentrated among a small minority of the individual market enrollees. And the majority of the consumers and patients will share less in the relief, and some including the 75,000 Marylanders who choose Kaiser Permanente through the exchange, many of whom are my patients, will experience much less premium relief. And as a Maryland physician, I want my patients to benefit from this reinsurance program that we're putting together to help keep their premiums affordable like everyone else in the state.*

*So we encourage the Exchange to include language in the draft section 1332 waiver application that indicates the state will adjust for this dynamic. And we also believe that Maryland should include incentives similar to what Mr. Ransom said in the reinsurance program that will align with broader state policy goals to improve quality and cost effectiveness of the care that is provided. To give you some ideas of some of these incentives that could be provided, you could reward high clinical ratings, for example breast cancer screening or colorectal cancer screening, controlling high-blood pressure. You mentioned the diabetes program before, we're able to control diabetes in the population. Shouldn't we be incentivized to do that? And thus designing a program that treats all carriers equitably and that includes these incentives for high-quality patient care and effective care management would attract new healthcare plans into the market, we want more choices as many of the people here today have indicated they want. And we want these carriers to focus on keeping people well, not just having them for a year and moving onto another carrier.*

*So in conclusion, we at Mid-Atlantic Permanente or Kaiser Permanente believe that the reinsurance program Maryland implements should not allow duplicate payments to be made to any one health plan. There can and should be an adjustment built into the program that makes sure that all patients who purchase their coverage in Maryland's individual market will benefit equally from this reinsurance. Finally, we should include incentives in the reinsurance program that are aligned with the state's broader policy goals in healthcare related to quality and cost effectiveness of care. Thank you very much, and I'm happy to answer any questions."*

Ellen Lerner, consumer, offered the following testimony:

*"I want to thank this group and the Maryland Health Benefit Exchange. I know your work is not easy; I think I am putting that mildly. I am certainly in favor of the application for this waiver. I hope we get it and we get it quickly. My sole purpose is to benefit those, well to everyone in the state of Maryland; I believe that everyone should be insured. I do want to caution as I did in my questions that this appears to be a patch, a very complicated patch. I hope it works. My husband is a physician. He practices as a teacher, teaching people about how to take care of themselves, how to be healthy, and he even still makes house calls to help people. To me, I know this isn't the purview of the Health Benefit Exchange, but yet it is. I recognize this group as being the one who helps people to find the best insurance they can with what they have available to them and this will help make more available to them. But I also urge caution in that you are dealing with for-profit insurance companies and that, ultimately, I hope that this will be the beginning as I see it of trickling into, kind of backing ourselves into, a single-payer system. I truly think in the end that's what will be the best, and I highly encourage that this be recognized as that little crack. Thank you."*

Delegate Carol Krimm of District 3A offered the following testimony:

*"Just to update people on how this process went during General Assembly, so when we came into session the federal government had just taken their actions, and it was communicated to all the legislators that this was going to have a devastating effect on our budget because of the cost involved in trying to repair what the federal government had done to our health exchange. So the Speaker and the Health and Government Operations Committee put this special committee into place, a special task force. The Chairman is Delegate Joseline Peña-Melnyk who in my estimation is probably one of the most knowledgeable legislators on healthcare, and they started meeting on a weekly basis with people in the industry, other legislators, and we just tried to get everyone at the table and we were getting updated through this process. So what I want to communicate to you is that this is not over. You know this is what we have to do, I think you've heard the words short-term. So we will continue to work on this, and we had to make very quick decisions because of the impact that came down from the federal government and that's what we did and not to say we're not moving towards some goals you think we should have in healthcare. But this is where we are, and these are the people that are going to guide us through the short-term, but we are going to continue the task force. So I would encourage the people here who have some very strong ideas on where we should be heading to get in touch with your legislators and let them know where you think we should be going because we're not done."*

Annette Breiling, Healthcare as a Human Right, Chapter of Frederick, offered the following testimony:

*"I'm sorry I came in late, and I'm with Healthcare as a Human Right, Chapter of Frederick and have long believed that everyone needs to get healthcare. And my understanding is that single-payer is the way that is ultimately going to have to happen, and the Medicare for all legislation is the way we're going to have to ultimately end up. My understanding also is that there are so many federal rules right now that are preventing a state to achieve this and the state whatever we can do to kind of move us in*

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*that direction is what I advocate. So that's why I came here and wanted to promote any steps that are going to move us to be able to get everybody healthcare."*

**Closing**

Ms. Eberle informed the audience that the MHBE has a navigator program and producers that can help consumers with assessing their options and navigate the system. Ms. Eberle closed the hearing and thanked everyone who attended.

**Participants**

*Maryland Health Benefit Exchange*

Michele Eberle, Executive Director

Andrew Ratner, Chief of Staff

John-Pierre Cardenas, Director of Policy and Plan Management

Kris Vallecillo, Senior Health Policy Analyst

*Maryland Insurance Administration*

Todd Switzer, Chief Actuary

Bob Morrow, Associate Commissioner

*Maryland Department of Health*

Robert Neall, Secretary

*Maryland Department of Human Services*

Lourdes, R. Padilla, Secretary

*Maryland General Assembly*

Delegate Carol L. Krimm

*Members of the Public*

Gene Ransom

David Hexter

Will Fawcett

Judith Rogers

Ellen Lerner

Mary Benove

Dan Mosebach

Amy Podd

Lisa Horner

Laurie Kuiper

Tinna Quigley

Rose McNeely

Kathy Ruben

James French

Mike Cumberland

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Jeannette Bartlett  
Natalie Ziegler  
Annette Breiling

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**Maryland 1332 Waiver Hearing #4**

**Southern Maryland**

**May 10, 2018**

**Charles County Health Department**

**4545 Crain Highway**

**White Plains, MD 20695**

### **Welcome & Introductions**

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and encouraged their participation.

### **1332 Waiver Presentation**

John-Pierre Cardenas, MHBE Director of Policy and Plan Management, noted that this is the final of four public hearings. He began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that HB 1795 directs the MHBE to apply for a 1332 waiver, and SB 387 places a 2.75 percent assessment on premiums to fund the program. An attendee asked whether the tax applies to employer-sponsored or individual health plans. Mr. Cardenas responded that the tax will apply to any policy that is subject to the authority of the state. He further explained that the reinsurance program's attachment point has not been finalized because it depends on available funding and stakeholder input. The MHBE Board has already voted to approve a reinsurance cap of \$250,000 and a coinsurance rate of 80 percent. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increase that has occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019. A member of the public asked whether the 5.8 percent increase refers to the percentage of individuals or the percentage of premiums. Mr. Cardenas responded that it is a 5.8 percent increase in the number of people enrolled.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation, noting that there is still opportunity to submit written comments. He also noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Michele Eberle acknowledged several audience members, including MHBE Board Vice Chair Tony McCann, MHBE Standing Advisory Committee member Evelyne Ward, Maryland Insurance Administration (MIA) staff, and MHBE staff.



## Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether non-core benefits will change under the waiver. Mr. Cardenas responded that the ten core essential health benefits will not change. Non-essential benefits are determined by the insurance company, and the waiver will not have a direct impact on these. The attendee also asked for the list of essential health benefits. Mr. Cardenas and Joseph Fitzpatrick, Assistant Chief Examiner, of the MIA listed the following benefits: ambulatory care, behavioral health, emergency services, hospitalizations, prescriptions, maternal and prenatal health, primary care, laboratory services, pediatric services, and rehabilitative and habilitative services.

An attendee asked if there is a "Plan B" if the federal government does not approve the waiver as expected. Mr. Cardenas responded that the MHBE has been working very closely with the federal government to ensure that the application is complete and ready for a quick response. He noted that the legislation authorizing the program is contingent upon federal approval, so further legislative action would be required if the federal government does not approve the waiver. Ms. Eberle commented that this would require a special session of the Maryland General Assembly.

An attendee asked about the program's effect on people who do not buy coverage through the exchange. Mr. Cardenas responded that the program applies to individual market rates both on and off of the exchange.

An attendee asked about the income requirements for participating on the exchange and what happens if someone's income exceeds that amount for a few months. Mr. Cardenas responded that subsidies are available to those up to 500 percent of the federal poverty level. He noted that individuals are expected to report income changes to the exchange within 30 days. Income for the upcoming plan year is predicted at the time of application, and this information is reconciled at the end of the year when taxes are filed. Ms. Eberle clarified that individuals with any income level can purchase on the exchange, but individuals can only obtain tax credits through the exchange.

Todd Switzer, Chief Actuary of the MIA, thanked the attendees for their participation and offered some additional comments. He stated that this waiver affects about 200,000 people in Maryland. Noting that the press release in regard to carrier rate increases was released earlier in the week, he explained that the impact of the reinsurance program is multiplicative. Mr. Switzer provided the theoretical example of a 50 percent rate increase coupled with the 30 percent decrease from the reinsurance program. He explained that this does not mean that there will still be a 20 percent increase in rates. He added that, if the increase is 50 percent, you multiply 1.5 by 0.7, and the increase in rates would be 5 percent and not 20 percent. Mr. Switzer explained that the reinsurance program has a much more leveraged impact, and he added that if the waiver is passed, it will have more of an impact than you might think. He stated that the reinsurance program will be more of an impact than just subtracting 30 percent.

Mr. Switzer emphasized the importance of the waiver and explained that the \$365 million, over the full five years, gets leveraged up to \$970 million, which is why the initial modeling can be stretched to try to improve the profile and risk of the pool to stabilize rates. Mr. Switzer stated

that there are still 360,000 uninsured in the state of Maryland, and about half of those people are eligible for a subsidy, whether it is Medicaid or a premium tax credit. He added that some of those uninsured people could get a free bronze plan, and economically speaking, people are making an irrational economic decision and leaving money on the table. Mr. Switzer expressed the hope that shining the light on this program will encourage people to take another look at insurance coverage.

An attendee noted that some of the literature she read stated that the waiver would limit the increase in premiums rather than decrease premiums. She asked if it is true that the waiver is supposed to decrease premiums, rather than just limit the increase in premiums. Mr. Switzer responded that a decrease in premiums is the hope, but there is no guarantee that it will happen. Mr. Cardenas added that the estimates provided are based on the data available currently, and a lot of it is projecting what will happen in 2019.

An attendee asked Mr. Switzer to explain the equation to determine the impact of the reinsurance program again. Mr. Switzer, using the example of a 50 percent overall increase, explained that you add 1 to the overall increase, which gives you 1.5, and then, with the reinsurance being a 30 percent decrease, you subtract the reinsurance percentage decrease from 1, which gives you 0.7. He continued by saying that when you multiply 1.5 by 0.7, you get 1.05. Mr. Switzer stated that whatever you get from that multiplying (1.05), you subtract 1, and that is what you can expect the impact of reinsurance to be. Mr. Cardenas added that every dollar magnifies its impact.

An attendee asked if any other states have applied for a Medicare waiver. Mr. Cardenas responded by clarifying that this is a 1332 waiver, which is for the Affordable Care Act, not necessarily Medicare. He note that a number of states have applied for 1332 waivers, and Minnesota, Oregon, and Alaska have been approved for reinsurance programs.

An attendee asked if there are any results from these other states. Mr. Cardenas responded yes and that the results have been promising. Mr. Cardenas provided Alaska's model as an example, stating that rates in Alaska were estimated to increase 40 percent, and rates only ended going up 7 percent. Mr. Cardenas added that Alaska is a unique example because Alaska is a small state with high costs. Mr. Cardenas also added that Oregon's and Minnesota's reinsurance programs have had downward impacts with lower rates of premium increases. Mr. Cardenas stated that the impact on each insurance company was also different because each company is different, and each company calculates their premiums differently. Mr. Switzer stated that Maryland is attempting to achieve the deepest discount that has been attempted so far. Mr. Switzer provided national context by adding that Minnesota attempted 20 percent and Oregon attempted 7 percent.

An attendee asked about the markets of the other states and if they only have two carriers like Maryland. Mr. Cardenas answered that Alaska has one, and Minnesota and Oregon have several participating insurance companies.

An attendee asked if this waiver could entice other carriers to come to the market. Mr. Cardenas answered that nothing is more attractive to an insurance company than a state that is committed to making the markets work, and the MHBE believes that a reinsurance program creates a more favorable environment. Mr. Cardenas stated that both the MHBE and the MIA work constantly to entice new insurance companies into Maryland.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Two individuals offered testimony.

Lore Rosenthal, consumer, offered the following testimony:

*“Hi, my name is Lore Rosenthal, and I may be the only person in this room who is actually on the Maryland health exchange. So, I guess I just wanted to share my personal story. I am sure the insurance carriers here have heard it before, and I am sure some of the panelists have heard it before. But, it is good to hear from a real person I think. So, I work three days a week. I am not a wealthy person, but I earn more than the cut-off, which is \$43,000, which is not a lot of money. This year, my premium, without any subsidy, is \$1,000, and at the time when my premiums went up from whatever they were last year to the \$1,000, there was not an increase in that cut-off of \$43,000. So, you would think if they were going to double your premiums, they would have said, ‘Oh, now you can earn like \$53,000 and still get a subsidy.’ Last year, with my old plan, my deductible was \$2,500, and believe it or not, you can use up the entire \$2,500 with one hospital stay. I happened to be in the hospital for a mental health reason, and it turns out my carrier did not cover inpatient mental health. So, I just blew through that money in five days.*

*This year, my deductible has gone up to \$3,500, and I am hoping that nothing is going to happen to me that I am actually going to blow through that money. You say that there is going to be a decrease of 30 percent, but so far the examples you have given is more that there was a decrease in the increase. So, I am very concerned that next year I may be paying \$1,100, and yippee, it is \$1,100 instead of \$1,400. People cannot afford, and I think you realize that, if you’re not on this subsidy, you cannot continue to afford that. It would never occur to me to just drop out of the program. I feel fortunate. I am a self-employed person, so I can’t go through a company. I feel fortunate to have insurance. For some people, it must be like 50 percent of their income. People are saying that housing costs are going up, and electricity costs are going up. For poor people, they are paying exorbitant amounts. I am sure this is all in the newspaper too, but people are just paying too much for insurance, and it shouldn’t be that way. I hope that you get the waiver, but I hope that in this case that the waiver gives us a 30 percent decrease, so I would only be paying like \$700 a month instead of \$1,000. Thank you.”*

Michael Hartman, consumer, offered the following testimony:

*“Hello, my name is Michael Hartman, and I am wondering if instead of a monetary amount for income, would it be possible to say that health costs should only be a percentage of your income? Let’s say, 15 percent or whatever. Might that be a more fair way of looking at things and understanding that a person earning \$10,000, if it’s 10 percent then it’s \$1,000. If you’re earning \$20,000, it would be \$2,000. It seems to me that might be a fairer way of looking at things. We look at things like Ms. Rosenthal mentioned about housing costs and generally, what is thought to be a good percentage is*

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*30 percent of your income for housing. Wouldn't it also be a good thing to put a percentage of your health care instead of a monetary amount? Thank you. "*

**Closing**

Ms. Eberle thanked everyone who attended; she encouraged consumers to look closely at the plan options available and to download the mobile application, which provides GPS-located assistance. She also noted the helpline and Navigator program as sources of consumer assistance.

An attendee expressed gratitude to the MIA for exemplary service in interceding with an insurance company on her behalf. She also commended the navigators. Ms. Eberle thanked the attendee for her comments and closed the meeting.

**Participants**

*Maryland Health Benefit Exchange*

Michele Eberle, Executive Director  
John-Pierre Cardenas, Director of Policy and Plan Management  
Kris Vallecillo, Senior Health Policy Analyst  
Tony McCann, Member, Board of Trustees

*Maryland Insurance Administration*

Todd Switzer, Chief Actuary  
Bob Morrow, Associate Commissioner  
Joseph Fitzpatrick, Assistant Chief Examiner

*Members of the Public*

Robert Axelrod  
Tinna Quigley  
R. Aaron Aist  
Evalyne B. Ward  
Sue Ehlenberger  
Angela Deal  
Louise Hayman  
Lore Rosenthal  
Michael Hartman

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## Comments Received Directly From Public

**Commenter:** Chet Burrell, CEO, CareFirst BlueCross BlueShield

**Comment Received:** Tuesday, April 24, 2018

**Comment:**

### CareFirst's View

**Kaiser Permanente's proposal to offset reinsurance with risk adjustment payments seeks to do what has never been done before and takes a position that was rejected by CMS when it operated the national ACA reinsurance program for three years.**

The reinsurance and risk adjustment programs are wholly separate concepts and are designed to address different issues:

- Risk adjustment reflects the illness levels of all enrollees that have chosen each payer in a market and transfers funds from plans with low-risk enrollees to plans with high-risk enrollees in order to equalize the costs of the risk burden borne by each payer.
- Reinsurance covers a portion of the costs of a very small percentage (3-5 percent) of high cost enrollees in order to reduce premiums for all.

The suggestion of offsetting risk adjustments against the reinsurance calculation – in order to avoid a possible double payment - mixes the two concepts inappropriately with the effect of materially lessening the premium reducing impact of reinsurance on premiums. This undermines the central purpose intended in the recently enacted legislation.

CMS considered and explicitly chose not to subtract federal risk adjustment payments when implementing the federal reinsurance program. CMS explained its reasoning at the outset of ACA in the Proposed 2014 Notice of Benefit and Payment Parameters as follows:

*“Adjusting for reinsurance payments in the HHS risk adjustment model would address the concerns that reinsurance and risk adjustment could compensate twice for the same high-risk individuals. Despite this potential, we **propose not** to adjust for reinsurance in the HHS risk adjustment model for a number of reasons:*

*First, removing reinsurance payments from risk adjustment would reduce protections for issuers of reinsurance-eligible plans that enroll high-cost individuals.*

*Second, it would be difficult to determine what portion of reinsurance payments were made for conditions included in each HHS risk adjustment model, and the appropriate model adjustment for these payments.”*

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The MHBE should strongly take into consideration the analysis that CMS conducted and its conclusions.

**Implementing Kaiser Permanente's recommendation could delay Maryland's 1332 waiver approval thereby threatening the State's ability to reduce premiums in 2019.**

CMS has indicated that the expedited approval timeframe that Maryland seeks is based on current 1332 waivers that have already been approved in other states. No other state has attempted to include a modification to its reinsurance program to offset risk adjustment payments.

Kaiser's proposal assumes there is a 100 percent double payment by subtracting the entirety of risk adjustment payments from the reinsurance calculation. This is not true, and moreover, ignores the impact that a robust reinsurance program will have on risk adjustment transfers.

If Maryland were to operate the reinsurance program as CMS and other states have, the full impact of the reinsurance program would reduce statewide average premium by as much as 30 percent from the levels that otherwise would have occurred (based on the analyses done to date).

This, in turn, will reduce risk adjustment transfers – accomplishing much of what Kaiser seeks without lessening the power of reinsurance to maximally hold premiums down.

**Kaiser seeks to justify its proposal, in part, because it makes an erroneous assumption that CareFirst is not managing costly PPO enrollees.**

Kaiser appears to suggest that CareFirst is not managing the care of its PPO members. This is fundamentally untrue. CareFirst actively manages care for all members in both PPO and HMO products through its Patient Centered Medical Home (PCMH) and Total Care and Cost Improvement (TCCI) programs. In fact, a disproportionate number of ACA individual PPO enrollees are in care plans through which intense care coordination efforts are made for these enrollees.

The central idea in PPO plans is to allow enrollees access to a broad array of providers. This attracts a more adverse risk population to these products. If the State wishes to continue a PPO offering, this must be recognized.

To design a reinsurance program in a way that does not equally treat PPO products with reinsurance protection would make PPO products even more unaffordable than they already are. This would be directly counter to the intended purpose of the market stabilization legislation just enacted and to the enormous efforts made by the State to expand network access and adequacy to ensure all Marylanders have the broadest possible access to providers in the State.

**CareFirst Recommendation.**

It is essential to recognize that any lessening of the impact of reinsurance through a risk adjustment offset will drive up PPO (as well as HMO) premiums and undermine the purpose of

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the recently enacted market stabilization legislation. Accordingly, prior to taking any further action in regulation or otherwise, the MHBE should direct Wakely to consider this impact and assess the impact of what Kaiser has proposed. CareFirst stands ready to cooperate with this effort and to work with Wakely toward an approach that fulfills the intent of the State to keep premiums for all individuals and their families as low as possible.

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**Commenter:** Gene M. Ransom, III, CEO, The Maryland State Medical Society

**Comment Received:** Monday, May 7, 2018

**Comment:**



May 7, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
6th Floor  
Baltimore, Maryland 21202  
Sent: [mhbe.publiccomment@maryland.gov](mailto:mhbe.publiccomment@maryland.gov)

**RE: 1332 Waiver Application**

Dear Board Members:

MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, appreciates the opportunity to comment on the DRAFT Maryland 1332 Waiver Application being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. MedChi strongly supports the Section 1332 waiver for the development of a reinsurance program. However, we have several minor adjustments that we feel are needed to improve the application prior to formal submission at the end of the month.

We understand and support the bipartisan action taken by the Governor and General Assembly to address the vital need to stabilize the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on this premise that MedChi believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers. Specific comments are articulated below.

First, MedChi is concerned that the reinsurance program as articulated in the DRAFT Section 1332 Waiver Application will effectively advantage only some health plans and provide premium relief primarily to the consumers enrolled in those companies' products. Under the proposal, some health plans could essentially receive a "double payment," being reimbursed twice for higher-risk members because it fails to adjust carriers' reinsurance payments by the amount they already receive under the federal risk adjustment program. By favoring these carriers, the program is essentially determining "winners and losers." Ultimately, this has the impact of limiting the benefit received by consumers who choose those health plans for their coverage. Designing a program that treats all carriers equitably would have the added benefit of attracting new health plans into the market.

Therefore, MedChi requests that MHBE include language in the DRAFT Section 1332 Waiver Application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans

over others. We believe including this language will improve the waiver application and would be accepted by CMS.

Second, MedChi believes specific payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions. MedChi also believes that it is equally important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP). We think participation and working with CRISP and the population health tools should be considered as a broader policy goal alignment as well.

Since the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MedChi believes that utilization practices of participating carriers should be examined. We also suggest not allowing non-staff model HMO product sold through the exchange to utilize prior authorization procedures.

In closing, we would also ask that the State make sure that the policies and procedures created and outlined in this waiver align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

MedChi again strongly supports getting this application done, and we understand the importance of expediency. However, we need to take the time to make sure we don't create new problems or unintended consequences.

Sincerely,



Gene M. Ransom, III  
Chief Executive Officer

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**Commenter:** Vincent DeMarco, President, Maryland Citizens Health Initiative

**Comment Received:** Thursday, May 10, 2018

**Comment:**

**HEALTH  
CARE  
for ALL**



**MARYLAND CITIZENS' HEALTH INITIATIVE**

2600 ST. PAUL STREET BALTIMORE, MD 21218

P: (410)235-9000

F: (410)235-8963

WWW.HEALTHCAREFORALL.COM

May 10, 2018

Michele Eberle  
Executive Director  
Maryland Health Benefit Exchange  
750 East Pratt Street, 6th Floor  
Baltimore, MD 21202

Dear Executive Director Eberle,

The Maryland Citizens' Health initiative strongly supports the Reinsurance and Market Stabilization programs established for Maryland in the 2017 General Assembly Session and we very much agree that your agency should work to support this program through an application for a State Innovation Waiver under section 1332 of the Affordable Care Act. This proposal will help stabilize Maryland health insurance markets and protect consumers from large rate increases, and represents a win for both consumers and the health insurance industry— all at no net cost to the federal government. Maryland consumers have faced large double-digit rate hikes in the individual health insurance market in both 2016 and 2017, though, as you know, the much larger increases have happened more recently since the Trump Administration and Congress have been trying to undermine the ACA.

This Maryland Reinsurance Program is a needed first step toward a stable and sustainable individual health insurance market, but it is only a first step. We also urge the state to take action to address the underlying causes of instability and higher costs in the individual market. These causes include insurance market dynamics such as adverse selection, but they also include the excessive and rising cost of health care services and prescription drugs. And, we believe Maryland must move quickly to replace the soon to be defunct federal individual mandate with our proposed health insurance down payment plan. By providing needed immediate relief for consumers, we hope that the Maryland Reinsurance Program will help buy our state and our health care system time to do the hard work necessary to address the underlying drivers of health care costs.

We understand that you have been asked by Kaiser Permanente to make two adjustments to the proposed reinsurance plan -- to include incentives to continue to manage health care cost and utilization and to account for any risk adjustment payments received by carriers to avoid duplicate payments. We agree with Senate Finance Committee Chairman Thomas "Mac" Middleton in his letter of April 10 to you and Commissioner Redmer (attached) that you should give "serious consideration" to these ideas.

**HEALTH  
CARE  
for  
All**



**MARYLAND CITIZENS' HEALTH INITIATIVE**

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In considering Kaiser's proposal and other ideas related to the reinsurance plan, including those put forward by Carefirst, we know that you will put first and foremost what is in the best interest of Maryland's health care consumers. To assist you in doing this, we recommend that you put two questions to the Wakely Group the answers to which we believe could be very helpful to you as you work to develop a reinsurance plan that will make health care more affordable. We suggest that you ask Wakely to compare the impact of a standard approach to reinsurance with Kaiser's proposal on:

1. The extent to which reinsurance and risk-transfer payments would duplicatively cover the same claims, and,
2. The median consumer's health premium costs and the total risk level of the individual market.

On behalf of our Maryland Health Care For All! Coalition we heartily commend you and everyone at the Maryland Health Benefit Exchange for all the great work you have done and are doing to make the Affordable Care Act a success in our state. We stand ready to help you in any way that we can to build on this success to achieve our common goal of quality, affordable health care for all Marylanders.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'Vincent DeMarco', written over a white background.

Vincent DeMarco, President

THOMAS M. MIDDLETON  
CHAIR

JOHN C. ASTLE  
VICE CHAIR



JOANNE C. BENSON  
BRIAN J. FELDMAN  
STEPHEN S. HERSHEY, JR.  
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JAMES N. MATTHIAS, JR.  
NATHANIEL T. OAKS  
EDWARD R. REILLY  
JIM ROSAPEPE

THE SENATE OF MARYLAND  
FINANCE COMMITTEE

April 10, 2018

Michelle Eberle  
Executive Director  
Maryland Health Benefit Exchange  
750 E. Pratt Street, 6<sup>th</sup> Floor  
Baltimore MD 21202

Alfred W. Redmer, Jr.  
Insurance Commissioner  
Maryland Insurance Administration  
200 St. Paul Street, Suite #2700  
Baltimore MD 21202

Dear Executive Director Eberle and Commissioner Redmer:

Thank you for attending the meeting that Chairman Pendergrass and I convened recently with representatives of Kaiser Permanente and Carefirst to discuss certain amendments that Kaiser requested to Senate Bill 387/House Bill 1782, the legislation which will generate funding in calendar year 2019 for a reinsurance mechanism for individual health insurance market stabilization. As you know, the legislation establishes a health insurance provider fee assessment at the rate of 2.75% on all amounts used to calculate the provider's premium tax or premium tax exemption value in calendar year 2018, with the proceeds of the assessment to be distributed to the Maryland Health Benefit Exchange Fund to support the reinsurance program. The intent is to recoup the aggregate fee that otherwise would have been assessed under § 9010 of the Affordable Care Act as a bridge to stability in the individual health insurance market.

The amendments requested by Kaiser Permanente would have required the reinsurance program under § 31-117 to (1) include incentives to continue to manage health care cost and utilization, and (2) account for any risk adjustment payments received by the carrier under 42 U.S.C. § 18063 to avoid duplicate payments, a potential circumstance noted in the March 15, 2018 report of the State's actuarial consultant, Wakely Consulting Group.


After discussion, the consensus at the meeting was that, in establishing the reinsurance program for 2019 and beyond, the MHBE, in consultation with the MIA, has the power to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments, if appropriate, even without the language requested by Kaiser being in the statute. There was also general agreement at the meeting that in

designing the reinsurance program, consideration should be given to including in the design incentives to manage cost and utilization and, if practicable, a mechanism to avoid duplication between risk adjustment and reinsurance to ensure the most effective use of the limited funding available.

We decided not to adopt the amendments requested by Kaiser because it is our understanding that you plan to consider inclusion of incentives to manage cost and utilization and a mechanism to avoid duplication between reinsurance payments risk adjustment payments in the reinsurance program. Accordingly, it is my hope and expectation that these elements will receive serious consideration as the parameters for the reinsurance program are established.

Thank you, again, for your assistance and cooperation during the 2018 session on this important legislation.

Sincerely,

A handwritten signature in cursive script that reads "Thomas M. Middleton".

Thomas McClain Middleton  
Chairman, Senate Finance Committee

TMM/PDC

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**Commenter:** Mary Wontrop, Executive Director, Epilepsy Foundation Maryland; Philip Gattone, President & CEO, Epilepsy Foundation

**Comment Received:** Monday, May 14, 2018

**Comment:**





May 14, 2018

Michele S. Eberle, Executive Director  
Maryland Health Benefit Exchange  
750 East Pratt Street, 16<sup>th</sup> Floor  
Baltimore, MD 21202

Re: Maryland Section 1332 State Innovation Waiver

Dear Director Eberle:

The Epilepsy Foundation and the Epilepsy Foundation Maryland appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 American will develop epilepsy at some point in their lifetime. For the majority of people living with epilepsy, prescription medications are the most common and cost-effective treatment for controlling and/or reducing seizures, and they must have meaningful and timely access to physician-directed care.

The Epilepsy Foundation and Epilepsy Foundation Maryland believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with epilepsy to access the coverage that they need. Epilepsy Foundation and Epilepsy Foundation Metropolitan Washington support Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for 5 years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with epilepsy, obtain affordable, comprehensive coverage.



The Epilepsy Foundation and Epilepsy Foundation Maryland believe the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in black ink that reads "Mary Wontrop".

Mary Wontrop  
Executive Director  
Epilepsy Foundation Maryland

A handwritten signature in black ink that reads "Philip M. Gattone".

Philip M. Gattone, M.Ed.  
President & CEO  
Epilepsy Foundation

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<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).

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**Commenter:** Deborah P. Brown, Chief Mission Officer, American Lung Association

**Comment Received:** Tuesday, May 15, 2018

**Comment:**

May 15, 2018

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

Re: Maryland 1332 State Innovation Waiver Application

Dear Director Eberle:

The American Lung Association in Maryland appreciates the opportunity to submit comments on Maryland's 1332 State Innovation Waiver Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 729,000 Maryland residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with lung disease to access the coverage that they need. The Lung Association supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help health insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. The state estimates that the program will reduce premiums by approximately 30 percent and increase the number of individuals obtaining health insurance through the individual market by an estimated 5.8 percent in 2019. This would help patients with pre-existing conditions, including patients with asthma, COPD, lung cancer, and other lung diseases, obtain affordable, comprehensive coverage.

The American Lung Association in Maryland believes the proposed 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, and we urge its adoption. Thank you for the opportunity to provide comments.

Sincerely,



Deborah P. Brown  
Chief Mission Officer  
American Lung Association

<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).

**Commenter:** Janet Harvey, Private Member of Public

**Comment Received:** Tuesday, May 15, 2018

**Comment:**

To whom it may concern;

Hello my Name is Janet Harvey from Accident, MD. I'm sending this e-mail as I am unable to attend a hearing due to my work.

Health Care Concerns of the working middle class;

I have been a Maryland resident all my life I work 3 jobs and I am self-employed. I have never [drawn] a day's unemployment is my life. My average income a year is around \$53,000.00. [The] first year that Insurance became a mandate my cost with Care First Blue Cross was \$368.00 per year with a deductible of \$3,500.00 year 2015. The next year 2016 my premium went to \$412.00 with a \$4,500.00 deductible, 2017 the premium went to \$687.00 with a \$6,550.00 deductible!!

That's when I decided I had to make a change and that is when I went to Christian Ministries and started paying \$150.00 per month and joined a Brothers Keeper increase of \$25.00 a Quarter for higher level care. This prevented the IRS from penalizing me at the end of the year. I have [driven a] school bus for 26 years and with the costs of Maryland Health care I was making myself sick worrying how I was to pay the premium and keep a roof over my head and a school bus on the road with working 3 jobs to survive. There is no cap on the deductible so at the start age of 54 when this system came to be at this rate my deductible would be with the current increase of \$3,050.00 is two years by the age of 65 my deductible could well be \$24,400.00 plus....ludicrous!!!! While I had Care First it would cost me \$125.00 to go to Urgent Care which I had to pay because my deductible had not been met. With no insurance it cost me \$35.00. A CDL physical cost \$200.00 with Insurance and \$75.00 with no Insurance. Also the fact that LAB CORP monopolizes blood work and completely over charges customers for labs that were never performed is a great concern!! When you have a Urine Culture sent out and they think you still have Insurance and bill an old policy number and you receive a denial of payment and come to find out that they was including Phlebotomy charge of \$25.00 when no blood was drawn.... awful if they did this to 100,000.00 people a day....terrible !!!!

There are no caps on your deductibles which is ridiculous! Please feel free to contact me at any time!

I feel we need to be heard regarding the issue of affordable health care. Also we that live in GC should be able to go to Morgantown, WV for care and they are affiliated with Garrett Regional Medical Center in Oakland MD. We should not have to pay more to go to Morgantown it is so much closer than Baltimore or John Hopkins. Thank you!

Sincerely yours

Janet Harvey  
Concerned Citizen

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**Commenter:** Lydia L. Seiders, Maryland Volunteer State Ambassador, Rare Action Network

**Comment Received:** Tuesday, May 15, 2018

**Comment:**



May 15, 2018

Maryland Health Benefit Exchange

**Re: Maryland Section 1332 State Innovation Waiver**

Dear MHBE Board Members,

As Maryland State Ambassador for the Rare Action Network, powered by the National Organization for Rare Disorders (NORD), I appreciate the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. Since 1983, we have been committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

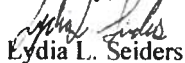
We believe everyone should have quality and affordable healthcare coverage. A strong, robust marketplace is essential for people with rare disorders to access the coverage that they need. NORD supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.<sup>1</sup>

Maryland's proposal will create a reinsurance program starting for the 2019 plan year and continuing for five years. This program is projected to reduce premiums by 30 percent and increase the number of individuals obtaining health insurance through the individual market by 5.8 percent. This would help patients with pre-existing conditions, including patients with rare disorders obtain affordable, comprehensive coverage.

I believe, as Ambassador, the 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers. Thank you for the opportunity to provide comments.

Sincerely,



Eydia L. Seiders

Maryland Volunteer State Ambassador

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<sup>1</sup> American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).

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**Commenter:** Laurie G. Kuiper, Senior Director of Government Relations, Kaiser Permanente  
**Comment Received:** Thursday, May 17, 2018  
**Comment:**





May 14, 2018

Maryland Health Benefit Exchange Board  
Baltimore, MD

Dear Maryland Health Benefit Exchange Board,

As the people of Kaiser Permanente, we applaud the Governor and Legislature's attention to the reinsurance issue to ensure Maryland maintains a strong, stable individual market that provides access to high quality care and choices. We believe the goal of the Maryland reinsurance program should be to stabilize the entire individual market and benefit all Maryland consumers equally — not to pick competitive "winners and losers" by favoring one company over another in the program's design.

We are concerned that — as drafted — the waiver outlining the program effectively advantages one health plan, CareFirst, and specifically their PPO product, over all Maryland consumers. It would lead to CareFirst being paid twice for their participation in the individual market, as they also receive compensation for their risk through the federal risk adjustment program — amounting to a "double dip." We are concerned that most Maryland consumers will receive much less benefit from the reinsurance program overall.

We recommend adjusting the waiver proposal so that the structure accounts for these payments being made towards this same end — participation in the individual market. The program should put into place incentives that would result in lower rates for all Marylanders, and reward cost-effective, high quality care. We would also encourage policymakers to ensure that the final waiver includes incentives to both manage cost and utilization and encourage delivery system innovation. Such a shift would be consistent with Maryland's broader policy objectives around affordability and access.

This is a solvable problem, and there can and should be an adjustment as we build a solid individual market into the future. There are only two health plans remaining in the individual market in Maryland. This means that any policy proposals should be particularly mindful of how reinsurance, risk adjustment, and other requirements of this market will work in this specific context, and the critical need to encourage new plans to come into this market.

Sincerely,

The undersigned of the Kaiser Permanente Mid-Atlantic community



Geneane	Adams	Anne Arundel
Ilene	Aiken	Montgomery
Jamie	Anderson	Prince Georges
Marbla	Atatsi	Montgomery
Valerie	Beckett	Montgomery
Mari-Viola	Bocchetto	Anne Arundel
Jayme	Brenneman	Montgomery
Laird	Burnett	Charles
Charlyn	Chandler	Baltimore
Maryam	Charmchi	Lane
Anne-Marie	Cox	Montgomery
Jill	Feldon	District of Columbia
Kelley	Flesher	Frederick
Kimberly	Fox	Montgomery
Mardela	Gonzalez	Prince Georges
Vilma	Gordon	Charles
Pamela	Hamorsky	Montgomery
Jeffrey	Hart	Montgomery
Denise	Hathaway	Alameda
Tara	Herberth	Baltimore City
Lena	Hershkovitz	Montgomery
Debbie	Jochum	Montgomery
Lauren	Kalastein	Anne Arundel
Becky	Kepple	Montgomery
Ryan	Mach	Alameda
Robin	McClave	Frederick
Gracelyn	McDermott	Howard
Shannon	Mcmahon	Montgomery
Dawda	Njie	Montgomery
Sam	Ongwen	Montgomery
William	Raisner	Montgomery
Marwan	Rateb	Baltimore City
Alma	Riberts	Montgomery
Daiga	Rutins	Montgomery
Jill	Sacks	Montgomery
Evetta	Sherman	Montgomery
Terri	Syme	Anne Arundel
Stephanie	Waszkiewicz	District of Columbia
Scott	Weier	District of Columbia

*Please consider this very carefully. KP is a wonderful organization and benefits a major market in our state both from an insurer perspective and an employer perspective. Thank you.*

Geneane Adams  
Anne Arundel County

*We are raising our voices to ensure a stable health insurance market that works for all Maryland consumers.*

Jamie Anderson  
Prince Georges County

*Thank you for tackling this most difficult issue. Maryland should be the leader in providing affordable health care to all its constituents.*

Mari-Viola Bocchetto  
Frederick County

*I urge you to put into place a measure that will provide lower health care costs for all Marylanders.*

Jayme Brenneman  
Anne Arundel County

*It would be absurd and unconscionable to take the money that people pay to KP for an efficient and high-quality plan and give it to Carefirst, for their more expensive and lower quality plan (beyond the reasonable risk adjustment payments required by the ACA.) That's not stability or fairness, it's highway robbery.*

Laird Burnett  
Montgomery County

*The decision you make will mean life and/or death to many Marylanders. Please reconsider how to move forward equitably in regards to the Maryland Health Exchange.*

Anne Marie Cox  
Baltimore County



*While we need to stabilize the individual plan market, Maryland needs to make sure its solution is fair to all those who live in the state, not just those with CareFirst insurance. Thank you.*

Jill Feldon  
Montgomery County

*I support Kaiser Permanente's initiative to revise the current proposed legislation to be more equitable to all Marylander's.*

Pamela Hamorsky  
Charles County

*Please ensure a stable health insurance market that works for ALL Maryland consumers.*

Jeffrey Hart  
Montgomery County

*I am concerned that the bill as drafted is not equal for all. Please look closely at the impact and that it doesn't advantage CareFirst.*

Debbie Jochum  
Montgomery County

*Please be sure your proposal creates incentives that reward cost-effective, high-quality care and result in lower costs for all Marylanders.*

Robin McClave  
Howard County

*Kaiser Permanente is the only plan with the mission to provide affordable health care to all people. Unduly burdening this non-profit plan will give an unfair advantage to other plans that do not necessarily hold this goal as their priority. Please make the rule fair to Kaiser Permanente so they can continue to provide the region's highest quality care to their members and communities.*

Jill Sacks  
Montgomery County

*As somebody who closely follows health policy, I'm deeply concerned that the re-insurance provision, as currently drafted, will further destabilize the market that it's seeking to fix. Why pump all that money to PPO plans and not support HMO plans that are proven to better integrate and coordinate care and get better value? This just doesn't make any sense.*

Scott Weier  
District of Columbia

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**Commenter:** Scott Hancock, Executive Director, The Maryland Municipal League

**Comment Received:** Tuesday, May 15, 2018

**Comment:**



## Maryland Municipal League

*The Association of Maryland's Cities and Towns*

May 17, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
Baltimore, MD 21202

SUBJECT: Maryland 1332 Waiver Application & Reinsurance Program

Dear Sir or Madam:

Thank you for the opportunity to provide public comment on the Maryland Health Benefit Exchange's draft Section 1332 waiver application. The Maryland Municipal League applauds the State of Maryland's proposed immediate steps to stabilize the individual health insurance market.

The Maryland Municipal League (MML) represents 1.5 million Maryland residents living in the 157 incorporated cities and towns. It is estimated that a large percentage of municipal residents have taken advantage of Maryland's health exchange program since its inception and would be impacted by the actions proposed in the Section 1332 waiver and the reinsurance program.

MML believes a reinsurance program could be beneficial in reducing health insurance premium increases for the residents of municipalities that purchase their coverage in the individual market. The reinsurance program that Maryland develops, however, should be designed to stabilize premiums in the entire market and equally benefit all Maryland consumers that get their coverage through the individual market.

The League is concerned that the reinsurance program, as currently proposed, would benefit the enrollees of one health plan over the other. We want to make sure that the premium relief provided by the program is spread among all residents of our communities and not just those who are enrolled in one company's product. We fear that if an adjustment is not included in the proposed program, instead of all Marylanders seeing premium relief compared to what they would otherwise be required to pay in 2019, the relief will be concentrated among a much smaller number of individual market enrollees.

1212 West Street, Annapolis, Maryland, 21401

410-295-9100

| [www.mdmutual.org](http://www.mdmutual.org)

| 800-492-7121

In conclusion, MML believes:

- All 1.5 million municipal residents throughout the State should benefit from reinsurance - to keep their premiums affordable – not just those who enroll in specific plans.
- There can and should be an adjustment built into the program to make sure all consumers and patients that purchase their coverage in Maryland's individual market benefit fairly and equally from reinsurance.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Hancock", written in a cursive style.

Scott Hancock  
Executive Director

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**Commenter:** Lisa B. Williams, CEO/Executive Director, Baltimore City Medical Society

**Comment Received:** Thursday, May 17, 2018

**Comment:**

# BCMS

**Baltimore City Medical Society**

1211 Cathedral Street, 3rd Floor  
Baltimore, Maryland 21201-5516

(410) 625-0022  
FAX (410) 385-0154  
info@bcmsdocs.org  
www.bcmsdocs.org

May 16, 2018

Board of Directors  
Maryland Health Benefit Exchange  
750 Pratt Street, 6<sup>th</sup> Floor  
Baltimore, MD 21202

Re: *Maryland Section 1332 Waiver Application (Draft)*

Dear Members of the Board:

Baltimore City Medical Society, a component of MedChi, The Maryland State Medical Society, the professional membership organization of physicians, supports the *Section 1332 Waiver Application* ("Application") for the development of a reinsurance program. We appreciate the opportunity to offer further comments on the Application.

We, too, are concerned that, as drafted, the reinsurance program outlined in the Application will advantage only some health plans and their patient subscribers. It is our position that the program must stabilize the entire market and equally benefit all plans and their subscribers. Adding language in the Application to address this concern would enhance the Application.

We encourage these additional enhancements to the Application: (1) delineating specific payment incentives to address quality of care, cost-effectiveness and innovation; (2) requiring all participating carriers engage with Maryland's health information exchange, Chesapeake Regional Information System for our Patients or CRISP; (3) examining utilization practices of participating carriers; and (4) assuring that the policies and procedures in the Application align with the term sheet agreement of the unique Maryland Medicare Hospital All Payer Waiver.

Again, we support the Application and appreciate your consideration of our concerns.

Sincerely,



Lisa B. Williams  
CEO/Executive Director



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**Commenter:** Maansi K. Raswant, Director of Policy and Data Analytics, Maryland Hospital Association

**Comment Received:** Friday, May 18, 2018

**Comment:**



Maryland  
Hospital Association

May 18, 2018

Secretary Robert Neall  
Chairman, Board of Trustees  
Maryland Health Benefit Exchange  
750 E. Pratt Street, 6th Floor  
Baltimore, Maryland 21201

Dear Secretary Neall:

On behalf of the 64 hospitals and health system members of the Maryland Hospital Association (MHA), I offer support for and feedback on the state's application for a waiver under section 1332 of the Affordable Care Act.

Maryland's hospitals support broad-based, continuous health coverage as an essential pillar of the state's unique agreement with the federal government, otherwise known as the All-Payer Model. The current model started in 2014 as a five-year demonstration, at the same time coverage was expanded; the synergy between the two has made Maryland a model in the nation for holding costs down and improving quality. Hospitals therefore wholly back the state's application for a section 1332 waiver and efforts to develop a reinsurance program. The following suggestions will improve the state's application and the resulting reinsurance program.

**First, the Maryland Health Benefit Exchange, working with the Maryland Insurance Administration, should hold carriers accountable to generate meaningful reductions in out-of-pocket costs, encouraging increased enrollment.**

While the short-term goal of the reinsurance program is to stabilize the individual insurance market, it should also bolster health care coverage (the state projections that the reinsurance program will increase enrollment by 6 percent are encouraging). Ultimately, efforts to cushion losses for carriers via reinsurance should translate to lower premiums and, in turn, increased coverage. Expanded coverage ensures that more Marylanders will receive preventive care, and care in the most appropriate setting, thereby reducing avoidable hospital utilization; a key metric under the All-Payer Model. Also, growth in coverage is directly proportional to reductions in the amount of uncompensated care built into hospital rates, increasing cost savings to commercial carriers, the state, and federal government.

**Second, the Board should include language in the 1332 waiver application indicating that the Maryland Health Benefit Exchange will explore care management incentives for carriers as part of the state reinsurance program.**

The reinsurance program offers a unique opportunity to strengthen the link between health care coverage and delivery via the creation of care management incentives for carriers, specifically those aimed at high-risk, high-cost enrollees. To develop these incentives, target conditions and

Sec. Robert Neall  
May 18, 2018  
Page 2

populations could be identified using current data sources, such as carrier submissions for the federal risk adjustment program, the state's all-payer claims database, and Health Services Cost Review Commission analyses. While specific incentives would be determined via a state regulatory process following the submission of the 1332 waiver application, incentives focused on management of chronic conditions, better primary care, or behavioral health care access would all result in significant improvement in quality of care and cost reduction, matching the goals of the All-Payer Model. Any reduction in the cost of care would also decrease reliance on a reinsurance program.

Thank you for your leadership on this effort. Hospitals believe that patient-centered, quality, and efficient care depends on broad-based health care coverage and reiterate our strong support of the 1332 waiver application. Maryland's hospitals stand ready to continue to work with payers, other providers, and the state to provide Marylanders with a high-performing health care system, one where insurance carriers offer affordable coverage so that hospitals can continue to deliver efficient, high-quality care.

Please contact me should you need additional information.

Sincerely,



Maansi K. Raswant  
Director, Policy and Data Analytics

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**Commenter:** Anna Davis, Health Policy Director, Advocates for Children and Youth  
**Comment Received:** Friday, May 18, 2018  
**Comment:**



May 10, 2018

Michele Eberle  
Executive Director  
Maryland Health Benefit Exchange  
750 E. Pratt Street, 6<sup>th</sup> Floor  
Baltimore, Maryland 21202

Dear Executive Director Eberle:

Thank you for the opportunity to comment on the Maryland Health Benefit Exchange's proposed Section 1332 waiver application. Advocates for Children and Youth strongly supports the waiver application and the Maryland Reinsurance program. On behalf of all Maryland families with children, ACY commends the MHBE Board and staff for all that you are doing to help stabilize the individual insurance market and to protect consumers from high rate increases.

Access to health care is essential for achieving and maintaining proper health throughout the life course. The assaults on the ACA and ongoing repeal efforts at the federal level have made it more difficult for consumers to find affordable coverage and to keep healthier people in plans that meet the requirements of the ACA. The Maryland Reinsurance program is a critical and much needed first step toward stabilizing the individual health insurance market. MHBE acknowledges that the Reinsurance program is but a short-term fix for market stability. ACY is optimistic that the Reinsurance program will buy time for the state and insurers to work together to develop a long-term solution that will address the underlying causes of market distortion and rising health care costs.

It is ACY's understanding that numerous stakeholders have advocated that the MHBE consider including incentives for issuers to manage high risk enrollees and to coordinate the reinsurance program to account for the ACA's risk adjustment program. ACY agrees with the suggestion of Senate Finance Committee Chairman Thomas "Mac" Middleton that the MHBE, in consultation with the Maryland Insurance Administration (MIA), has the authority to include incentives to manage health care cost and utilization and to account for risk adjustment payments to avoid duplication with reinsurance payments. In designing the Reinsurance program, ACY urges the MHBE to take these stakeholder concerns into account and to employ those policy options that will promote consumer choice and achieve the broader goals of the reinsurance program.

Thank you for your consideration.

Best,

Anna Davis, JD, MPH  
Health Policy Director



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**Commenter:** Steve Butterfield, Regional Director of Government Affairs, Leukemia & Lymphoma Society

**Comment Received:** Friday, May 18, 2018

**Comment:**



May 18 2018

Michele Eberle  
Executive Director  
Maryland Health Benefit Exchange  
750 East Pratt St.  
6<sup>th</sup> Floor  
Baltimore, MD 21202

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on Maryland's Section 1332 State Innovation Waiver, and respectfully submits the following.

At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. It is in service to these principles that we offer these comments in support of a reinsurance program in Maryland that prioritizes improved access to stable, affordable coverage for patients and consumers, as is proposed to be established by this waiver.

Cancer patients need access to meaningful health insurance coverage in order to access necessary care and treatment. LLS has adopted a set of Coverage Principles that outline what, exactly, from the organization's perspective, constitutes "meaningful" health insurance coverage.<sup>1</sup> Among these, LLS knows that meaningful coverage for cancer patients must be both affordable and stable. We feel that instituting a reinsurance program will help Maryland meet these standards.

Reinsurance programs in other states have shown promising initial results in controlling overall premium growth, and even, in some cases, resulting in premium reductions. Alaska, Oregon, and Minnesota all currently operate reinsurance programs on models similar to that proposed by this waiver<sup>2</sup>, and all have received significant federal pass-through funding returned as a result of reductions in premium growth and, consequently, advanced premium tax credit (APTC) payments in their states.

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<sup>1</sup> *Principles for Meaningful Coverage*. The Leukemia & Lymphoma Society. Retrieved from <http://www.lls.org/cancercost/Principles>

<sup>2</sup> *State 1332 Waiver Reinsurance Proposals: Wisconsin Releases Draft 1332 Waiver Seeking \$170 Million in Pass-Through Funding*. State Health Access Data Assistance Center. March 30 2018. Retrieved from <http://www.shadac.org/news/state-1332-waiver-reinsurance-proposals-wisconsin-releases-draft-1332-waiver-seeking-170>

**National Office**  
3 International Drive  
Suite 200  
Rye Brook, NY 10573  
main 914.949.5213  
[www.LLS.org](http://www.LLS.org)

**BEATING  
CANCER  
IS IN  
OUR BLOOD.**



In addition, Maine, prior to the implementation of the Affordable Care Act (ACA), operated a state-based reinsurance program that was estimated to reduce premiums by 12% to 15%.<sup>3</sup> Maine is now also seeking a 1332 waiver to reactivate their reinsurance association.

At the federal level, reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the ACA and reduced premiums by an estimated 10% to 14% in its first year.<sup>4</sup>

Because LLS believes Maryland's 1332 State Innovation Waiver will help stabilize the individual market in Maryland and protect patients and consumers, we are pleased to support the establishment of a reinsurance program as proposed by this waiver.

Thank you for the opportunity to provide comments. Questions or requests for further information on LLS and our position can be addressed to Steve Butterfield, Regional Director of Government Affairs, at either 207-213-7254 or [steve.butterfield@lls.org](mailto:steve.butterfield@lls.org).

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<sup>3</sup> *The Impact of PL90 On Maine's Health Insurance Markets*. Gorman Actuarial LLC. December 2011. Retrieved from

[http://www.maine.gov/pfr/insurance/publications\\_reports/archived\\_reports/pdf/gorman\\_actuarial\\_report.pdf](http://www.maine.gov/pfr/insurance/publications_reports/archived_reports/pdf/gorman_actuarial_report.pdf)

<sup>4</sup> *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. American Academy of Actuaries, Individual and Small Group Markets Committee. January 2017. Retrieved from [https://www.actuary.org/files/publications/Acad\\_eval\\_indiv\\_mkt\\_011817.pdf](https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf).



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**Commenter:** Ashley Kenneth, Director of Advocacy and Policy, National Multiple Sclerosis Society

**Comment Received:** Friday, May 18, 2018

**Comment:**



National Multiple Sclerosis Society  
Comments Regarding Maryland's Application for a Section 1332 State Innovation Waiver

Ashley Kenneth  
Director, Advocacy & Policy

May 17, 2018

The National Multiple Sclerosis Society (the Society) is grateful for the opportunity to submit comments regarding Maryland's Section 1332 State Innovation Waiver application.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. There are over 1 million people in the United States diagnosed with the disease, including at least 12,000 people in Maryland.

The National MS Society believes that everyone should have access to quality and affordable healthcare. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for people living with MS. A strong, robust marketplace is essential for people with MS to access the coverage and care that they need.

However, insurance premiums are rising and will soon price people out of the healthcare system. The Society is committed to ensuring that people living with MS have reliable access to comprehensive health insurance plans with affordable premiums, deductibles, and out-of-pocket costs. Without market stabilization measures like reinsurance, Marylanders who are currently relying on the marketplace for their health insurance could lose their only affordable coverage option. The Society supports Maryland's efforts to strengthen its marketplace by submitting this 1332 State Innovation Waiver to implement a reinsurance program.

Reinsurance is an important tool to help stabilize the health insurance market by covering a percentage of the claims of very high cost enrollees. This will help make premiums more affordable for all individuals who buy insurance on the individual market. Maryland's proposed reinsurance program is projected to reduce premiums by 30% in 2019 and increase the number of individuals obtaining health insurance through the individual market by 5.8%. The program

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will undoubtedly help people who live with MS, an expensive pre-existing condition, to obtain and retain affordable, comprehensive coverage.

The Society applauds Maryland for moving forward with this application and believes the 1332 State Innovation Waiver will help stabilize the individual market in Maryland while protecting consumers. If we can be of any assistance in the future to help increase access to health care in Maryland, please contact me at [ashley.kenneth@nmss.org](mailto:ashley.kenneth@nmss.org).

---

**Commenter:** Beth Sammis, President, Consumer Health First

**Comment Received:** Friday, May 18, 2018

**Comment:**



May 18, 2018

Michelle Eberle  
Executive Director  
Maryland Health Benefit Exchange  
mhbe.publiccomments@maryland.gov

Dear Ms. Eberle:

Consumer Health First (CHF), along with the undersigned 10 organizations and 11 individuals, very much appreciates the opportunity to provide our strong support for Maryland's 1332 State Innovation Waiver Application. In doing so we wish to acknowledge the commitment of the General Assembly, the Insurance Commissioner and the Board of the Maryland Health Benefit Exchange (MHBE) to address the needs of Maryland's consumers by taking steps to stabilize the individual health insurance market.

One of the most important steps is to establish a state reinsurance program. We believe this should be designed to accomplish three goals: (1) equitably lower costs for HMO and PPO products; (2) improve health outcomes; and (3) promote consumer choice. We explain our thinking on each of these below with the understanding that there is still a lot more work to do to launch a state reinsurance program. During this process, we look forward to engaging with you and other stakeholders to be sure that the design of a state reinsurance program meets these three goals.

**(1) Equitably Lower Costs for HMO and PPO products:** There is a strong correlation between health status (the focus of the risk adjustment program) and claims (the focus of a state reinsurance program). It is theoretically possible that monies from both programs will overlap and benefit the product receiving all the risk adjustment monies thus reducing PPO premiums more than HMO premiums. Such an outcome runs counter to what we believe should be one goal of the state reinsurance program, equitable premium decreases for HMO and PPO products. To be sure this is achieved, we respectfully request that you simulate the impact of alternative attachment points on HMO and PPO premiums with, and without, adjusting for risk adjustment payments. We also recommend that the results of the simulation be made available to the public. This would help to guide the public discussion of the alternatives for the technical aspects of the state reinsurance program. In addition, it would lead to greater confidence on the part of the public in the final design of the reinsurance program.

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**(2) Improve health:** A state reinsurance program provides an opportunity to incentivize carriers to develop meaningful health improvement programs. Such programs should, over time, reduce premium increases and help consumers lead healthier, more productive lives. A carrier's eligibility to receive funds from a state reinsurance program should be predicated on having such programs in place and we commend you for considering such an approach.

**(3) Promote consumer choice:** Consumers generally benefit when there is more choice. Today, consumers may select a PPO product offered by CareFirst or an HMO product offered by CareFirst or Kaiser Permanente. The reinsurance program should be designed, at a minimum, to maintain the participation of these two carriers in the individual market. Optimally, we hope that it will encourage other carriers to join the market. CareFirst, the state's only nonprofit health service plan, is required under the provisions of section 14-106 (d) (1) (ii) of the Insurance Article to offer products in the individual market, and so it cannot exit the market. Therefore, it is important that the design of Maryland's reinsurance program does not unintentionally competitively disadvantage Kaiser Permanente or other carriers.

In closing, we would like to thank you and the MHBE Board and staff for your efforts to recognize the challenges consumers are facing in finding affordable health insurance in the individual market. We believe that the pursuit of a 1332 waiver to establish a state reinsurance program is critical and we reiterate our strong support for this program. We very much appreciate the opportunity to provide our perspective on this issue and look forward to working with you and other stakeholders to be sure this program results in lower costs, better quality, and more consumer choice.

Sincerely,



Beth Sammis  
President, Consumer Health First  
bethsammis@gmail.com

Consumer Health First is a nonpartisan & nonprofit organization  
that works to promote health equity through access to  
high-quality, comprehensive and affordable health care for all Marylanders.

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**Signatory Organizations:**

Advocates for Children and Youth  
League of Women Voters of Maryland  
Maryland-DC Society of Addiction Medicine  
Maryland Occupational Therapy Association  
Mental Health Association of Maryland  
NARAL-Pro Choice Maryland  
National Alliance on Mental Illness Maryland  
Primary Care Coalition  
Progressive Cheverly  
Public Justice Center

**Signatory Individuals:**

Rabbi Charles Arian  
Laurie Caldwell  
Laura Carr  
Holly Cooper  
Ward Cooper  
Frank Mahlmann  
Barbara Manns  
Joan Moyers  
Dee Schofield  
Carol Stemple  
Patricia Tice

---

**Commenter:** Susan G. D'Antoni, Executive Director, Montgomery County Medical Society

**Comment Received:** Friday, May 18, 2018

**Comment:**



May 16, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
6<sup>th</sup> Floor  
Baltimore, Maryland 21202

Sent: [mhbe.publiccomments@maryland.gov](mailto:mhbe.publiccomments@maryland.gov)

RE: 1332 Waiver Application

Dear Board Members:

Montgomery County Medical Society (MCMS), a professional association for physicians practicing/resident in Montgomery County, Maryland, represents more than 1,600 Maryland physicians and their patients. We are a component of MedChi, The Maryland State Medical Society.


We appreciate the opportunity to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, MCMS supports the Section 1332 waiver for the development of a reinsurance program. We understand the importance of stabilizing the individual health insurance market to ensure that the greatest number of Marylanders have access to affordable insurance. It is on that premise that MCMS believes that the program designed must stabilize the entire market and equally benefit all Maryland consumers.

We encourage inclusion of the following elements:

- Designing a program that treats all carriers equitably. This added benefit of attracting new health plans into the market. Under the current proposal, some health plans could receive double payments for higher risk members. We encourage the MHBE to include language in the draft Section 1332 waiver application that indicates the state's intent to include an adjustment in 2019 for federal risk adjustment payments to ensure that the program doesn't unfairly advantage some health plans over others.
- Payment incentives should be included in the reinsurance program which are aligned with the State's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should be included that directly reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures such as breast cancer screening, colorectal cancer screening, controlling high blood pressure and care for diabetes and cardiovascular conditions.
- MCMS believes that it is important to require all participating carriers to collaboratively work with the State's Health Information Exchange (CRISP).
- Because the central issue for applying for a reinsurance program is to make sure that costs can be stabilized for both the carriers as well as the consumers, MCMS does believe that utilization practices of participating carriers should be examined, including not allowing non-staff model HMO product sold thru the exchange to utilize prior authorization procedures.

Thank you for the opportunity to provide comment re: *DRAFT Maryland 1332 Waiver Application*.

Sincerely,

  
Susan G. D'Antoni  
Executive Director

*Working for Physicians and Their Patients in Montgomery County*

---

**Commenter:** Teresa Healey-Conway, Executive Director, Anne Arundel & Howard County  
Medical Societies

**Comment Received:** Friday, May 18, 2018

**Comment:**



**224 Main Street  
Annapolis, MD 21401  
410-544-0312**

May 18, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
6th Floor  
Baltimore, Maryland 21202  
Sent: [mhbe.publiccomment@maryland.gov](mailto:mhbe.publiccomment@maryland.gov)

**RE: 1332 Waiver Applications**

Dear Board Members:

The Anne Arundel & Howard County Medical Societies (AAHCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, AAHCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

AAHCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, AAHCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

A handwritten signature in black ink, appearing to read 'TAC', is written over a horizontal line.

Teresa Healey-Conway  
Executive Director, AAHCMS

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**Commenter:** Teresa Healey-Conway, Executive Director, Prince George's County Medical Society

**Comment Received:** Friday, May 18, 2018

**Comment:**



224 Main Street  
Annapolis, MD 21401  
410-544-0312

May 18, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
6th Floor  
Baltimore, Maryland 21202  
Sent: [mhbe.publiccomment@maryland.gov](mailto:mhbe.publiccomment@maryland.gov)

**RE: 1332 Waiver Applications**

Dear Board Members:

The Prince George's County Medical Society (PGCMS) wishes to comment on the *DRAFT Maryland 1332 Waiver Application* being submitted by the Maryland Health Benefit Exchange (MHBE) to the United States Department of Treasury and the United States Department of Health and Human Services. Overall, PGCMS supports the Section 1332 waiver for the development of a reinsurance program. However, we have a few concerns.

First, PGCMS is concerned that the reinsurance program as outlined in the *DRAFT Section 1332 Waiver Application* does not treat all carriers equally. Under the current proposal, some health plans will be put at a disadvantage resulting in a limited benefit to people who choose those health plans for their coverage. Furthermore, unequal treatment amongst carriers will deter new carriers from joining the market.

PGCMS proposes that the draft Section 1332 waiver application be revised to include a commitment to equitable treatment of all of the health plans. We believe this will improve the waiver application and be accepted by CMS.

Second, PGCMS supports the creation of specific payment incentives be included that directly reward delivery of quality care.

Lastly, PGCMS believes that all participating carriers should work with the State's Health Information Exchange (CRISP) to make sure that costs can be stabilized for both the carriers as well as the consumers.

Sincerely,

Teresa Healey-Conway  
Executive Director, PGCMS

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**Commenter:** Kim K. Horn, President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

**Comment Received:** Saturday, May 19, 2018

**Comment:**



Mid-Atlantic Permanente Medical Group, P.C.  
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Submitted electronically to: [mhbe.publiccomments@maryland.gov](mailto:mhbe.publiccomments@maryland.gov)

May 20, 2018

Maryland Health Benefit Exchange  
750 East Pratt Street  
Baltimore, MD 21202

Re: *Draft Maryland 1332 Waiver Application*

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the Draft Maryland 1332 Waiver Application published on April 20, 2018 by the Maryland Health Benefit Exchange (MHBE). Kaiser Permanente supports the Section 1332 waiver and a reinsurance program benefitting all Marylanders equally. We appreciate MHBE's commitment to stabilizing the individual market and offer recommendations in support of its waiver application.

Kaiser Permanente of the Mid-Atlantic States provides and coordinates complete health care services for over 780,000 members through 30 medical office buildings in the District of Columbia, Maryland and Virginia. Kaiser Permanente is a total health organization composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C., an independent medical group that is comprised of approximately 1,500 physicians who provide or arrange care for patients throughout the region, and Kaiser Foundation Hospitals which contracts with community hospitals for the provision of hospital services to our patients. Kaiser Permanente is committed to the individual market and the consumers who do not have access to group coverage.

Maryland's reinsurance program will significantly impact Kaiser Permanente and our members. As one of two carriers currently operating in the individual market in Maryland, Kaiser Permanente provides care and coverage to 46 percent of Maryland's on-exchange individual market as of April 2018. We experienced losses of \$117 million in the individual market, or an average of negative 28 percent annually, between 2014 and 2017.<sup>1</sup>

A properly designed and fairly implemented reinsurance program may help stabilize individual market premiums. To ensure the greatest number of consumers realize the program's benefits, MHBE should include the following specific elements in its final Section 1332 waiver application:

1. A description and analysis of the varying impact of reinsurance on market participants.

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<sup>1</sup> This represents Kaiser Permanente's loss on the Individual market from 2014-2016 plus an estimate for 2017.

2. Language describing MHBE’s intent to ensure that the federal risk adjustment program and the Maryland reinsurance program do not duplicate payments for the same high-risk membership.
3. Language describing MHBE’s intent to determine the extent of overlap between payments made under the federal risk adjustment program and the state reinsurance program.
4. Program incentives rewarding quality and cost-management.

We discuss these requests below.

#### MHBE Should Include a Description and Analysis of the Varying Impact of Reinsurance on Market Participants.

An equitably designed state-based reinsurance program mitigates the impact of high risk individuals on premiums caused by elimination of the Affordable Care Act (ACA)’s individual mandate penalty in 2019 and uncertainty at the federal level. It could also provide an incentive for more carriers to enter the individual market.

A poorly designed reinsurance program has the potential to reward carriers who are not effectively managing costs. MHBE should design its program to reward cost-management. The first step is an account and analysis of the varying impact of reinsurance on market participants. As the March 2018 Wakely Consulting Group report for the Maryland legislature noted “individual issuers may be affected differently by reinsurance. Issuers with relatively higher claims cost will receive relatively more reinsurance payments.”<sup>2</sup> Accordingly, the final waiver application should acknowledge that variation and break out the anticipated effect on premiums by plan.

#### MHBE Should Account for Risk Adjustment in Structuring Its Reinsurance Program.

MHBE’s final waiver application should clarify that the state intends to account for federal risk adjustment payment and to design a reinsurance program that pays only for uncompensated high risk. This will ensure that reinsurance funds have the broadest impact for all consumers, incentivize new market entrants and encourage current participants to remain. Kaiser Permanente is concerned that the reinsurance program proposed by the draft waiver application will effectively favor one health plan’s membership and provide rate relief disproportionately to those consumers.

The ACA compensates carriers for high-risk members through a federal risk adjustment program that transfers money among carriers based on their enrollment of individuals with high cost diagnoses. As the Centers for Medicare and Medicaid Services (CMS) noted in its 2019 Notice of Benefit and Payment Parameters regulation, the scale of such transfers plays a crucial role in issuer decisions to participate in the individual market. Kaiser Permanente will transfer

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<sup>2</sup> Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.



approximately \$80 million to CareFirst for the 2017 plan year to account for its higher risk membership in Maryland. We expect that amount to increase substantially in 2018 and beyond.

The goal of the Maryland reinsurance program should be to stabilize the entire individual market by benefitting all Maryland consumers equally. The draft application does not account for federal risk adjustment payments and thus fails to stabilize the entire market. Rather, the reinsurance funds will pay twice for the same members – first from the federal risk adjustment program and a second time for claims reimbursable under the Maryland reinsurance program. As previously discussed, this effect magnifies the existing distortion under risk adjustment and thereby picks competitive “winners and losers.”

In addition, providing rate relief to healthier consumers, who overwhelmingly enroll in HMOs, is of paramount importance if the reinsurance program is to achieve its stated goal of stabilizing the Maryland individual market. As presently designed, the program directs over *one third* of reinsurance funds to premium relief for fewer than seven percent of the state individual market enrollment that chooses a PPO, while the remaining funds will provide significantly less rate relief to over 200,000 Marylanders enrolled in HMOs offered by both of the state’s individual market carriers. This approach is sub-optimal for Maryland’s individual market and produces an inequitable result for the vast majority of Maryland consumers.

MHBE’s expert recognized this disparity in its own March 2018 analysis: “Some enrollees with Hierarchical Condition Categories (HCCs) will get compensated both for risk adjustment and reinsurance. The result could be very different profitability patterns within the market than currently exists, and the result could also vary depending on the chosen funding level and reinsurance parameters.”<sup>3</sup>

Actuarial experts endorse the reinsurance-level adjustments for risk adjustment as sound policy. Milliman notes that “the current federal risk adjustment methodology does not account for payments from a state-based reinsurance program and can result in double compensation for high-risk members, both from the reinsurance program and from risk adjustment. This finding may be important to many other states considering reinsurance-like proposals under Section 1332 to help stabilize their markets. Specifically, if appropriate changes to risk-adjustment are not made, a reinsurance program could lead to pricing inefficiencies and distortions that negatively impact the market and could work against the goals of the reinsurance program overall.”<sup>4</sup> Similarly, the American Academy of Actuaries has recommended against compensating insurers twice for the same risk.<sup>5</sup>

We do not believe including these adjustments will delay or compromise federal approval of Maryland’s waiver. During a May 4, 2018 meeting with Kaiser Permanente, senior CMS career staff informed Kaiser Permanente that they did not foresee the inclusion of an element

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<sup>3</sup> Wakely Consulting Group. (March 15, 2018). *State of Maryland: Individual Market Stabilization – Reinsurance Analysis*, 7.

<sup>4</sup> Milliman. (August 2017). *Pairing Risk Adjustment to Support State 1332 Waiver Activities*. Retrieved from <http://www.milliman.com/insight/2017/Pairing-risk-adjustment-to-support-state-1332-waiver-activities/#>.

<sup>5</sup> American Academy of Actuaries. (May 2017). *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*. Retrieved from <http://www.actuary.org/content/how-changes-health-insurance-market-rules-would-affect-risk-adjustment>.

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accounting for federal risk adjustment payments to prevent carriers from receiving double compensation slowing their review of the waiver.

Maryland's program should not have the unintended effect of creating market distortions among products offered by the remaining two carriers in the individual market. The program design should promote stabilization and create a market that is more attractive to new entrants. We recommend that the waiver application specify that individual market plans that receive risk adjustment transfers will have those transfers “netted out” from claims on reinsurance funds.

#### MHBE Should Direct Wakely to Quantify Risk Adjustment Overlap.

While Kaiser Permanente believes the degree of overlap between risk adjustment payments and claims reimbursable through reinsurance is substantial, an actual estimate of the amount is unavailable without access to all carriers' claims data. Wakely Consulting Group, MHBE's retained actuary for purposes of this waiver, possesses the data necessary to quantify the overlap. We appreciate that MHBE has directed Wakely to project the overlap and inform stakeholders on the projection.

We ask that the analysis compare scenarios that would more evenly distribute reinsurance funding and avoid distorting the competitive balance in Maryland's individual insurance market. The analysis should also evaluate the impact of risk adjustment transfer reductions in 2020 on enrollment or affordability, should the state choose to exercise this authority.

We believe this analysis will be useful to regulators, MHBE and relevant stakeholders in the regulatory process for reinsurance program design.

#### MHBE Should Include Quality and Utilization Management Incentives.

As the United States moves towards value-based payment in health care, Maryland's reinsurance program should not move its individual market in the opposite direction. MHBE should include incentives in the reinsurance program aligned with the state's broader policy goals related to quality, cost-effectiveness and innovation. Incentives should reward quality in care delivery through strategies like payment multipliers for high clinical quality ratings in preventive care measures.

Integrated, managed care frequently outperforms PPO models in quality and cost-effectiveness. PPOs may be more expensive because of inefficiencies, such as ineffective care management, not just higher risk profiles. Maryland's reinsurance program should reward high-performing models and avoid compensating plans for inefficiencies.

In its final waiver application, MHBE should specify incentives for quality and cost-management. The CMS Checklist for Section 1332 State Innovation Waiver Applications requires states to address “whether the reinsurance program includes incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals

eligible for the described reinsurance (if any).”<sup>6</sup> A stated commitment in the application will strengthen the final application.

We recommend the state include multiplication factors in its design of reinsurance payments based on 1) third-party estimates of product and network cost-effectiveness and efficiency for each of Maryland’s individual market products; and 2) achieving the highest ratings in clinical quality from the Maryland Health Care Commission’s independent quality rating program. We believe this approach is consistent with the broader health policy goals of the MHBE.

With regard to the network efficiency factor, in the attached letter, Milliman estimates that a well-managed HMO in the Maryland marketplace has a 27 percent advantage over the state’s PPO. MHBE should allocate reinsurance program dollars to reward this efficiency.

Taken together, these recommendations would distribute the benefits of the Maryland Reinsurance program roughly equally to all Marylanders enrolled in HMOs. Those enrolled in the PPO would still benefit disproportionately, but to a lesser extent. Specifically, with these adjustments, HMO enrollees would see significantly reduced proposed 2019 rates close to the expected overall market reduction and PPO enrollees would see proposed 2019 rates cut roughly in half (rather than by a significant 95 percent if no adjustments for double payment, cost effectiveness and clinical quality are made).

\* \* \*

Thank you for your time and consideration. Please do not hesitate to contact Laurie Kuiper, Senior Director of Government Relations, at 301-816-6480 or [Laurie.Kuiper@KP.org](mailto:Laurie.Kuiper@KP.org), if you have any questions or require additional information.

Sincerely,



Kim K. Horn  
President  
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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<sup>6</sup> See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf>.



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*Via email only: Andrew.L.See@kp.org*

May 18, 2018

Mr. Andrew L. See, FSA, MAAA  
Vice President, Pricing  
Kaiser Foundation Health Plan, Inc.  
300 Lakeside Drive  
Oakland, CA 94612

**Re: Cost Benchmarks – Maryland**

Dear Andrew,

At the request of Kaiser Foundation Health Plan ("Kaiser"), Milliman, Inc. ("Milliman") developed combined medical and pharmaceutical cost estimates for best-practices well-managed HMO networks and loosely-managed PPO networks in the state of Maryland. This letter provides the expected allowed cost differential of these networks and also describes the methodology and assumptions used in developing the cost estimates.

## **CONSULTING SERVICES AGREEMENT**

This work was done under the terms of the Consulting Services Agreement between Milliman and Kaiser signed May 16, 2018.

## **BACKGROUND**

Kaiser desires our assistance in obtaining a comparison of expected combined medical and pharmaceutical costs for well-managed HMOs and loosely-managed PPOs in the state of Maryland.

## **SUMMARY OF RESULTS**

We developed illustrative combined medical and pharmaceutical cost models projecting the 2019 cost of care per member per month (PMPM) under each network assumption using the Milliman 2018 Commercial Health Cost Guidelines (HCGs)<sup>1</sup>. We used national standard demographics for the large-group market. The estimated allowed costs for a well-managed HMO is approximately 27% less than the costs for a loosely-managed PPO in the state of Maryland. **The cost projections used in estimating this differential represent a composite plan, network and medical management practices, not any specific plan, network or set of medical management practices.**

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<sup>1</sup> The HCGs are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research and judgment. An extensive amount of data is used in developing the HCGs and that data is updated annually.

## METHODOLOGY AND ASSUMPTIONS

To develop the cost estimates, we used the 2018 Milliman Commercial Health Cost Guidelines. The HCGs consider utilization and average charge levels for roughly 60 benefit categories. These models make provision, by type of service category, for benefit characteristics and cost-sharing such as copays, deductibles, coinsurance and out-of-pocket maximums. The model was adjusted for the following characteristics:

- Region: Maryland (Statewide)
- Product type: commercial HMO (well-managed) and PPO (loosely-managed)
- Network discounts: 60% Facility, 40% Professional

We used a single representative plan design for both the HMO and PPO plan, with no Out-of-Network component for the PPO plan, to determine the cost differences attributable solely to Degree of Health Management. The plan designs are shown in **Table 1**:

**Table 1: Summary Plan Design:**

Benefit	Cost Sharing
Deductible (Single/Family)	\$1,500 / \$3,000
Out-of-Pocket Maximum (Single/Family)	\$3,500 / \$6,000
Inpatient	\$500/Day
Emergency Department	20%
Outpatient Surgery	20%
Preventive	\$0
Primary Care Physician	\$20
Specialist	\$30
Other Medical Services	20%
Pharmacy:	
Generic	\$10
Preferred Brand	\$30
Non-Preferred Brand	\$35
Specialty	20%

We applied trend to estimate claims incurred in 2019. We did not adjust for changes in morbidity or selection considerations.

## VARIABILITY OF RESULTS

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

## LIMITATIONS

It is our understanding that the information contained in this letter will be shared with the state of Maryland and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.



Mr. Andrew L. See  
Cost Estimates for Maryland  
5/18/2018

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Kaiser Foundation Health Plan by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

#### **DATA RELIANCE**

For our analysis, we have relied on information provided to us by data contributors and vendors. We have not audited or verified this data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

#### **PROFESSIONAL QUALIFICATIONS**

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this letter, Susan E. Pantely, is a member of the American Academy of Actuaries, and meets the qualification standards for performing the analysis in this letter.

Sincerely,

A handwritten signature in black ink that reads "Susan E. Pantely".

Susan E. Pantely, FSA, MAAA  
Principal and Consulting Actuary

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**Commenter:** Tinna Quigley, Executive Director, Alliance of Maryland Dental Plans

**Comment Received:** Saturday, May 19, 2018

**Comment:**



May 20, 2018

Michelle Eberle  
Executive Director  
Maryland Health Benefit Exchange  
750 East Pratt Street, 6th Floor  
Baltimore, MD 21202

RE: Maryland 1332 Innovation Waiver Application

Dear Executive Director Eberle,

Thank you for the opportunity to provide input as the State prepares the 1332 Waiver Application. I am writing on behalf of the Alliance of Maryland Dental Plans to express the concerns of our member dental plan companies about the proposed reinsurance program.

Our members think that it is of paramount importance for the State to find a long-term, broad-based funding solution to address our current challenges with the health insurance markets in the State that create stability for funding, require all stakeholders to be a part of the solution, limit the impact on any one constituency, and minimize the cost to individual Marylanders who will ultimately carry the burden. We look forward to being actively engaged in the Maryland Health Insurance Coverage Protection Commission as it continues its work on this issue throughout the interim and are willing to serve on any workgroups and provide stakeholder input as the co-chairs deem appropriate.

Our members are committed to Maryland and are supportive of steps taken to stabilize the State's insurance markets. While we understand that the 2.75% assessment is a short-term fix, we are concerned that stand-alone dental plans are subject to the assessment in Senate Bill 387/House Bill 1782 despite the fact the dental plans will not see any benefit from the proposed reinsurance program.

We would respectfully inquire how the Maryland Health Benefit Exchange (MHBE), in conjunction with the Maryland Insurance Administration, plan to use reinsurance funds, if any, to enhance dental plans.

As the MHBE has used ample opportunity to promote the expanded take-up of dental coverage in promotion of the Exchange's value as an organization and as a pathway to better health for Marylanders, we think it is appropriate to continue to extend dental coverage in appropriate ways as we move forward in conjunction with a new reinsurance program framework. We would ask that if our



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companies are subject to an assessment in which they will see no return, there be a continued commitment in which our companies would be presented with a landscape to thrive.

Please do not hesitate to contact me at 240-476-9308 or [tquigley@fblaw.com](mailto:tquigley@fblaw.com) should you have any questions or concerns. Members of the Alliance of Maryland Dental Plans greatly appreciate the consideration of our concerns.

Sincerely,

A handwritten signature in black ink that reads "Tina Quigley". The signature is written in a cursive, flowing style.

Tinna Quigley  
Executive Director  
Alliance of Maryland Dental Plans

***Attachment 4. Public Hearing Process***



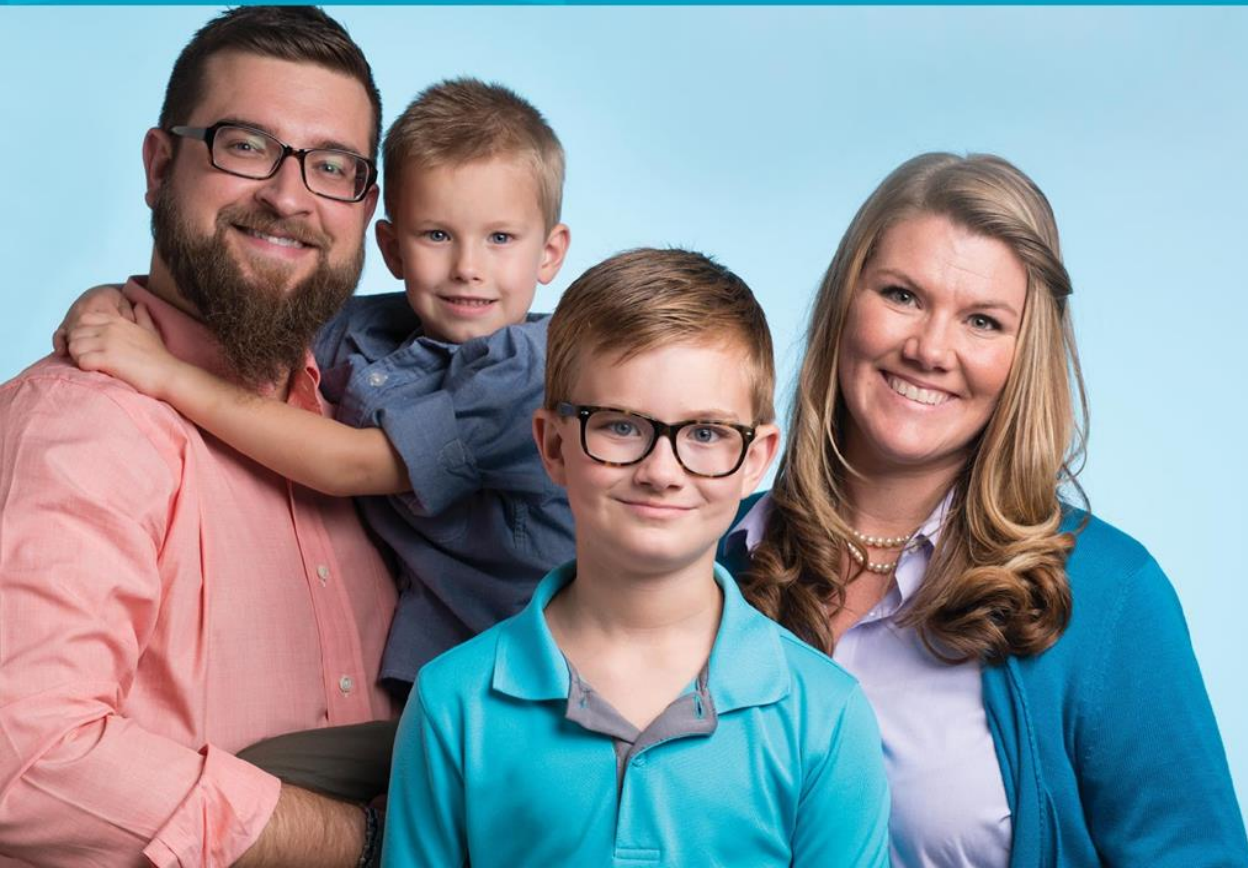
<b>MHBE 1332 Waiver Public Hearing Agenda</b>	<p>Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (Section 1332 waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage.</p> <p>Before submitting its Section 1332 waiver application, the state must also provide a public notice and comment period, including public hearings, sufficient to ensure a meaningful level of public input, and enact a law providing for implementation of the waiver.</p>
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PUBLIC HEARING AGENDA		
Topic	Presenter	Time Allotted
Welcome, Introductions, and Purpose of the Public Hearing	MHBE   MIA   MDH	5 minutes
Maryland 1332 State Innovation Waiver Application: Walkthrough & Estimated Impact	MHBE	15 minutes
Question and Answers	MHBE   MIA   MDH Staff	10 minutes
Public Comments	Public	Until hearing end
Closing Remarks	MHBE	

**Public Hearing Locations, Dates, and Times:**

1. **Thursday, April 26, 5 p.m. to 6 p.m., at the Talbot County Department of Parks and Recreation (Chesapeake Room), [10028 Ocean Gateway, Easton, MD 21601](#)**
2. **Thursday, May 3, 4 p.m. to 5 p.m., at the office of the Maryland Health Benefit Exchange, [750 E. Pratt St., 6th Floor, Baltimore, MD 21202](#)**
3. **Monday, May 7, 3 p.m. to 4 p.m., at the Frederick County Local Health Department, [350 Montevue Lane, Frederick, MD 21702](#)**
4. **Thursday, May 10, 5 p.m. to 7 p.m., at the Charles County Local Health Department, [4545 Crain Highway, White Plains, MD 20695](#)**

# Maryland State Innovation Waiver Application: State Reinsurance Program April 20 – May 20, 2018



# State Reinsurance Program Legislation & Action to Date

- Two bills from the 2018 Maryland Legislative Session impact the State Reinsurance Program House Bill 1795 – Establishment of a Reinsurance Program & Senate Bill 387 Maryland Health Care Access Act of 2018.
- Signed by Governor Larry Hogan on April 5 and April 10. These bills are a bipartisan short-term solution to address premium affordability and market stabilization in Maryland’s individual health insurance marketplace.
- HB 1795, establishes a claims-based State Reinsurance Program to offset the impact of high cost enrollees in the individual marketplace. MHBE is required to apply for a State Innovation Waiver under section 1332 of the Affordable Care Act. Implementation of the program is contingent upon approval of waiver application.
- SB 387 places a 2.75% assessment on carriers to recoup the aggregate amount of the health insurance provider fee that was previously assessed under Section 9010 of the ACA. The Tax Cuts and Jobs Act to 2017 waived this fee for 2019. This funding source provides an estimated \$365 million (MIA/OCA) for the State Reinsurance Program.

# State Reinsurance Program Legislation & Action to Date

- Applying for State Innovation Waiver allows the State to access federal pass-through funds to supplement the State Reinsurance Program - maximizing the impact of State funding.
- Important requirements to be included in a State Innovation Waiver include a funding level and parameters for the program. SB 387 supplies the funding level requirement.
- HB 1795 directs the MHBE Board of Trustees to determine parameters for the State Reinsurance Program. During the April 2018 Board meeting the MHBE Board of Trustees approved a resolution that supplies the parameters to be included in the draft State Innovation Waiver application:
  - an attachment point that will be determined based on funding availability and consideration of stakeholder feedback, a coinsurance rate of 80%, and a cap of \$250,000.
- MHBE released the State Innovation Waiver Application for public comment on Friday, April 20, 2018.

# State Reinsurance Program Legislation & Action to Date

- MHBE has worked with Wakely Consulting Group, contracted through the Department of Legislative Services, to prepare the actuarial and economic analysis of the waiver.
- MHBE leveraged the Hilltop Institute at UMBC to develop the narrative portion of the application through an existing MOU.

# State Innovation Waiver Application Walk-through and Estimated Impact

- Maryland seeks to waive Section 1312(c)(1) of the Affordable Care Act – determination of the market index rate. This would allow Maryland carriers to include expected State Reinsurance Program payments when determining their market index rate. The higher the index rate, the higher the premium.
- Maryland is seeking federal pass-through funding, through net APTC savings, to fund a reinsurance program that targets a 30% premium reduction for 2019 and 2020. Total program costs for 2019 are approximately \$462 million.
- The decreased premiums will decrease federal spending on APTCs. The actuarial analysis estimates that federal savings will be \$280 million, \$293 million, and \$32 million in 2019, 2020, and 2021, respectively.
- Maryland estimates that the premium impact will result in a 5.8% increase in individual market enrollment in 2019.



# State Innovation Waiver Application Walk-through and Estimated Impact

- Four “guardrails” apply to 1332 State Innovation Waivers. The waiver must:
  1. Provide access to quality health care that is **at least as comprehensive** as would be provided without the waiver.
  2. Provide access to quality health care that is **at least as affordable** as would be provided without the waiver.
  3. Provide coverage to **at least a comparable number** of residents as would be provided without the waiver.
  4. Does **not increase the federal deficit**.
- Maryland’s 1332 State Innovation Waiver is compliant with these guardrails. Guardrails two, three, and four are affected by the waiver. It would decrease premiums by 30 percent from what they would be absent the waiver, increases enrollment by 5.8% in 2019, and saves \$695 million over the 10-year budget window.
- Average premiums for 2018 in the individual market are \$604.50 per month. Absent the waiver, premiums are estimated to rise to \$735.66 in 2019. With the reinsurance program, premiums are estimated to be \$508.03 - a net **decrease** from 2018.

# State Innovation Waiver Application Walk-through and Estimated Impact

- Its important to note that these estimations are based on average premiums and are not specific to any single carrier participating in the individual market.
- Each carrier has unique and specific factors that go into their rate determinations. The reinsurance program may have different impacts on each carrier.
- The MHBE Board of Trustees has left the attachment point for the reinsurance program to be determined at a later date after consideration of stakeholder feedback and additional carrier data is available.
- HB 1795 directs the MHBE Board of Trustees to adopt regulations administering the State Reinsurance Program and program parameters no later than January 1, 2019. MHBE will engage stakeholders over the summer of 2018 to inform the regulatory process.

## Public Hearings Timeline and Opportunities to Provide Comment

- MHBE will host four public hearings across the state to gather public input:

**Thursday, April 26, from 5 to 6 p.m. at the Chesapeake Room at the Talbot County Department of Parks and Recreation** located at 10028 Ocean Gateway, Easton, MD 21601

**Thursday, May 3, from 4 to 5 p.m. at the office of the Maryland Health Benefit Exchange**, 750 East Pratt St., 6th Floor, Baltimore, MD 21205

**Monday, May 7, 3 to 4 p.m., at Frederick County Local Health Department**, 350 Montevue Lane, Frederick, MD 21702

**Thursday, May 10, from 5 to 7 p.m., at the Charles County Local Health Department**, 4545 Crain Highway, White Plains, MD 20695
- All supply written comments for the 1332 State Innovation Waiver to [mhbe.publiccomments@maryland.gov](mailto:mhbe.publiccomments@maryland.gov). The comment period ends on May 20, 2018.

**Thank you!**

For more information: [marylandhbe.com](http://marylandhbe.com)  
Comment: [mhbe.publiccomments@maryland.gov](mailto:mhbe.publiccomments@maryland.gov)



## Maryland 1332 Waiver Hearing

April 26, 2018

Talbot County Department of Parks and Recreation  
10028 Ocean Gateway  
Easton, MD 21601

### Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate John Mautz and a staff member from the office of Senator Adelaide Eckardt.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### 1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program’s attachment point is not yet finalized since it depends on the available funding.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in enrollment in 2019.

Next, Mr. Cardenas laid out the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including three additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether, in the event that the reinsurance program does not meet its savings targets, consumers will have to make up the difference. Mr. Cardenas replied in the negative.

An attendee asked whether the reinsurance program would affect only on-exchange policies. Mr. Cardenas replied that the program would involve all individual market policies, both on- and off-exchange.

An attendee asked whether the 30 percent reduction in average premium is expected in the first year, or averaged over two years. Mr. Cardenas replied that the program is expected to realize the 30 percent reduction in the first year and maintain that level into the second year.

An attendee asked whether the reinsurance program would cover Medigap policies. Mr. Cardenas replied in the negative, noting that the waiver only has jurisdiction over individual market policies governed by the Affordable Care Act.

An attendee asked the likelihood that the waiver program would continue into 2020. Mr. Cardenas replied that the waiver application covers a five-year period, meaning that the program would run from 2019 through 2023, with the opportunity for extensions beyond 2023.

An attendee asked what the MHBE expects to happen with premium prices in 2021 and beyond. Mr. Cardenas replied that, while they do not know exactly what is going to happen at that point, they hope for continued savings. He added that the chief strategy for market health in that extended period is to attract additional insurance carriers into the market and a healthier risk pool.

An attendee, noting that some portion of the funding for this program would come from a fee on insurance companies, asked whether that fee would negatively impact premiums in the group market. Mr. Cardenas replied that, since the fee was already calculated into the rates, the affect on group premium would be neutral.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record.

James Burdick offered the following testimony:

*“As a doctor, I’d like to see everybody get health care. And, actually, I meant what I said about Maryland. Congratulations to the work that’s been done and other good things that are happening in Maryland compared to other states, so this isn’t a criticism. But, long run, as I said, stepping back, a national health program, improved Medicare for all, single payer system would get rid of the admittedly confusing, or at least complicated, details and also save money, cover everybody, and improve quality. It’s really true. Senator Pinsky has introduced a bill in the Senate and there is some enthusiasm for a state single-payer bill. I’d like to see a national program, ideally, but I just want to provide that perspective on the complexity and the potential lack of insurance or uncertain insurance for so many Marylanders still, in spite of the great work that you have been doing.”*

### **Closing**

Ms. Eberle closed the hearing and thanked everyone who attended.

### **Participants**

#### *Maryland Health Benefit Exchange*

Tony McCann, Member, Board of Trustees  
Michele Eberle, Executive Director  
Andrew Ratner, Chief of Staff  
John-Pierre Cardenas, Director of Policy and Plan  
Management  
Kris Vallecillo, Senior Health Policy Analyst

#### *Maryland Insurance Administration*

Todd Switzer, Chief Actuary  
Brad Boban, Senior Actuary  
Joseph Fitzpatrick, Assistance Chief Examiner

#### *Maryland Department of Health*

Robert Neall, Secretary  
Nikki Laska, Director, Communications

#### *Maryland General Assembly*

Delegate Johnny Mautz  
Melissa Einhorn, Office of Senator Addie Eckhardt

#### *Members of the Public*

Kathy Ruben  
Elizabeth Carson  
Larry Carson  
Matt Celentano  
Laurie Kuiper  
Dan Mosebach  
Chester King  
Billy D. Weber  
Karen Millison  
Jim Burdick  
Paul Davin





Public Hearing - Maryland 1332 State Innovation Waiver  
 Thursday, April 26, 2018  
 Talbot County Department of Parks and Recreation

SIGN-IN SHEET

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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Kathy Ruben	Consumer Health First	Kathyruben@consumerhealthfirst.org	<input type="checkbox"/>
Elizabeth Carson	Health care is a Human Right, MD	carso121@hotmail.com	<input type="checkbox"/>
LARRY CARSON	" "	Karason1@hotmail.com	<input type="checkbox"/>
Matt Celentano	Issue of Life and Health Insurers	mcCelentano@fblaw.com	<input type="checkbox"/>
Lauree Kuiper	Kaiser Permanent		<input type="checkbox"/>
Dan Mosebach	CareFirst	daniel.mosebach@carefirst.com	<input type="checkbox"/>
Chester King	CONSUMER	SEAKING98@hotmail.com	<input type="checkbox"/>
Nikki Larson	MDH		<input type="checkbox"/>
Det. Maytz			<input type="checkbox"/>
Billy D Weber	Me (Ins. Agent)	bdrweber@verizon.net	<input type="checkbox"/>
Karen Millison	CareFirst	Karen.millison@carefirst.com	<input type="checkbox"/>
Melissa Einhorn	Senator Adelie Eckardt	meinhorn@senate.state.md.us	<input type="checkbox"/>



Public Hearing - Maryland 1332 State Innovation Waiver  
 Thursday, April 26, 2018  
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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Jim Burtick	HCHP PNHP	jburtick1@yahoo.com	<input checked="" type="checkbox"/>
Paul Davin		pdavin84@gmail.com	<input type="checkbox"/>
Todd Switzer	MIA	todd.switzer@maryland.gov	<input type="checkbox"/>
Brad Boban	MIA	bradley.boban@maryland.gov	<input type="checkbox"/>
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## Maryland 1332 Waiver Hearing

May 3, 2018

Maryland Health Benefit Exchange  
750 E. Pratt Street, 6<sup>th</sup> Floor  
Baltimore, MD 21205

### Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself. She explained the process and purpose of the 1332 waiver hearings and provided a brief overview of the current state of the marketplace and the proposed state reinsurance program.

She acknowledged the presence of staff from the MHBE and the Maryland Insurance Administration (MIA) and introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### 1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018.

Mr. Cardenas emphasized the importance of stakeholder input on the proposed reinsurance program and gave a brief summary of the proposed reinsurance program, including funding sources. He explained that the reinsurance program's attachment point has not been finalized because it is dependent on the available funding.

Mr. Cardenas then described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By waiving Section 1312(c)(1) of the Affordable Care Act, carriers are allowed to factor the reinsurance program into their premium rates, resulting in a reduction of those premiums. The MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with the guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that the estimations presented are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including two additional hearings in the coming weeks. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

There were no questions.

**Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Three individuals offered testimony.

John Kunkel, Chief Financial Officer, Kaiser Permanente, offered the following testimony:

*“I am proud to represent Kaiser today. We are the only insurer that participates in both the exchanges and the Medicaid program, so we are very much impacted by the 1332 waiver. I would reiterate what JP said at the outset. This is something very cool. Kaiser Permanente supports this waiver. What is important to us is that it is done in a very thoughtful and balanced way, and so I will focus my brief comments today around how we believe that should work. And for us it is all about impacting all Marylanders equally regardless of who your insurance carrier is. As the board is aware, Kaiser is concerned that the program could advantage one health plan over the other. We want to make sure that this rate relief that was referenced is spread across everyone and that no carrier has the ability to be paid twice, a double dip concept for both the risk adjustment program as well as this reinsurance program that will hopefully be created for 2019. The issue of double payments is something that has been written about widely by experts, such as the American Academy of Actuaries and Milliman.*

*We have asked the staff of MHBE to seek an estimate from Wakely who is uniquely positioned to look at this because they have the data for the carriers in Maryland. We understand that that work is forthcoming, and we are very appreciative of that. We think that will be important and very instructive to understand the dynamics and ensure that we create the right program for Maryland. So why would this matter to a consumer? During the presentation, it was referenced that this could bring rates down by 30 percent. What is important to Kaiser is that this brings everyone’s rates down 30 percent or at least as well as you can model that. We are afraid that the minority will see a disproportionate level of rate decrease and the majority, including the 75,000 members that utilize Kaiser Permanente’s care delivery system today will see less than a balanced shift. We would also urge the MHBE to include language in the draft Section 1332 waiver that would indicate the state’s intent to implement this type of program.*

*We believe CMS would not hesitate to approve a waiver with this language. And finally, we believe that a program that treats all carriers equally will increase the chances of additional carriers coming to the state. Today, we only have two carriers: Kaiser Permanente and CareFirst, and Kaiser Permanente is not statewide. Our delivery system does not cover all of Maryland. A balanced program that treats carriers equally, particularly those who are incentivized around controlling costs would make Maryland more attractive to additional competitors. In conclusion, Kaiser Permanente believes three important things. One, the program should not allow duplicate payments to be made to any health plan. Two, the program should benefit all Marylanders as equally as possible and not disproportionately those enrolled in just one type of plan. And finally, that this is a solvable problem that we have the data and we have the time to design a program that would accomplish the goals that I have laid out today. So, thank you for your consideration.”*

Beth Sammis, President, Consumer Health First, Board of Directors, offered the following testimony:

*“I am President of the Board of Consumer Health First, a statewide consumer advocacy organization, and I am here today to deliver our strong support for the 1332 waiver for all of the reasons that JP so eloquently stated. Obviously, all of us know that consumers who do not qualify for financial assistance have borne the brunt of the eye-popping premium increases over the last four years of the Affordable Care Act, and from the data that was provided by the MIA to the General Assembly of this year, we know that premiums in the individual market for consumers who do not qualify for financial assistance range from 26-73 percent of their after tax income. I would submit to you that if any of us in the group market were required to pay anything close to that then we would respectfully decline that coverage from our employers, and so to us this is a crisis deserving of some solution. Although I must say that we see the reinsurance program together with a very thorough rate review, which we are going to be working with the MIA to ensure happens, is one way to modestly impact the rates, but long-term we believe that there is going to have to be other solutions. One of the solutions that we advocate is a Medicaid buy-in.*

*We understand that there is still a lot of work to do before the reinsurance program is launched. You've made many of the decisions about some of the technical aspects of this program already. Regarding the cap on the reinsurance payments, it is much lower than the cap was at the federal level, the federal reinsurance program, and it is much lower than, at least what we understand, what other states have done. We understand that is being done primarily because you want deeper coverage, and so we would certainly support that. We are concerned for slightly different reasons but along the same lines of concern that Kaiser has already expressed, that this reinsurance program will not equitably impact all consumers. It is not so much that we are concerned about what happens to Kaiser, with all due respect. But, there is a difference between the PPO market and the HMO market. In the PPO market, we know that the risk adjustment program that has been put in place at the federal level, all of those monies go to the PPO product, and the monies raised for that program are from the HMO market. Those HMO premiums are in effect increased in order to subsidize the PPO product because the PPO product has higher risks.*

*We know that theoretically there are many who have argued that when you have a reinsurance program and it is combined with a risk adjustment program that nothing further needs to be done, but we are concerned that that is not the truth. And, that it is particularly not going to be the case given the level and the scale of this particular program. So, our ask is that during this time period between now and the end of the year that you take the claims data from 2017 and do a simulation of what exactly would have happened if there had been in effect the risk adjustment program, which of course we know will be in place, and you know what those payouts will be for the 2017 plan year in June and then simulate what the reinsurance payments would have been in 2017 to be sure that the attachment points and whether or not there should be any true up between the risk adjustment program and the reinsurance program so that the percentage decrease in premiums that we expect on average is the same for HMO products and PPO products. I think that we are well aware of the fact that there can be plan differences, there can be differences between Kaiser and CareFirst, but at the end of the day, if we are looking at a 30 percent reduction in rate increase, that should be the same whether or not you are enrolled in an HMO or a PPO. Otherwise, we believe that that is an unfair subsidy again on the part of HMO members.*

*We also understand that, to us anyways, there is the potential, and I wouldn't say that it is absolute, but it is a potential, that consumers would see this in an inequitable way if their premium decreases were not similar for the HMO and PPO products. This could also lead to some market distortions and would lead some carriers, in particular Kaiser Permanente, to rethink their commitment to this market. After all, Kaiser Permanente is not required by law to remain in the individual market. It is another reason why we have seen other carriers depart; they are a business, and they get to decide if they want to stay in this line of business or not. That is not true for CareFirst. CareFirst is the state's only non-profit health service plan, and under the provisions of Section 14-106 (d)(1)(ii) of the Insurance Article, they are required to offer products in the individual market and thus, may not exit. It is not in consumers' interest to have only CareFirst HMO and PPO products. It is in our interest to have more carriers. I am doubtful about the number of other carriers coming in, but at least we should try to hang on to those that are already here. And, obviously some consumers have elected to join Kaiser Permanente and believe that it best meets the needs of them and their families.*

*Finally, we would ask that we take this opportunity with the development of a state reinsurance program where essentially carriers are going to be given a pretty significant amount of money to help out with their travails in this market to put in place meaningful health improvement programs. There is no requirement in Maryland, that I know of, that the Exchange has placed on carriers in the individual market or any other market to demonstrate they are in fact well aware of the healthcare conditions that are driving up premiums and that they have developed meaningful interventions to control those costs going forward. I believe that is in consumers' interests for two reasons. One is that if they are effective, they will lead to a lower rate of increase, which is in consumers' interests, and second of all, if they are effective, it should mean that consumers who have these chronic conditions lead healthier, more productive lives, which is in all of our interests as well as theirs. Again, I would like to close by thanking you for moving forward with this effort, to the Secretary for being here to listen, and we look forward to working with you to try to bring as much benefit to the market as possible to all consumers. Thank you."*

Jeff Ratnow, consumer, offered the following testimony:

*"I am a consumer on the Exchange. I am going to give you my personal story. In 2015, I was fired, and I decided that now was the time to start my business. I started my business. My parents said to me, 'What are you going to do for health insurance?' because health insurance was always provided by my company, and I didn't really think about that. I was so grateful that Obamacare was in effect, and I went to a broker on Eastern Avenue in Highlandtown. He said, 'You're all set. You qualify for Medicaid,' so through the Affordable Care Act, because I was making no money, I got to build my business. As soon as I made \$75,000, I got my bill of \$650 a month, \$3,500 premium [deductible]. That isn't bad. That is kind of reasonable. That is a good deal. The next year, I grew my business a little bit more, and the reward is \$1,200 a month, about the same premium [deductible]. Okay, still alright, but now, it is getting tight at home. I have two kids and a wife, a wife with a pre-existing condition. I found out that I do because I had a sleep apnea test 20 years ago that has been flagged since then, so we are essentially uninsurable without the public markets.*

*So, those of you who buy on the market, I am sure you watched with bated breath when the Republicans tried to kill Obamacare. I had nightmares. When John McCain voted against it, it was better than any Ravens SuperBowl ever. It was literally preserving my chance to live the American dream and build my business because without that, I knew I would have to give up and go get a job. So, the next year, my premium then went up to \$1,350 a month with a \$13,000 deductible. We go skiing, and now we have to make choices. My son breaks his arm. I didn't know if he broke his arm. We kind of waited it out a little bit. Urgent care is about \$300, and they are just going to put him in a splint. What do I do here? My friend is an ER doctor, so we went and saw him. He said, 'I think you need to get it taken care of.' Anyway, it changes how you take care of your family because the monetary pressures are so big.*

*This year, I probably have an exposure of about \$30,000, which is going to be about 30 percent of my net income. That is more than housing and is more than any other expense, and when I read that the state of Maryland was thinking about doing this, I thanked God that I live in a progressive state that really cares about the people. This will help me grow my small business. I will be able to instead pull money out of my business and right into a health savings account and my health insurance. I could look at hiring people. I could look into creating a better life for other folks as well, which I learned through the Goldman Sachs 10,000 Small Businesses Program how to do that. My constraints have been financial, and now this, hopefully if it works out the way that it is written, it will provide stabilization and insulate us from the craziness going on 40 miles south of here. And really create a state where people really want to move to and live in. Thank you."*

**Closing**

Ms. Eberle recognized Jeff Ratnow and thanked him for sharing his story. Ms. Eberle closed the hearing and thanked everyone who attended.

## Participants

### *Maryland Health Benefit Exchange*

Ben Steffen, Member, Board of Trustees  
Dana Weckesser, Member, Board of Trustees  
Michele Eberle, Executive Director  
Andrew Ratner, Chief of Staff  
John-Pierre Cardenas, Director of Policy and Plan  
Management  
Kris Vallecillo, Senior Health Policy Analyst  
Betsy Plunkett, Marketing Director

### *Maryland Insurance Administration*

Todd Switzer, Chief Actuary  
Cathy Grason, Chief of Staff  
Brad Boban, Senior Actuary  
Bob Morrow, Associate Commissioner  
Joseph Fitzpatrick, Market Conduct Examiner

### *Maryland Department of Health*

Robert Neall, Secretary  
Laura Goodman, Division Chief

### *Members of the Public*

Rich Albertoni  
Zena Alhija  
Jen Brock-Cancellieri  
Scott Brown  
Jackie Cahill  
Kim Cammarata  
Matt Celentano  
Tim Curtis  
Xue Dai  
Linda Dietsch  
Morgan Eichensehr  
Calvin Holmes  
Laura Hooper  
Stephanie Klapper  
Laurie Kuiper  
Jon Kunkle  
Diane Lawrence  
Mark Longerbeam  
Natasha Murphy  
Maansi Raswant  
Jeff Ratnow  
Dourakine Rosarion  
Kathy Ruben  
Beth Sammis  
Delora Sanchez  
Jared Sussman  
Bill Wehrle  
Wayne Wilson  
Bryant Woodford



Public Hearing - Maryland 1332 State Innovation Waiver  
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 Maryland Health Benefit Exchange

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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Kathy Ruben	Consumer Health First	Kathyruben@ConsumerHealthFirst.org	<input type="checkbox"/>
Jon Kunkle	Kaiser Permanente	jon.i.kunkle@kp.org	<input checked="" type="checkbox"/>
Lauree Kuiper	Kaiser Permanente		<input type="checkbox"/>
Wayne Wilson	Kaiser Permanente	Wayne.A.Wilson@KP.org	<input type="checkbox"/>
Bill Wehrle	"	bill.g.wehrle@kp.org	<input type="checkbox"/>
Jackie Cahill	HPS	jacahill@healthplan	<input type="checkbox"/>
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Laura Hooper	AOTA	lhooper@aota.org	<input type="checkbox"/>
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Bob Morrow	MIA	bob.morrow@maryland.gov	<input type="checkbox"/>





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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Diane Lawrence		diane.lawrence54@yahoo.com	<input type="checkbox"/>
Natasha Murphy	CareFirst BlueCross BlueShield	natasha.murphy@carefirst.com	<input type="checkbox"/>
Dana Weckesser	M H B E X		<input type="checkbox"/>
Zena A	consumer health first	zenaah@a@consumerhealthfirst.org	<input type="checkbox"/>
Laura Goodman	MDH	laura.goodman@maryland.gov	<input type="checkbox"/>
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D. Sanchez	mmcoa	dsanchez@cgagroup.com <del>delorator@mmcoa</del>	<input type="checkbox"/>
Beth Sammis	CHF	bethsammis@gmail.com	<input checked="" type="checkbox"/>
Jeff Reher	Self	jeff@Sight-in-Site.com	<input checked="" type="checkbox"/>
Scott Brown	Self	brown.scott@comcast.net	<input type="checkbox"/>



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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Matt Celentano	League of Life + Health Insurers	mcclintano@fblaw.com	<input type="checkbox"/>
Cathy Grason	MIA	catherine.grason@maryland.gov	<input type="checkbox"/>
Rich Albertoni	PCG	ralbertoni@pcgns.com	<input type="checkbox"/>
Kim Conumowatn	OAG HEAM		<input type="checkbox"/>
Bryant Woodford			<input type="checkbox"/>
Mansi Roswant	MHA		<input type="checkbox"/>
Jen Brock-Cancellieri	1199 SEIU	jenbc@1199.org	<input type="checkbox"/>
Xue Dai	CareFirst	xue.dai@carefirst.com	<input type="checkbox"/>
Mark Longbeans	BME Systems		<input type="checkbox"/>
Joe Fitzpatrick	MIA		<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>





## Maryland 1332 Waiver Hearing

May 7, 2018  
Frederick County Health Department  
350 Montevue Lane  
Frederick, MD 21702

### Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and introduced herself along with other MHBE staff in attendance. She acknowledged the presence of staff from the Maryland Insurance Administration (MIA), as well as Delegate Carol Krimm and Robert Neall, the Secretary of the Maryland Department of Health and Chair of the MHBE Board.

Ms. Eberle provided a brief overview of the proposed state reinsurance program then introduced John-Pierre Cardenas, the MHBE Director of Policy and Plan Management.

### 1332 Waiver Presentation

Mr. Cardenas began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that the reinsurance program’s attachment point has not been finalized because it depends on available funding. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increases that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier. An attendee asked if the expected premium decrease factors in subsidies, and Mr. Cardenas responded that the estimate of the premium decrease is based on premiums without a subsidy.

Mr. Cardenas concluded his presentation by describing the upcoming opportunities to gather stakeholder feedback, including one additional hearing later in the week. He noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

### Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee commented that the reinsurance program will lower premiums, but asked if it will increase the number of plan options available through the exchange because the attendee is currently paying \$600 per month for a bronze plan with a \$7,000 deductible. Mr. Cardenas responded that affordability is very important to the MHBE and that the reinsurance program will create a more favorable environment for insurers, which will hopefully encourage more

insurers to participate in the exchange. Todd Switzer, Chief Actuary of the MIA, noted that the reinsurance program will have a greater impact on premium prices than one might think. For example, if a carrier files for a 50 percent rate increase, then the estimated 30 percent decrease from the reinsurance program would not result in a 20 percent rate increase but only a 5 percent rate increase because of how premiums are calculated. Mr. Switzer also asked if the attendee was referring to the fact that CareFirst recently decided to offer only one option for each metal level and that the number of Affordable Care Act (ACA) plans has decreased. The attendee responded that BlueCrossBlueShield is widely accepted, so it is difficult to look at another plan and determine the network; the only plan she can afford has a \$7,000 deductible. The attendee reported that it is sometimes cheaper to self-pay rather than use insurance. Mr. Switzer thanked the attendee for her comments.

An attendee asked whether the MHBE was concerned that the option of federal pass-through funding for the reinsurance program could disappear given the changes the current administration has made to weaken the ACA. Mr. Cardenas responded that the section 1332 waiver is protected by statute and that there are currently no proposed regulations that would threaten the waiver. Furthermore, the administration is encouraging states to apply for waivers to implement state based reinsurance programs.

An attendee then asked if the waiver is working in other states. Mr. Cardenas responded that the states that are focusing their 1332 waiver solely on a reinsurance program have had success with their programs; states with multiple programs have had more difficulty. For example, Minnesota has a reinsurance program and basic health plan that both draw from the same pot of money.

An attendee asked if the reinsurance program is still a short-term solution and if there is a long-term plan. Mr. Cardenas confirmed that the reinsurance program is intended to be a short-term solution to control premium costs. Ms. Eberle noted that the waiver application is for five years, though the funding is for two and a half years. New state funding will need to be secured at that point.

An attendee expressed concern about limited carrier participation in the exchange. Ms. Eberle responded that the MHBE is reaching out to carriers and have heard that carriers are interested in the reinsurance program as a way to control the costs of high-risk enrollees. Bob Morrow, Associate Commissioner of the MIA, added that the MIA is constantly reaching out to carriers to encourage participation in the exchange and that it is a top priority. Ms. Eberle noted that a carrier must build its network before entering the marketplace, which can take well over a year.

An attendee asked whether wellness programs, which have been proven to lower healthcare costs, will be part of the reinsurance program. Ms. Eberle responded that public testimony is always helpful and will become part of the application. A section of the 1332 waiver addresses issuer incentives for containing costs and utilization, and the MHBE is interested in that issue.

Regarding carrier participation, Mr. Switzer added that there were seven carriers in the individual market and now there are two; all carriers have been invited to participate. The \$365 million in state funding combined with the federal pass-through funding is expected to last for two years, reducing premiums by 30 percent. This gives Maryland time to look for a long-term solution and the ultimate goal of attracting a more robust and healthier pool to stabilize the market.

An attendee expressed concern that the reinsurance program is a patch until the next step is figured out. She also expressed support of a previous comment regarding well care, stating it has been statistically proven to reduce the cost of healthcare. She commented that the reinsurance program looks like the beginning of a single-payer system; other countries have shown that a single-payer system reduces administrative overhead. She asked where the conversation is heading since the reinsurance program is only a short-term solution. She also commented that the estimated savings for the future tend to be optimistic and she expressed concern that there will continue to be a downward spiral. She commented that insurance companies are for-profit and are not interested in reducing healthcare costs; she reiterated that a single-payer system for Maryland may be a better long-term solution and that it has been shown to work. Mr. Cardenas thanked the attendee for her insight, and noted that SB 387 included a series of studies for the Maryland Health Insurance Coverage Protection Commission, such as Medicaid buy-in and an individual mandate. He encouraged attendees to supply comments. Mr. Morrow noted that these public hearings are not the right place to advocate for a single-payer system because the MIA and MHBE are implementing the rules that are passed. They may provide information to legislators, but they are not involved in the policy making process. He explained that this group is trying to implement the reinsurance program and receive federal approval of the

Section 1332 waiver that the legislature authorized. The attendee commented that this group would be uniquely qualified to be the administrators of the single-payer system. Mr. Morrow responded that if single-payer legislation was passed that directed the MIA or MHBE to implement a single-payer system, then they would do so.

Regarding wellness programs, Mr. Switzer added that some carriers have such programs, and the MIA is seeking more information regarding the effectiveness of these programs and trying to bolster them. He noted that the MIA will be looking at whether there is a better way to distribute the premium tax credit. Mr. Morrow added that every carrier in the individual and group markets has some wellness program or component in their plans and that could be improved on.

An attendee commented that she is confused by the distribution of the tax credit because she is self-employed. Sometimes it makes more sense for her to file separately from her husband, but that in turn caused her to lose her subsidy, which she feels is not helpful or productive for someone in her situation. Mr. Cardenas responded that the ACA requires married couples to file jointly in order to be eligible for a tax subsidy. If a married couple files separately, then they are ineligible for a subsidy. A future Section 1332 waiver could fix that problem, but that would be further in the future. Ms. Eberle added that the MHBE can connect the attendee to a navigator or a broker to receive assistance with this problem.

An attendee asked if the MHBE and other medical groups are working towards a federal single-payer system because as long as insurance companies are involved, then it will always be for-profit and will not benefit consumers. Ms. Eberle responded that this is not the charge of the MHBE, which was created to roll out health coverage and provide a marketplace for individual insurance through the ACA. Any activity at the federal level must be done through federal policy, and she recommended contacting the federal delegation for Maryland. The attendee commented that the MHBE staff are the experts who should tell the federal government what they want. Ms. Eberle responded that the state legislators would need to direct the MHBE to take that action, as they are a state agency implementing the rules. She noted that the MHBE can connect the attendee to the people to speak to.

An attendee asked if Maryland will act as the reinsurer if the waiver is approved. Mr. Cardenas responded in the affirmative. The attendee asked if Maryland was considering transferring the risk into the traditional reinsurance market after the program is established. He commented that this is a subsidy not a reinsurance plan, and asked if Maryland considered transferring the risk to the traditional reinsurance instead of taking the risk on their own. Mr. Morrow clarified that the attendee meant that Maryland could purchase a reinsurance plan to cover their obligations; he responded that Maryland has not considered this option but could do so in the future.

An attendee asked if the reinsurance program will be in place in time to affect 2019 rates since open enrollment starts on November 1, 2018. The attendee expressed concern that rates could change halfway through open enrollment. Mr. Cardenas responded that the Centers for Medicare & Medicaid Services (CMS) encouraged Maryland to apply for a waiver starting in 2019, to get relief to as many Marylanders as soon as possible. The MIA and MHBE stand ready to implement adjusted rates after the reinsurance program is established. The recommended approval date for the waiver is the end of July, and previous states have had their waivers approved quickly. For example, Oregon's waiver was approved in 99 days, so a quick approval is possible. The MHBE is trying to submit the application as quickly as possible. Mr. Morrow added that they recognize that time is of the essence and everyone is working very hard to get the waiver done quickly.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Five individuals offered testimony.

Gene M. Ransom, III, CEO of MedChi, offered the following testimony:

*“First of all, I’m Gene Ransom. I’m CEO of MedChi, which is the Maryland State Medical Society, and on behalf of our members, we’d like to strongly support the application but we have three issues that we think need to be addressed before it moves forward. First and foremost, I’d say most important, we would like that language be included in the draft 1332 waiver that indicates the state’s intent to include an adjustment in 2019 for federal risk adjustment payments. We think this is really important. This plan should be designed to stabilize the entire market for everybody and benefit all Maryland consumers equally. We don’t*

want a situation where certain patients of my members are benefited more than others, and we think this is, from a fairness point of view, really important—that everybody be treated equally. We don't want a situation where the state is essentially picking winners and losers in the market. We also think, if you make this adjustment, it will be another incentive to solve the problem we've heard about where there are not carriers in the market and, if we're clear that we're treating everybody fairly and equally, we might attract more folks into the market. My members and MedChi have complained about the concentration in the health insurance market for years. Our rating is off the charts. We're one of the most heavily concentrated markets and it creates all kinds of problems. It creates problems on the cost side for patients. It creates problems for my physician members when they're negotiating contracts with the insurers, and this is an opportunity to either make it worse by subsidizing one carrier more than the others or make it better by subsidizing everybody equally, creating a fair and equal playing field.

The second issue that we think needs to be addressed is that specific payment incentives should be included in the reinsurance program that are aligned with the state's broader policy goals related to quality, cost effectiveness, and innovation. I also think that this would be an opportunity to address the wellness issues that came up before that Delegate Krimm and others have brought up. We also believe, specifically in that section, that the carriers should be required to participate and work collaboratively with CRISP, the other HIE, the HIE that's not here. We think that's really important. The population health tools and the work of the health information exchange can create a lot of opportunities for savings and better quality and better outcomes. We have one of the most highly recognized HIE's, again, health information exchange—the same acronym. I don't know why they do that. They should have given you guys different names. CRISP is recognized as one of the best-run HIEs in the country. There needs to be alignment. I don't think this is something that is a major problem. I think you might be able to do this even possibly with a resolution, maybe after the fact if it's a problem including in the application for approval reasons, but we just need to incentivize the carriers, particularly the dominant carrier, to participate with the information exchange so we can have better information and better outcomes.

The third thing, and I'm not saying you guys haven't done this, I just think that it's so important and it's such a high priority. We really just think that it's important for you to look at the newly approved—newly soon-to-be-approved hospital all payer Medicare waiver and make sure that this is properly aligned with the Medicare waiver. The Medicare waiver is really important to Maryland. MedChi has been working proactively with the state to get that approved, and we hopefully will have that approved in the matter of a few weeks or months maybe. We just think it's really important that that unique model that keeps our hospitals funded appropriately is aligned with this. And, again, I'm not saying it isn't, I'm just saying let's make a point to not screw that one up by accident. Let's look at it and combine the two.

So, in closing, I just want to reiterate that we really appreciate the work of Governor Hogan, of Commissioner Redmer, Secretary Neall who's in the back, and the Democrats in the General Assembly who really worked together in a bipartisan fashion to come up with this solution. We think it makes sense, and I think these three tweaks are positive changes that can be achieved before the application deadline. Thank you.”

David Hexter, MD, Emergency Physician and Physician in Chief at Mid-Atlantic Permanente, offered the following testimony:

“Good afternoon, my name is David Hexter. I am an Emergency Physician and Physician-in-Chief at Mid-Atlantic Permanente. We care for the patients of Kaiser Permanente in the Baltimore area in general and the Baltimore area as well. Kaiser Permanente is one of only two carriers—we mentioned this several times—that is still on the exchange, and we're also the only one that cares for Medicaid patients. We first of all want to express our support for the section 1332 waiver reinsurance program and really applaud the state legislature, the Hogan administration, and Exchange for working to move forward with this waiver application. And we believe that a reinsurance program like this if it's implemented fairly will go a long way to stabilizing the market and improve affordability, many of the problems of which you've heard today. But we think it must be, we believe it must be implemented fairly because the reinsurance program that Maryland develops should stabilize the entire insurance market and not just part of it. My fellow Permanente physicians are concerned that the reinsurance program as it is currently proposed will give an advantage to one health plan over another. We want to make sure that the rate relief that is provided by the

*program is spread across all Marylanders, not just those that enroll in one company's products. So unless a specific adjustment is made, the proposed program would allow carriers that are paid substantial amounts under the current federal risk adjustment program to be paid twice for accepting those higher-risk members under the reinsurance program. But why does this matter to consumers and patients? Well, if an adjustment is not included in the program, then the relief is going to be concentrated among a small minority of the individual market enrollees. And the majority of the consumers and patients will share less in the relief, and some including the 75,000 Marylanders who choose Kaiser Permanente through the exchange, many of whom are my patients, will experience much less premium relief. And as a Maryland physician, I want my patients to benefit from this reinsurance program that we're putting together to help keep their premiums affordable like everyone else in the state.*

*So we encourage the Exchange to include language in the draft section 1332 waiver application that indicates the state will adjust for this dynamic. And we also believe that Maryland should include incentives similar to what Mr. Ransom said in the reinsurance program that will align with broader state policy goals to improve quality and cost effectiveness of the care that is provided. To give you some ideas of some of these incentives that could be provided, you could reward high clinical ratings, for example breast cancer screening or colorectal cancer screening, controlling high-blood pressure. You mentioned the diabetes program before, we're able to control diabetes in the population. Shouldn't we be incentivized to do that? And thus designing a program that treats all carriers equitably and that includes these incentives for high-quality patient care and effective care management would attract new healthcare plans into the market, we want more choices as many of the people here today have indicated they want. And we want these carriers to focus on keeping people well, not just having them for a year and moving onto another carrier.*

*So in conclusion, we at Mid-Atlantic Permanente or Kaiser Permanente believe that the reinsurance program Maryland implements should not allow duplicate payments to be made to any one health plan. There can and should be an adjustment built into the program that makes sure that all patients who purchase their coverage in Maryland's individual market will benefit equally from this reinsurance. Finally, we should include incentives in the reinsurance program that are aligned with the state's broader policy goals in healthcare related to quality and cost effectiveness of care. Thank you very much, and I'm happy to answer any questions."*

Ellen Lerner, consumer, offered the following testimony:

*"I want to thank this group and the Maryland Health Benefit Exchange. I know your work is not easy; I think I am putting that mildly. I am certainly in favor of the application for this waiver. I hope we get it and we get it quickly. My sole purpose is to benefit those, well to everyone in the state of Maryland; I believe that everyone should be insured. I do want to caution as I did in my questions that this appears to be a patch, a very complicated patch. I hope it works. My husband is a physician. He practices as a teacher, teaching people about how to take care of themselves, how to be healthy, and he even still makes house calls to help people. To me, I know this isn't the purview of the Health Benefit Exchange, but yet it is. I recognize this group as being the one who helps people to find the best insurance they can with what they have available to them and this will help make more available to them. But I also urge caution in that you are dealing with for-profit insurance companies and that, ultimately, I hope that this will be the beginning as I see it of trickling into, kind of backing ourselves into, a single-payer system. I truly think in the end that's what will be the best, and I highly encourage that this be recognized as that little crack. Thank you."*

Delegate Carol Krimm of District 3A offered the following testimony:

*"Just to update people on how this process went during General Assembly, so when we came into session the federal government had just taken their actions, and it was communicated to all the legislators that this was going to have a devastating effect on our budget because of the cost involved in trying to repair what the federal government had done to our health exchange. So the Speaker and the Health and Government Operations Committee put this special committee into place, a special task force. The Chairman is Delegate Joseline Peña-Melnyk who in my estimation is probably one of the most knowledgeable legislators on healthcare, and they started meeting on a weekly basis with people in the industry, other legislators, and we just tried to get everyone at the table and we were getting updated through this process.*

*So what I want to communicate to you is that this is not over. You know this is what we have to do, I think you've heard the words short-term. So we will continue to work on this, and we had to make very quick decisions because of the impact that came down from the federal government and that's what we did and not to say we're not moving towards some goals you think we should have in healthcare. But this is where we are, and these are the people that are going to guide us through the short-term, but we are going to continue the task force. So I would encourage the people here who have some very strong ideas on where we should be heading to get in touch with your legislators and let them know where you think we should be going because we're not done."*

Annette Breiling, Healthcare as a Human Right, Chapter of Frederick, offered the following testimony:

*"I'm sorry I came in late, and I'm with Healthcare as a Human Right, Chapter of Frederick and have long believed that everyone needs to get healthcare. And my understanding is that single-payer is the way that is ultimately going to have to happen, and the Medicare for all legislation is the way we're going to have to ultimately end up. My understanding also is that there are so many federal rules right now that are preventing a state to achieve this and the state whatever we can do to kind of move us in that direction is what I advocate. So that's why I came here and wanted to promote any steps that are going to move us to be able to get everybody healthcare."*

### **Closing**

Ms. Eberle informed the audience that the MHBE has a navigator program and producers that can help consumers with assessing their options and navigate the system. Ms. Eberle closed the hearing and thanked everyone who attended.

### **Participants**

#### *Maryland Health Benefit Exchange*

Michele Eberle, Executive Director  
Andrew Ratner, Chief of Staff  
John-Pierre Cardenas, Director of Policy and Plan Management  
Kris Vallecillo, Senior Health Policy Analyst

#### *Maryland Insurance Administration*

Todd Switzer, Chief Actuary  
Bob Morrow, Associate Commissioner

#### *Maryland Department of Health*

Robert Neall, Secretary

#### *Maryland Department of Human Services*

Lourdes, R. Padilla, Secretary

#### *Maryland General Assembly*

Delegate Carol L. Krimm

#### *Members of the Public*

Gene Ransom  
David Hexter  
Will Fawcett  
Judith Rogers  
Ellen Lerner  
Mary Benove  
Dan Mosebach  
Amy Podd  
Lisa Horner  
Laurie Kuiper  
Tinna Quigley  
Rose McNeely  
Kathy Ruben  
James French  
Mike Cumberland  
Jeannette Bartlett  
Natalie Ziegler  
Annette Breiling





Public Hearing - Maryland 1332 State Innovation Waiver  
Thursday, May 3, 2018  
Maryland Health Benefit Exchange

SIGN-IN SHEET

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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Gene M. Ransom III	MED CHI, THE MARYLAND STATE MEDICAL SOCIETY	Gransom@medchi.org	<input checked="" type="checkbox"/>
David Hexter, MD	Mid Atlantic Permanente	david.a.hexter@kp.org	<input checked="" type="checkbox"/>
Bob Morrow	MIA		<input type="checkbox"/>
Wm Fawcett	Haverford Bermuda	WILLIAM.FAWCETT@HAVERFORDBERMUDA.COM	<input checked="" type="checkbox"/> POSS (BZ)
Judith A. Rogers	Self	jrogers948@gmail.com	<input type="checkbox"/>
ELLEN LERNER	Self	mlerner52@gmail.com	<input checked="" type="checkbox"/>
Mary Benove	self	marybenove@gmail.com	<input type="checkbox"/>
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Amy Podt	self	apsolutions757@gmail.com	<input type="checkbox"/>
Lisa Horner	Self	lisa.horner@corefirst.com	<input type="checkbox"/>
Lauree Kuiper	Kaiser Permanente	Lauree.Kuiper@kp.org	<input type="checkbox"/>
Delegate Carol Krimm	MD General Assembly		<input type="checkbox"/>



Public Hearing - Maryland 1332 State Innovation Waiver  
 Monday, May 7, 2018  
 Maryland Health Benefit Exchange

SIGN-IN SHEET

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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Tinna Quigley	The League of Life+Health Insurers	TQuigley@fblaw.com	<input type="checkbox"/>
ROSE MCNEELY	RM Benefits of Maryland	ROSE@RM BENEFITS MD.COM	<input type="checkbox"/>
Kathy Ruben	Consumer HealthFirst	kathyruben@consumerhealthfirst.org	<input type="checkbox"/>
James French	HCHR-MD	french.james74@gmail.com	<input type="checkbox"/>
Ulise Cumberbatch	Keller Stenbrocker	ulise@cksiinc.com	<input type="checkbox"/>
Jeannette Bartelt	Self	jmbartelt@gmail.com	<input type="checkbox"/>
Natalie Ziegler	Candidate for House of Delegates GA	Natalie@NatalieP9A.com	<input type="checkbox"/>
Annette Breiding	HCHR.MD	annette_breiding@gmail.com	<input type="checkbox"/>
			<input type="checkbox"/>
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## Maryland 1332 Waiver Hearing

May 10, 2018  
Charles County Health Department  
4545 Crain Highway  
White Plains, MD 20695

### Welcome & Introductions

Michele Eberle, Executive Director of the Maryland Health Benefit Exchange (MHBE), welcomed the public to the hearing and encouraged their participation.

### 1332 Waiver Presentation

John-Pierre Cardenas, MHBE Director of Policy and Plan Management, noted that this is the final of four public hearings. He began by describing the state legislation enabling the reinsurance program—House Bill (HB) 1795 – Establishment of a Reinsurance Program and Senate Bill (SB) 387 – Maryland Health Care Access Act of 2018. He explained that HB 1795 directs the MHBE to apply for a 1332 waiver, and SB 387 places a 2.75 percent assessment on premiums to fund the program. An attendee asked whether the tax applies to employer-sponsored or individual health plans. Mr. Cardenas responded that the tax will apply to any policy that is subject to the authority of the state. He further explained that the reinsurance program's attachment point has not been finalized because it depends on available funding and stakeholder input. The MHBE Board has already voted to approve a reinsurance cap of \$250,000 and a coinsurance rate of 80 percent. Mr. Cardenas explained that the reinsurance program is intended to address the large premium increases that have occurred over the past several years.

Next, Mr. Cardenas described how two outside organizations contributed to the waiver application process. The Wakely Consulting Group prepared the actuarial and economic analysis, and The Hilltop Institute developed the narrative portion of the waiver application.

Mr. Cardenas then provided a basic description of the waiver, explaining that it would reduce premiums by an average of 30 percent in the first year using a combination of state funds and federal pass-through funds. By allowing carriers to factor the reinsurance program into their premium rates, thus reducing those premiums, the MHBE expects the program to result in a 5.8 percent increase in individual market enrollment in 2019. A member of the public asked whether the 5.8 percent increase refers to the percentage of individuals or the percentage of premiums. Mr. Cardenas responded that it is a 5.8 percent increase in the number of people enrolled.

Next, Mr. Cardenas presented the four guardrails in which all 1332 State Innovation Waivers must comply. He explained that the proposed reinsurance program would be compliant with these guardrails. He added that, absent the waiver, the average premium is estimated to rise from \$604.50 per month to \$735.66 per month in 2019, whereas under the waiver, the average premium is expected to decrease from \$604.50 per month to \$508.03 per month. Mr. Cardenas emphasized that these estimates are based on average premiums and are not specific to any single carrier.

Mr. Cardenas concluded his presentation, noting that there is still opportunity to submit written comments. He also noted that there will be additional opportunities for stakeholder involvement in the regulatory process over the summer of 2018.

Michele Eberle acknowledged several audience members, including MHBE Board Vice Chair Tony McCann, MHBE Standing Advisory Committee member Evelyne Ward, Maryland Insurance Administration (MIA) staff, and MHBE staff.

### Q&A/Discussion

Mr. Cardenas then opened the floor for questions and discussion from the attendees.

An attendee asked whether non-core benefits will change under the waiver. Mr. Cardenas responded that the ten core essential health benefits will not change. Non-essential benefits are determined by the insurance company, and the waiver will not have a direct impact on these. The attendee also asked for the list of essential health benefits. Mr. Cardenas and Joseph Fitzpatrick, Assistant Chief Examiner, of the MIA listed the following benefits: ambulatory care, behavioral health, emergency services, hospitalizations, prescriptions, maternal and prenatal health, primary care, laboratory services, pediatric services, and rehabilitative and habilitative services.

An attendee asked if there is a "Plan B" if the federal government does not approve the waiver as expected. Mr. Cardenas responded that the MHBE has been working very closely with the federal government to ensure that the application is complete and ready for a quick response. He noted that the legislation authorizing the program is contingent upon federal approval, so further legislative action would be required if the federal government does not approve the waiver. Ms. Eberle commented that this would require a special session of the Maryland General Assembly.

An attendee asked about the program's effect on people who do not buy coverage through the exchange. Mr. Cardenas responded that the program applies to individual market rates both on and off of the exchange.

An attendee asked about the income requirements for participating on the exchange and what happens if someone's income exceeds that amount for a few months. Mr. Cardenas responded that subsidies are available to those up to 500 percent of the federal poverty level. He noted that individuals are expected to report income changes to the exchange within 30 days. Income for the upcoming plan year is predicted at the time of application, and this information is reconciled at the end of the year when taxes are filed. Ms. Eberle clarified that individuals with any income level can purchase on the exchange, but individuals can only obtain tax credits through the exchange.

Todd Switzer, Chief Actuary of the MIA, thanked the attendees for their participation and offered some additional comments. He stated that this waiver affects about 200,000 people in Maryland. Noting that the press release in regard to carrier rate increases was released earlier in the week, he explained that the impact of the reinsurance program is multiplicative. Mr. Switzer provided the theoretical example of a 50 percent rate increase coupled with the 30 percent decrease from the reinsurance program. He explained that this does not mean that there will still be a 20 percent increase in rates. He added that, if the increase is 50 percent, you multiply 1.5 by 0.7, and the increase in rates would be 5 percent and not 20 percent. Mr. Switzer explained that the reinsurance program has a much more leveraged impact, and he added that if the waiver is passed, it will have more of an impact than you might think. He stated that the reinsurance program will be more of an impact than just subtracting 30 percent.

Mr. Switzer emphasized the importance of the waiver and explained that the \$365 million, over the full five years, gets leveraged up to \$970 million, which is why the initial modeling can be stretched to try to improve the profile and risk of the pool to stabilize rates. Mr. Switzer stated that there are still 360,000 uninsured in the state of Maryland, and about half of those people are eligible for a subsidy, whether it is Medicaid or a premium tax credit. He added that some of those uninsured people could get a free bronze plan, and economically speaking, people are making an irrational economic decision and leaving money on the table. Mr. Switzer expressed the hope that shining the light on this program will encourage people to take another look at insurance coverage.

An attendee noted that some of the literature she read stated that the waiver would limit the increase in premiums rather than decrease premiums. She asked if it is true that the waiver is supposed to decrease premiums, rather than just limit the increase in premiums. Mr. Switzer responded that a decrease in premiums is the hope, but there is no guarantee that it will happen. Mr. Cardenas added that the estimates provided are based on the data available currently, and a lot of it is projecting what will happen in 2019.

An attendee asked Mr. Switzer to explain the equation to determine the impact of the reinsurance program again. Mr. Switzer, using the example of a 50 percent overall increase, explained that you add 1 to the overall increase, which gives you 1.5, and then, with the reinsurance being a 30 percent decrease, you subtract the reinsurance percentage decrease from 1, which gives you 0.7. He continued by saying that when you multiply 1.5 by 0.7, you get 1.05. Mr. Switzer stated that whatever you get from that multiplying (1.05), you subtract 1, and that is what you can expect the impact of reinsurance to be. Mr. Cardenas added that every dollar magnifies its impact.

An attendee asked if any other states have applied for a Medicare waiver. Mr. Cardenas responded by clarifying that this is a 1332 waiver, which is for the Affordable Care Act, not necessarily Medicare. He note that a number of states have applied for 1332 waivers, and Minnesota, Oregon, and Alaska have been approved for reinsurance programs.

An attendee asked if there are any results from these other states. Mr. Cardenas responded yes and that the results have been promising. Mr. Cardenas provided Alaska's model as an example, stating that rates in Alaska were estimated to increase 40 percent, and rates only ended going up 7 percent. Mr. Cardenas added that Alaska is a unique example because Alaska is a small state with high costs. Mr. Cardenas also added that Oregon's and Minnesota's reinsurance programs have had downward impacts with lower rates of premium increases. Mr. Cardenas stated that the impact on each insurance company was also different because each company is different, and each company calculates their premiums differently. Mr. Switzer stated that Maryland is attempting to achieve the deepest discount that has been attempted so far. Mr. Switzer provided national context by adding that Minnesota attempted 20 percent and Oregon attempted 7 percent.

An attendee asked about the markets of the other states and if they only have two carriers like Maryland. Mr. Cardenas answered that Alaska has one, and Minnesota and Oregon have several participating insurance companies. An attendee asked if this waiver could entice other carriers to come to the market. Mr. Cardenas answered that nothing is more attractive to an insurance company than a state that is committed to making the markets work, and the MHBE believes that a reinsurance program creates a more favorable environment. Mr. Cardenas stated that both the MHBE and the MIA work constantly to entice new insurance companies into Maryland.

### **Public Testimony**

Mr. Cardenas then invited any attendee who so desired to offer their testimony for the record. Two individuals offered testimony.

Lore Rosenthal, consumer, offered the following testimony:

*"Hi, my name is Lore Rosenthal, and I may be the only person in this room who is actually on the Maryland health exchange. So, I guess I just wanted to share my personal story. I am sure the insurance carriers here have heard it before, and I am sure some of the panelists have heard it before. But, it is good to hear from a real person I think. So, I work three days a week. I am not a wealthy person, but I earn more than the cut-off, which is \$43,000, which is not a lot of money. This year, my premium, without any subsidy, is \$1,000, and at the time when my premiums went up from whatever they were last year to the \$1,000, there was not an increase in that cut-off of \$43,000. So, you would think if they were going to double your premiums, they would have said, 'Oh, now you can earn like \$53,000 and still get a subsidy.' Last year, with my old plan, my deductible was \$2,500, and believe it or not, you can use up the entire \$2,500 with one hospital stay. I happened to be in the hospital for a mental health reason, and it turns out my carrier did not cover inpatient mental health. So, I just blew through that money in five days.*

*This year, my deductible has gone up to \$3,500, and I am hoping that nothing is going to happen to me that I am actually going to blow through that money. You say that there is going to be a decrease of 30 percent, but so far the examples you have given is more that there was a decrease in the increase. So, I am very concerned that next year I may be paying \$1,100, and yippee, it is \$1,100 instead of \$1,400. People cannot afford, and I think you realize that, if you're not on this subsidy, you cannot continue to afford that. It would never occur to me to just drop out of the program. I feel fortunate. I am a self-employed person, so I can't go through a company. I feel fortunate to have insurance. For some people, it must be like 50 percent of their income. People are saying that housing costs are going up, and electricity costs are going up. For poor people, they are paying exorbitant amounts. I am sure this is all in the newspaper too, but people are just paying too much for insurance, and it shouldn't be that way. I hope that you get the waiver, but I hope that in this case that the waiver gives us a 30 percent decrease, so I would only be paying like \$700 a month instead of \$1,000. Thank you."*

Michael Hartman, consumer, offered the following testimony:

*"Hello, my name is Michael Hartman, and I am wondering if instead of a monetary amount for income, would it be possible to say that health costs should only be a percentage of your income? Let's say, 15 percent or whatever. Might that be a more fair way of looking at things and understanding that a person*

*earning \$10,000, if it's 10 percent then it's \$1,000. If you're earning \$20,000, it would be \$2,000. It seems to me that might be a fairer way of looking at things. We look at things like Ms. Rosenthal mentioned about housing costs and generally, what is thought to be a good percentage is 30 percent of your income for housing. Wouldn't it also be a good thing to put a percentage of your health care instead of a monetary amount? Thank you. "*

### **Closing**

Ms. Eberle thanked everyone who attended; she encouraged consumers to look closely at the plan options available and to download the mobile application, which provides GPS-located assistance. She also noted the helpline and Navigator program as sources of consumer assistance.

An attendee expressed gratitude to the MIA for exemplary service in interceding with an insurance company on her behalf. She also commended the navigators. Ms. Eberle thanked the attendee for her comments and closed the meeting.

### **Participants**

#### *Maryland Health Benefit Exchange*

Michele Eberle, Executive Director  
John-Pierre Cardenas, Director of Policy and Plan  
Management  
Kris Vallecillo, Senior Health Policy Analyst  
Tony McCann, Member, Board of Trustees

#### *Maryland Insurance Administration*

Todd Switzer, Chief Actuary  
Bob Morrow, Associate Commissioner  
Joseph Fitzpatrick, Assistant Chief Examiner

#### *Members of the Public*

Robert Axelrod  
Tinna Quigley  
R. Aaron Aist  
Evalyne B. Ward  
Sue Ehlenberger  
Angela Deal  
Louise Hayman  
Lore Rosenthal  
Michael Hartman





Public Hearing - Maryland 1332 State Innovation Waiver  
 Thursday, May 10, 2018  
 Charles County Local Health Department

SIGN-IN SHEET

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NAME	ORGANIZATION	EMAIL	Check if you would like to speak
Bob Morrow	MIA		<input type="checkbox"/>
Louise Hayman	MDH		<input type="checkbox"/>
Lore Rosenthal	self	simplicitygroupsmd@gmail.com	<input checked="" type="checkbox"/>
Michael Hartman	self	michaelhartman23@gmail.com	<input type="checkbox"/>
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***Attachment 5. Actuarial and Economic Analysis Report***





## State of Maryland

### **Section 1332 State Innovation Waiver Actuarial and Economic Analysis**

May 29, 2018

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## Introduction

The individual health insurance market in the state of Maryland (“Maryland”) has shown symptoms of destabilization in recent years. For example, the state experienced rate increases in excess of 40% in 2018. In order to mitigate further potential destabilization, Maryland is submitting a Section 1332 State Innovation Waiver (“1332 waiver” or “waiver”). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Maryland’s 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four “guard rails.” The four guard rails are defined as:

1. Coverage (there must be at least a comparable number of individuals with coverage under the waiver);
2. Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);
3. Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and
4. Deficit neutrality (the waiver should not increase the federal deficit).

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2019. The reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at \$250,000, and coinsurance rate at 80%, and the attachment point will be solved for but is currently estimated to be around \$20,000. The 80% coinsurance rate should encourage insurers to continue to manage the cost of care for high cost members even with the reinsurance program.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, with an assessment equal to 2.75% of all 2019 state-regulated health and Medicaid managed care organization premiums (including the individual ACA-compliant market) and Federal pass-through dollars. Reinsurance funding for the 2019 benefit year is not to exceed approximately \$462 million for the 2019 plan year.

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one insurer as well as to lower premiums for the individual market in total (as most of the reinsurance funding will come from sources outside the individual market). In doing so, the reinsurance program would incentivize enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to residents of Maryland, the reinsurance program would also reduce federal outlays through lower premium tax credits.

As part of its 1332 waiver, Maryland is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Maryland's reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Advance Premium Tax Credits (APTCs) Marylanders receive over the next ten years. APTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of APTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in APTCs will also be reduced.

This report demonstrates that the savings of aggregate APTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather would improve Marylanders access to affordable and comprehensive coverage. The waiver requests that Maryland receive the amount of federal savings from APTCs, net of other costs, as a result of the reinsurance program.

The state of Maryland retained Wakely Consulting Group, LLC (Wakely), through Bolton Partners, to analyze the potential effects of a state-based reinsurance program on the 2019 individual Affordable Care Act (ACA) market. This document has been prepared for the sole use of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Maryland's 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

## Analysis Results

As described previously, the four guard rails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely’s analysis estimated that the waiver meets each of the four guard rails not only in 2019 but in each subsequent year over the 10-year window. The high-level 2019 guard rail results are shown in the following table.

**Table 1: 2019 High-Level Guard Rail Results**

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2019)	Relative premium decrease of 28.5% to 34.4%
Comprehensiveness	No change to EHBs
Deficit Neutrality (2019)	Federal savings between \$262 million and \$364 million

Also, there are no additions to the Federal deficit for any year of the 10-year window.

### Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from Congressional Budget Office (CBO)<sup>1</sup> to the Council of Economic Advisors<sup>2</sup> has noted that premium decreases should result in enrollment increases. As the reinsurance program has no impact on other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

### Deficit Impact

The following tables display the impact of the reinsurance program on Maryland’s individual market both for 2019 and for the 10-year budget window. Based on the best estimate

<sup>1</sup> <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf>

<sup>2</sup> [https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701\\_individual\\_health\\_insurance\\_market\\_cea\\_issue\\_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf)

assumptions, in 2019, the waiver reduces premiums by -30.0%<sup>3</sup>, increases non-group enrollment by 5.8%, and creates \$304 million in federal savings (which incorporates APTC savings net of other federal revenue). Based on the assumption for 2019 premium increases prior to reinsurance and the premium impact as a result of reinsurance, net 2019 premiums are expected to change, relative to 2018, by -16.0%. These results are shown in the following table. The results are similar for years 2020 to 2028 as is shown in Appendix C.

**Table 2: 2019 Impact of Waiver on Premium, Enrollment, and Federal Deficit**

	Premium Impact	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-30.0%	+5.8%	\$304 Million

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in the following table.<sup>4</sup>

**Table 3: 10-Year Deficit Impact of Reinsurance Program**

Category of Impact	Impact to Federal Deficit (\$ millions)
<b>Difference in APTCs</b>	<b>\$791</b>
Difference in Mandate Penalty	\$0
Difference in User Fees	\$0
Difference in HIT	-\$12
<b>Estimated Net Federal Savings</b>	<b>\$779</b>

<sup>3</sup> The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2019. They do not show 2019 premium changes relative to 2018 unless otherwise stated.

<sup>4</sup> Individual mandate penalties were set to \$0 effective for the 2019 benefit year. Issuers that utilize the Healthcare.gov platform are assessed a fee by the Federal government (called a User Fee). This fee is calculated as percent of Exchange premium. This does not apply for Maryland. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. There is a moratorium on the fee in 2019.

## Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Maryland’s individual market both for 2019 and for the 10-year deficit window.

1. Wakely’s model incorporates 2016, 2017, and emerging 2018 experience as base data, which was provided by Maryland insurers.

Wakely sent a data call to all Maryland insurers that offered individual market ACA-compliant plans in 2016, 2017, or 2018. The data call requested full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates. The 2017 and 2018 enrollment and premiums were summarized to create a baseline picture of Maryland’s market. The 2018 enrollment data was adjusted to account for expected attrition to estimate average yearly enrollment. The summarized amounts are shown in the following table.

**Table 4: 2017 to 2019 Baseline Average Enrollment and Premium Data / Estimates**

Baseline	2017	2018	2019
<b>Average Annual Enrollment</b>			
Total Non-Group Enrollment	224,921	190,607	171,526
Exchange Enrollment	130,409	129,047	121,503
APTC Enrollment	99,523	107,039	103,620
Non-APTC Exchange Enrollment	30,886	22,008	17,883
Off-Exchange Enrollment	94,512	61,559	50,023
Total Non-APTC Enrollment	125,398	83,567	67,906
<b>Per Member Per Month (PMPM) Amounts</b>			
Total Non-Group Premium PMPM	\$419.37	\$604.50	\$725.66
Exchange Premium PMPM	\$439.36	\$633.10	\$759.98
Gross Premiums PMPM for APTC Members	\$463.86	\$658.36	\$814.05
Net Premiums PMPM for APTC Members	\$147.14	\$125.57	\$126.83
APTC PMPM	\$316.72	\$532.79	\$687.22
<b>Total Annual Dollars</b>			
Total Non-Group Premiums	\$1,131,897,734	\$1,382,661,373	\$1,493,625,346
Total APTCs	\$378,248,946	\$684,354,798	\$854,516,632

2. The 2019 enrollment, premium, and APTC amounts were estimated using 2017 and February 2018 insurer information submitted to Wakely, as well as 2017 data from the Center for Medicaid and Medicare Services (CMS).
  - a. The 2018 state average premium was based on the February 2018 insurer information. The 2018 average premiums were increased by the average estimated 2019 rate increase, which includes increases to account for trend, mix changes, market morbidity changes, lower premiums due to the delay in the health insurance tax (also known as the health providers fee or the HIT), the assessment to fund reinsurance, and an overall uncertainty factor. Further details are included in Appendix A.
  - b. To estimate the average 2019 APTC amounts, Wakely used the emerging 2018 APTC information from Maryland Health Exchange including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We then inflated gross premiums for APTC enrollees by the estimated 2019 premium increase, but then increased the amounts by 3.0% to account for faster growth in the second-lowest cost silver relative to overall premiums, given emerging 2019 rate information and Maryland Insurance Administration (MIA) feedback. Net premiums were increased by 1% from 2018 to 2019 as an approximation for APTC indexing. The 2019 average gross premium is then reduced by the 2019 average net premium (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts.
  - c. The 2019 individual market enrollment was calculated using 2017 and 2018 data from Maryland insurers. The data was compared to CMS reports to confirm consistency. It was adjusted to account for changes in enrollment due to net attrition throughout 2018 and expected 2019 premium changes, as discussed in Appendix A. APTC enrollment was increased 1% to account for continued up-take of those that are eligible for subsidies but have not yet enrolled.
  - d. Finally, to account for the effective repeal of the individual mandate, enrollment was decreased 10%. This amount aligns with recent survey work by the Kaiser Family Foundation.<sup>5</sup> The proration of how this decrease affected subsidized versus unsubsidized enrollees was calculated using Maryland specific enrollment data. The resulting increase in morbidity was included in the premium estimates. The estimated 2019 information is shown in the following table.

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<sup>5</sup> <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

3. To estimate the effects of the reinsurance program, Wakely assumed that \$462 million dollars would be spent to reduce premiums in 2019. The best estimate assumptions resulted in a reduction in premiums of 30.0% due to the reinsurance program and a resulting change in morbidity.

**Table 5: Projected 2019 Average Enrollment and Premium Amounts, After Reinsurance**

After Reinsurance	
Reinsurance Funding	\$462,000,000
Reduction in Premiums (Reinsurance Funding)	-30.9%
Reinsurance Assessment	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%
Total Non-Group Premium PMPM	\$508.03
Exchange Premium PMPM	\$532.07
APTC PMPM	\$443.09
Change in Total Non-Group Enrollment	5.8%
Total Non-Group Enrollment	181,522
Exchange Enrollment	124,136
APTC Enrollment	103,620
Total Premiums	\$1,106,629,629
Total APTCs	\$550,954,999

4. Enrollment was re-estimated with the lower post-reinsurance premium, using Maryland specific data, input from Maryland’s Insurance Administration, and an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a revised non-group market average enrollment. The initial enrollment change is estimated to be 5.6%.
5. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.
  - a. Multiple studies, such as a health reform study from Massachusetts,<sup>6</sup> indicated

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<sup>6</sup>[https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701\\_individual\\_health\\_insurance\\_market\\_cea\\_issue\\_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf)



that enrollees who leave the market have lower costs relative to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program.

Wakely considered whether Maryland state-specific data could be used to determine the morbidity adjustment. However, there were unique factors in recent years (e.g., issuer exits, cost-sharing reduction (CSR) silver loading, etc.) which caused additional disruption making it difficult to assess what state-specific appropriate morbidity factors would be for future year morbidity shifts from risk pool size change. In an environment of limited data, multiple independent and intervening variables, and the high likelihood of reversion to the mean, Wakely believes pure statistical analysis would have been inappropriate. Instead, we relied on published studies and incorporated qualitative information provided by Maryland, given their expertise, as to expectations of local market conditions and outcomes. Wakely did additional sensitivity analyses for morbidity as well as for other key assumptions, to assure reasonability of the results for Maryland.

- b. The result is an additional 1.4% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program. Applying the additional 1.4% reduction to the 30.9% reduction in premiums (from the \$462 million in reinsurance funding), and the 2.75% assessment, results in an overall premium reduction estimate of 30.0% (under the best estimate scenario). The results of the best estimate can be seen in Table 5.
6. After adjusting the premium impact by the assessment and morbidity impact, Wakely again applied the enrollment function (described in item 4). It resulted in an additional 0.2% increase in enrollment, causing the total enrollment growth from the baseline to be 5.8%. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of this iteration.
7. The following were the assumptions incorporated for the 10-year estimates:
  - a. Premiums were trended using National Health Expenditure Data from CMS.<sup>7</sup> In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.

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<sup>7</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/> - Table 17. Premiums were trended by spending per enrollee for direct purchase.

- b. In 2020, the non-group market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function comparing 2020 premiums to 2019 premiums. Similarly, the 2020 premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase by 0.5% to account for further take-up of those enrollees who are eligible for subsidies but have not yet taken up coverage. In years 2021 and beyond, total enrollment was decreased each year by the expected effects of premium increases as calculated by the CEA take-up function and the corresponding worsening morbidity was incorporated into the premiums.
- c. Reinsurance total funding amounts are \$459 million in 2020 and \$223 million in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond, no reinsurance funds are estimated to be expended. To the extent unexpected funds become available, they would be used in 2022 and / or 2023 (the fourth and fifth years of the program).

The results of these assumptions, such as enrollment (both in total and various distributions), and impact on the federal deficit are discussed in Appendix A and Appendix C.

## Scenario Testing for 2019

Wakely performed scenario testing which primarily involved changing the enrollment and premium assumptions for 2019. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis.

We tested for a scenario (Scenario 2) in which the effective repeal of the individual mandate had a larger impact (which resulted in less enrollment and higher premiums) and a scenario (Scenario 3) in which individual mandate repeal had minimal impact on enrollment and premiums. One of the key differences between scenario 3 and the other scenarios is the difference in morbidity between those exiting the market and those that stay. All other scenarios have a morbidity level in line with CBO's estimated impact while Scenario 3 had a lower morbidity impact, generally in line with morbidity differences identified in research.<sup>8</sup>

Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for

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<sup>8</sup>[https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701\\_individual\\_health\\_insurance\\_market\\_cea\\_issue\\_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf)

subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth and the second lowest cost silver premiums increased at a lower rate than the market premiums.

Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. This scenario also assumes higher premium rate increases.

Finally, we tested a scenario (Scenario 6) that was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound.

Further details regarding the scenario testing can be found in Appendix A and Appendix C.

The high-level results of the scenario testing are shown in the following table. Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

**Table 6: High-Level Results of Scenario Testing**

Scenario	1 – Best Estimate	2	3	4	5	6
Description	Moderate Mandate Impact	Higher Mandate Impact	No Mandate Impact	Scenario 1 with Conservative Assumptions (Overall Low)	Highest Mandate Impact	Highest Mandate Impact (Overall High)
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Total Reduction in Premiums	-30.0%	-30.8%	-28.5%	-31.5%	-34.4%	-31.5%
Estimated Net Federal Savings	\$303,561,634	\$310,462,493	\$291,558,026	\$262,128,430	\$350,271,874	\$363,755,678

## Scenario Testing with Inertia

As discussed above, Wakely performed scenario testing for the ten year projections using the Best Estimate (Scenario 1). One source of uncertainty is the extent to which those that take-up insurance as a result of the reinsurance program may maintain insurance. There is evidence that individuals have a propensity for loss aversion<sup>9</sup> and that upon gaining insurance, individuals have greater proclivities to maintain coverage. This may be especially true in an environment of positive news surrounding reinsurance.

In such a scenario, it is possible enrollees that take-up coverage during the reinsurance program would have a greater propensity for maintaining coverage. Wakely modeled a scenario in which the cohort of enrollees that take-up coverage during the initial years of the reinsurance program have a greater propensity to maintain coverage, creating savings even after the reinsurance program is no longer in effect. Using an illustration of the potential effects of inertia, the 10-year net Federal savings would increase by approximately \$83 million, driven by the proposition that the initial take-up of healthier enrollees results in future years having a larger and healthier risk pool. Maryland requests discussion on whether this approach would be considered for future years of the program, assuming more detailed data and analysis support this concept. Further details can be found in Appendix A.

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<sup>9</sup> Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

# Appendix A

## Data and Methodology

## 2019 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely collected and summarized the 2016 EDGE premium, claims, and enrollment data. The data was compared to CMS reports to confirm consistency. An additional data request was collected from the insurers consisting of full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates.
2. Wakely used the 2017 insurer data to calculate average enrollment and average premium.

Wakely incorporated February 2018 Maryland insurer data for enrollment, including splits by Exchange status and subsidy status. Wakely assumed that overall enrollment had attrition comparable to historical attrition patterns which was then applied by month from February through December. The total attrition, equal to -8.2% when comparing the resulting yearly average enrollment to February data, was applied to all market segments equally to calculate average 2018 enrollment.

Wakely incorporated February 2018 Maryland insurer data and March 2018 Maryland Health Exchange data for the following components: state average premium, average APTC amount, gross premiums for individuals with APTC, and net premium for individuals with APTC. The data was compared to CMS reports to confirm consistency. These amounts were assumed to be consistent with the full year 2018 averages and no attrition adjustments were made to the data.

3. For the best estimate, overall enrollment in 2019 was estimated using 2018 enrollment in conjunctions with the Kaiser Family Foundation survey data to estimate the size of the enrollment drop. APTC enrollment was first increased by 1% relative to 2018 to account further take-up among eligible for APTC but have not yet done so. Then overall enrollment was decreased by 10% to account for the effect for the mandate repeal.<sup>10</sup> It was assumed that individuals that would drop due to premium increases were the same group of people that would drop due to the mandate repeal. The proportion of individuals who are subsidized that dropped was set equal to proportion of non-group enrollees individuals who have incomes between 250% FPL and 400% FPL relative all non-group enrollees above 250% FPL.
4. For 2019, premiums were estimated using the 2018 insurer submitted data. The average 2018 premium was increased by 20% to account for all rating factors such as trend, metal

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<sup>10</sup> <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

level mix changes, insurer uncertainty, change in morbidity, and to account for the health insurance tax delay for the 2019 benefit year.

5. To estimate 2019 APTC PMPMs, we used 2018 Maryland insurer data to calculate the average net premium among APTC enrollees (that is, the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) 1% to conform with the indexing of the contribution rate. We then inflated gross premiums for APTC enrollees (the 2018 APTC amounts plus net premiums) by the 2019 estimated premium increase (20%) and also increased them by 3.0% due to faster growth in the SLCSF relative to overall premiums to account for emerging 2019 rate information. The 3.0% was calculated using regional estimates of the rate change of the SLCSF relative to the average premium increases, which were provided by the state of Maryland. This new gross premium amount is reduced by the net premium amount (since APTC enrollees' share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

## 2019 Waiver Effects

The impact of the \$462 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount by the total estimated 2019 baseline non-group market. This resulted in an approximate 30.9% reduction to premiums. In addition, an adjustment was made to account for younger, healthier members remaining covered due to the implementation of the reinsurance program. This reduced premium another 1.4%. Finally, premiums were adjusted to account for the assessment. The premium adjustments due to reinsurance were made equally to gross premiums for individuals with APTC (to calculate APTC), on-Exchange premiums, and off-Exchange premiums. The total aggregate reduction of premiums was 30.0%.

The decrease in premiums is expected to produce an increase in enrollment relative to what Maryland would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function and compared to other data sources (incorporating actuarial judgement) to assess for reasonability within Maryland-specific context (as discussed previously). APTC enrollment is assumed to stay the same as the baseline estimates since these members are generally unaffected by rate changes.<sup>11</sup> Consequently, the new enrollees are

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<sup>11</sup> This assumption does not preclude normal churn that occurs within the non-group market. Normal churn, including enrollees leaving for employer-sponsored insurance or enrollees joining the non-group market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2019 as had coverage in 2018.



expected to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and / or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.<sup>12</sup> These results were discussed previously and are shown in Table 5.

## Alternative Scenarios for 2019

Wakely estimated five additional 2019 scenarios to analyze the robustness of the initial 2019 findings. The following were the enrollment scenarios that were modeled, as they compare to Scenario 1, as discussed previously.

- Scenario 2 shows the impact if the effective repeal of the individual mandate had a larger impact (which results in less enrollment and higher premiums). In this scenario, we estimated that the national attrition rate would be 10% but that Maryland, because of its demographic and economic characteristics, was more susceptible to the effects of the effective mandate repeal than the national average. We further assumed that individuals dropping coverage would be more expensive on average than those that remained. Finally, we assumed that the SLCP would grow 3.0% faster than the rate of premium growth.
- Scenario 3 was modeled to reflect the scenario in which individual mandate repeal had minimal impact on enrollment and premiums. In this scenario, enrollment decreases relative to 2018 entirely as a function of premium increases as projected by the CEA take-up function. Additionally, morbidity difference for those exiting the market was lower in this scenario than the other scenarios. This scenario also assumed the SLCP would grow 3.0% faster than the rate of premium growth.
- Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth at 15% and the second lowest cost silver premiums increased 5% slower than average premium.
- Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. CBO estimates for national projected enrollment losses were applied to Maryland, in which Maryland was assumed to have worse than the

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<sup>12</sup><https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/>

national average experience in enrollment losses. This scenario also assumes higher premium rate increases (30%) compared to Scenario 1. The SLCP was adjusted to grow 3.0% faster than state average premium.

- Scenario 6 was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound. In this scenario, premiums were expected to grow at 40% and the SLCP was adjusted to grow 5.0% faster than state average premium. APTC enrollment was expected to be 5% higher than Scenario 5.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: \$462 million in reinsurance funding was applied to the non-group market and enrollment was re-estimated using the CEA take-up function. Each scenario produced a decrease in the state average premiums PMPM in 2019 between 28.5% and 34.4%. In each scenario, the lower premiums resulted in more enrollees in the non-group market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars being spent in 2019 as a result of the reinsurance program. The detailed results of the scenario testing are shown in the following table.

Scenario 1 is the best estimate scenario including reactive enrollment and premiums to match Maryland's recommended premium increases. This scenario was used for the 10-year economic analysis.

**Table 7: Summary of Alternative Scenario Results for 2019**

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
<b>Baseline</b>						
Total Non-Group Enrollment	171,526	164,989	185,857	171,546	138,619	139,348
Exchange Enrollment	121,503	118,458	128,585	116,143	107,436	109,915
APTC Enrollment	103,620	101,823	108,110	96,336	96,287	99,392
Total Non-Group Premium PMPM	\$725.66	\$735.62	\$702.78	\$695.14	\$785.88	\$846.27
Exchange Premium PMPM	\$759.98	\$770.42	\$736.03	\$728.03	\$823.06	\$886.31
APTC PMPM	\$687.22	\$698.40	\$661.56	\$592.40	\$754.78	\$840.93
Total Non-Group Premiums	\$1,493,625,346	\$1,456,435,659	\$1,567,400,734	\$1,430,988,776	\$1,307,254,646	\$1,415,114,944
Total APTCs	\$854,516,632	\$853,358,609	\$858,253,567	\$684,829,540	\$872,108,491	\$1,002,985,000
<b>After Reinsurance</b>						
Reinsurance Funding	\$462,000,000	\$462,000,000	\$462,000,000	\$462,000,000	\$462,000,000	\$462,000,000
Reduction in Premiums (Reinsurance Funding)	-30.9%	-31.7%	-29.5%	-32.3%	-35.3%	-32.6%
Reinsurance Assessment	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-1.4%	-1.7%	-1.3%	-1.1%
Total Premium Impact	-30.0%	-30.8%	-28.5%	-31.5%	-34.4%	-31.5%
Total Non-Group Premium PMPM	\$508.03	\$509.12	\$502.44	\$475.99	\$515.65	\$579.57

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Exchange Premium PMPM	\$532.07	\$533.21	\$526.21	\$498.50	\$540.04	\$606.99
APTC PMPM	\$443.09	\$444.31	\$436.82	\$365.65	\$451.63	\$535.95
Percent Change in Total Enrollment	5.8%	5.8%	5.8%	6.9%	5.3%	4.5%
Total Non-Group Enrollment	181,522	174,587	196,625	183,369	145,967	145,551
Exchange Enrollment	124,136	120,986	131,421	119,256	109,371	111,548
APTC Enrollment	103,620	101,823	108,110	96,336	96,287	99,392
Total Premiums	\$1,106,629,629	\$1,066,640,334	\$1,185,518,554	\$1,047,373,717	\$903,210,853	\$1,012,287,098
Total APTCs	\$550,954,999	\$542,896,117	\$566,695,541	\$422,701,111	\$521,836,618	\$639,229,322
<b>Savings</b>						
Estimated APTC Savings	\$303,561,634	\$310,462,493	\$291,558,026	\$262,128,430	\$350,271,874	\$363,755,678
Estimated Net Federal Savings	\$303,561,634	\$310,462,493	\$291,558,026	\$262,128,430	\$350,271,874	\$363,755,678
Estimated Pass Through	65.7%	67.2%	63.1%	56.7%	75.8%	78.7%

## Beyond 2019

For years beyond 2019, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as Gross Premium Amounts for individuals with APTC were trended by the Office of the Actuaries' National Health Expenditure projections for each year of the 10-year window.<sup>13</sup>
- APTC Net Premiums were increased 1% annually to account for indexing.
- In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.
- In 2020 and beyond, the non-group market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function based on the pre-reinsurance premium growth each year. Similarly, the premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase 0.5% in 2020 only to account for further take-up of those enrollees eligible for subsidies that have not yet taken up coverage.
- Reinsurance or total funding amounts are \$459 million in 2020 and \$223 million in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond no reinsurance funds are estimated to be expended. To the extent unexpected funds are available they would be used in 2022 and / or 2023 (the fourth and fifth years of the program).

For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2019. The detailed results are shown in the following table.

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<sup>13</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/> Table 17. Premiums were trended by spending per enrollee for direct purchase.

**Table 8: Baseline Data and Detailed Results after Reinsurance, by Year<sup>14</sup>**

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
<b>Baseline</b>										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$725.66	\$776.34	\$816.00	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Gross Premium PMPM for APTC Mbrs	\$814.05	\$870.90	\$915.40	\$963.10	\$1,012.26	\$1,063.90	\$1,117.04	\$1,173.81	\$1,233.44	\$1,296.07
Net Premium PMPM for APTC Mbrs	\$126.83	\$128.09	\$129.37	\$130.67	\$131.98	\$133.30	\$134.63	\$135.97	\$137.33	\$138.71
APTC PMPM	\$687.22	\$742.81	\$786.02	\$832.43	\$880.28	\$930.60	\$982.42	\$1,037.84	\$1,096.11	\$1,157.36
Total Premiums	\$1,493,625,346	\$1,581,638,554	\$1,650,194,003	\$1,723,288,558	\$1,798,214,776	\$1,876,517,192	\$1,956,686,587	\$2,041,894,570	\$2,130,944,926	\$2,224,015,748
Total APTCs	\$854,516,632	\$928,250,717	\$982,254,331	\$1,040,247,966	\$1,100,046,253	\$1,162,932,958	\$1,227,678,659	\$1,296,938,368	\$1,369,751,587	\$1,446,296,235
<b>After Reinsurance</b>										
Reinsurance Funding	\$462,000,000	\$459,000,000	\$223,000,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reduction in Premiums (Reinsurance Funding)	-30.9%	-29.0%	-13.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reinsurance Assessment	2.75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Non- Group Premium PMPM	\$508.03	\$543.36	\$701.55	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34

<sup>14</sup> Please see Appendix C for total federal savings net of federal losses under the reinsurance program.

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
APTC PMPM	\$443.09	\$481.45	\$657.63	\$832.43	\$880.28	\$930.60	\$982.42	\$1,037.84	\$1,096.11	\$1,157.36
Change in Total Non-Group Enrollment	5.8%	5.7%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Non-Group Enrollment	181,522	179,439	172,468	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Premiums	\$1,106,629,629	\$1,169,998,256	\$1,451,933,124	\$1,723,288,558	\$1,798,214,776	\$1,876,517,192	\$1,956,686,587	\$2,041,894,570	\$2,130,944,926	\$2,224,015,748
Total APTCs	\$550,954,999	\$601,644,964	\$821,807,384	\$1,040,247,966	\$1,100,046,253	\$1,162,932,958	\$1,227,678,659	\$1,296,938,368	\$1,369,751,587	\$1,446,296,235
<b>Savings</b>										
Estimated APTC Savings	\$303,561,634	\$326,605,753	\$160,446,948	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Estimated Net Federal Savings	\$303,561,634	\$318,784,587	\$156,679,991	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Estimated Pass Through	65.7%	69.5%	70.3%	0%	0%	0%	0%	0%	0%	0%

## Inertia Scenario

One additional potential scenario is that the initial increases in enrollment due to the reinsurance funds will provide longer term improvements to the risk pool. Long standing research by Tversky and Kahneman<sup>15</sup> have shown that individuals tend to be more loss averse. In other words, individuals often have diminishing values associated with gains but increasing sensitivities to losses. Handel<sup>16</sup> finds that loss aversion extends to how individuals value insurance. While the study is focused on the employer market, not the non-group market, the basic precepts may hold. Individuals, upon obtaining insurance, may be less likely to drop coverage. In such an event, there may be additional benefits to the risk pool over the long term if individuals have higher risk aversion and that those that stay in the risk pool are on average healthier.

Wakely does note that the non-group market has long been characterized by churn.<sup>17</sup> As a result, individuals associated with the non-group market may exit non-group market coverage, for other forms of coverage, which would reduce inertia influences in the non-group market relative to other forms of coverage. Furthermore, individuals that remaining in coverage could have different morbidity than the average of those who initially joined. In such an instance, the effects of risk pool improvement may be negated.

Nonetheless, the following table illustrates that if individuals have higher risk aversion of coverage loss and that there is no risk selection among those who remain, there could be long term risk pool improvements. This scenario uses the Best Estimate (Scenario 1) for 2019 and adjusted the out-year estimates. This analysis was done by assuming that enrollees who take up coverage due to lower premiums from the reinsurance program are more likely to maintain coverage over multiple years.

This inertia effect was estimated using Maryland Health Benefit Exchange specific enrollment data. Inertia was measured using multiple data points, including the number people who had coverage in both 2017 and 2018, the number people who had coverage in both 2016 and 2017, and the number of enrollees that were passively enrolled in 2017 and 2018 and maintained coverage through April of that year. The data points served as ranges for possible inertia rates,

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<sup>15</sup> Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

<sup>16</sup> Handel, Benjamin (2011) "Adverse Selection and Switching Costs in Health Insurance Markets: When Nudging Hurts" NBER Working Paper. 17459

<sup>17</sup> Sommers, Ben and Sara Rosenbaum (2011). "Issuers in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges". Health Affairs



recognizing there are other limitations to the data, such as the proportion of subsidy-eligible members. Off-Exchange enrollment inertia was assumed to be the same rate as on-Exchange.

Wakely chose an estimate roughly in the middle of the data points for illustrative purposes. The result is that we assume a continuation rate, or inertia rate, for this cohort of enrollees of 50%. This means that each year, 50% of the new reinsurance cohort maintain coverage. The resulting higher enrollment for the entire risk pool is then adjusted for improved morbidity and then a further adjustment is made for additional enrollment as a result of the lower premiums, using the methodology outlined prior. As noted above, if there is risk selection among those that maintain coverage the effect would be reduced. While more in-depth analysis is needed to identify the long-term potential positive effects of a Maryland-specific reinsurance program on retention/enrollment, below is an example of the potential long-term effects Maryland could experience as a result of a reinsurance program.

**Table 9: Baseline Data and Detailed Results after Reinsurance, by Year (Inertia Scenario)**

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
<b>Baseline</b>										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$725.66	\$776.34	\$816.00	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Gross Premium PMPM for APTC Mbrs	\$814.05	\$870.90	\$915.40	\$963.10	\$1,012.26	\$1,063.90	\$1,117.04	\$1,173.81	\$1,233.44	\$1,296.07
Net Premium PMPM for APTC Mbrs	\$126.83	\$128.09	\$129.37	\$130.67	\$131.98	\$133.30	\$134.63	\$135.97	\$137.33	\$138.71
APTC PMPM	\$687.22	\$742.81	\$786.02	\$832.43	\$880.28	\$930.60	\$982.42	\$1,037.84	\$1,096.11	\$1,157.36
Total Premiums	\$1,493,625,346	\$1,581,638,554	\$1,650,194,003	\$1,723,288,558	\$1,798,214,776	\$1,876,517,192	\$1,956,686,587	\$2,041,894,570	\$2,130,944,926	\$2,224,015,748
Total APTCs	\$854,516,632	\$928,250,717	\$982,254,331	\$1,040,247,966	\$1,100,046,253	\$1,162,932,958	\$1,227,678,659	\$1,296,938,368	\$1,369,751,587	\$1,446,296,235
<b>After Reinsurance</b>										
Reinsurance Funding	\$462,000,000	\$451,000,000	\$287,000,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reduction in Premiums (Reinsurance Funding)	-30.9%	-28.5%	-17.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reinsurance Assessment	2.75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%	-2.1%	-1.8%	-1.0%	-0.5%	-0.3%	-0.1%	-0.1%	0.0%	0.0%
Total Non- Group Premium PMPM	\$508.03	\$543.52	\$661.66	\$849.90	\$897.50	\$945.68	\$994.26	\$1,045.54	\$1,099.06	\$1,155.09
APTC PMPM	\$443.09	\$481.63	\$612.88	\$822.76	\$874.84	\$927.58	\$980.74	\$1,036.92	\$1,095.60	\$1,157.08

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Change in Total Non-Group Enrollment	5.8%	8.7%	7.7%	4.0%	2.1%	1.1%	0.6%	0.3%	0.2%	0.1%
Total Non-Group Enrollment	181,522	184,486	181,445	174,014	169,580	166,715	164,703	163,113	161,763	160,549
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Premiums	\$1,106,629,629	\$1,203,254,918	\$1,440,650,590	\$1,774,739,491	\$1,826,373,325	\$1,891,911,260	\$1,965,087,429	\$2,046,479,986	\$2,133,446,355	\$2,225,379,610
Total APTCs	\$550,954,999	\$601,869,440	\$765,884,961	\$1,028,164,882	\$1,093,252,115	\$1,159,151,104	\$1,225,587,907	\$1,295,785,208	\$1,369,116,839	\$1,445,947,305
<b>Savings</b>										
Estimated APTC Savings	\$303,561,634	\$326,381,277	\$216,369,370	\$12,083,084	\$6,794,138	\$3,781,853	\$2,090,752	\$1,153,160	\$634,748	\$348,930
Estimated Net Federal Savings *	\$303,561,634	\$319,191,988	\$212,388,045	\$12,083,084	\$6,794,138	\$3,781,853	\$2,090,752	\$1,153,160	\$634,748	\$348,930
Estimated Pass Through	65.7%	70.8%	74.0%	0%	0%	0%	0%	0%	0%	0%

\* Estimated Net Federal Savings are lower or equal to the Estimated APTC Savings (that is, any potential savings produced by the offsets are not included).

## **Appendix B**

# **Reinsurance Parameters**

## Reinsurance Parameters

As noted previously, the reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at \$250,000, the coinsurance rate at 80%, and the attachment point is anticipated to be approximately \$20,000. The 80% coinsurance rate should encourage insurers to continue to manage the cost of care for high cost members, even with the reinsurance program.

Wakely used continuance tables provided for the 2017 calendar year from the two remaining insurers in 2018 to estimate the attachment point for the program. In addition, 2016 calendar year continuance tables and 2016 EDGE files served as a cross-check for reasonability and consistency.

To obtain a 2019 continuance table consistent with the best estimate scenario, various adjustments to the data were performed including enrollment, morbidity, and annual claim increases. The following components were considerations in adjusting the 2017 continuance tables, incorporating sources of public data, sensitive / proprietary data, and actuarial judgement.

1. The best estimate scenario enrollment drop of 19.3% from 2017 to 2019 was applied to the data.
2. The morbidity change from 2017 to 2019 was modeled under the assumption that members leaving the market were healthier relative those staying in the market.
3. The claims were increased annually from 2017 to 2019. This annual claim increase includes adjustments outside of trend such as metal mix changes and unit cost shifts.
4. The resulting medical loss ratio in 2019 was reviewed (prior to the impact of the reinsurance program and after the impact of reinsurance) to ensure reasonability.

Enrollment and morbidity were modeled in tandem by removing membership and associated claims from the continuance tables to obtain the projected changes of 19.3% decrease in enrollment and a corresponding increase in morbidity (estimated by an increase in paid claims). This was modeled using an attrition distribution assuming lower cost membership is more likely to terminate coverage than higher cost membership.

In some instances, the trend and / or morbidity was higher than anticipated; however, it was necessary in order to achieve the level of premium increase we understood to be reasonable from Maryland and / or the insurers. The premium levels may be higher than otherwise expected as a

result of uncertainty in the market. Trend and / or morbidity were adjusted similarly to achieve appropriate Medical Loss Ratios (MLRs).

The resulting 2019 continuance table was used to determine the reinsurance parameters. Wakely used a fixed coinsurance rate of 80% and cap \$250,000. Assuming a funding level of \$462,000,000 and the preceding parameters, Wakely estimates that the attachment point will be approximately \$20,000, based on the 2019 estimated data. The attachment point may change if methodology, assumptions, or other changes are incorporated.

It is important to note that the assumptions in this estimate are inherently uncertain. The resulting parameters will vary from these estimates to the degree the actual enrollment, morbidity, trend, and other assumptions vary from those used in this analysis. In addition, if there are significantly more or fewer high cost claimants in 2019 compared to 2016 and 2017, the results from this analysis may also vary. Finally, insurers are expected to have differing impacts from the reinsurance program based on how they vary from the market average in their historical claims and assumptions discussed previously in this section.

## **Appendix C**

# **Guard Rail Requirements**

## Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. We expect enrollment to be greater than or equal to each year relative to what would have occurred if the reinsurance program were not in place in each year of the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least comparable number of enrollees (and most likely a greater number of individuals covered).

## Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be approximately 30% lower in 2019, and lower than or equal to what they otherwise would have been each year of the waiver as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

## Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive of coverage for residents.

## Deficit Neutrality

### **APTCs**

Since APTCs are benchmarked to the SLCSPP, the decrease in premiums (specifically the SLCSPP) will result in lower per person APTC amounts in 2019. Since enrollees who have APTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with APTCs. Due to the combination of a non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to APTC amounts, Wakely's analysis estimates that the overall aggregate amount of APTCs will be lower or equal to what they



otherwise would have been each year over the 10-year window. Wakely further estimates that the total federal savings of APTC expenditures will be \$304 million, \$327 million, and \$160 million in 2019, 2020, and 2021, respectively. APTC savings net of other federal losses will be \$304 million, \$319 million, and \$157 million in 2019, 2020, and 2021, respectively. These results are shown in the following table. Using the inertia scenario, there are additional federal savings in all ten years of the estimates.

**Table 10: Detailed Results of Federal Savings, by Year**

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
<b>Baseline</b>										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	121,503	121,042	120,713	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$725.66	\$776.34	\$816.00	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Exchange Premium PMPM	\$759.98	\$813.06	\$854.60	\$899.14	\$945.03	\$993.24	\$1,042.86	\$1,095.86	\$1,151.52	\$1,209.99
APTC PMPM	\$687.22	\$742.81	\$786.02	\$832.43	\$880.28	\$930.60	\$982.42	\$1,037.84	\$1,096.11	\$1,157.36
<b>After Reinsurance</b>										
Total Non-Group Enrollment	181,522	179,439	172,468	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	124,136	123,587	121,751	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$508.03	\$543.36	\$701.55	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Exchange Premium PMPM	\$532.07	\$569.06	\$734.74	\$899.14	\$945.03	\$993.24	\$1,042.86	\$1,095.86	\$1,151.52	\$1,209.99
APTC PMPM	\$443.09	\$481.45	\$657.63	\$832.43	\$880.28	\$930.60	\$982.42	\$1,037.84	\$1,096.11	\$1,157.36
<b>Federal Savings Calculations</b>										
Exchange User Fees	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HIT	0.0%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
Difference in APTCs	\$303,561,634	\$326,605,753	\$160,446,948	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in Mandate Penalty	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in User Fees	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in HIT	\$0	(\$7,821,166)	(\$3,766,957)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Estimated Net Federal Savings</b>	<b>\$303,561,634</b>	<b>\$318,784,587</b>	<b>\$156,679,991</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Pass Through as a Percent of Total Funding</b>	<b>65.7%</b>	<b>69.5%</b>	<b>70.3%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>

## Offsets to APTC Savings

### INDIVIDUAL RESPONSIBILITY REQUIREMENT

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. However, as part of the Tax Cuts and Jobs Act of 2017, the individual responsibility requirement was set to \$0 for 2019 and future years. Therefore, it will not directly affect federal savings.

### EXCHANGE USER FEE

Given Maryland's status as a State-Based Exchange, Wakely notes that there will not be a loss of revenue to the Federal government for Federally-facilitated Exchange user fees (also known as user fees) due to the reduction in premium amounts.

### HEALTH INSURANCE PROVIDERS FEE

The reinsurance program would also impact the health insurance providers fee, or HIT. Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling \$14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. As part of the Tax Cuts and Jobs Act of 2017, the HIT was suspended for the 2019 benefit year. For years beyond 2019, we estimate that Maryland's reinsurance program will have minimal impact on national premium growth rate. To estimate the decrease in collected fees, Wakely first estimated the baseline collection using the 2018 rate filing information. Weighting the 2018 fee by expected enrollment yielded an estimated HIT amount of 1.9% of premiums. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total HIT (defined as total premiums multiplied by 1.9%) for the baseline and the waiver scenario to arrive at the change in federal costs due to the implementation of the waiver. These estimates are conservative as the losses on Maryland's insurers may be partially or fully captured by taxes on non-Maryland health insurance providers given that statutory construction of the fee.

### OTHER FEDERAL IMPACTS

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac or Excise tax, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.<sup>18</sup>

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<sup>18</sup> <http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf>

## **ADMINISTRATIVE COSTS TO ADMINISTER THE REINSURANCE PROGRAM**

Per the Maryland Health Benefit Exchange (MHBE), the waiver program will have a minor impact on state agency burden. The MHBE will be responsible for administering the program, including administering funds, reviewing and collecting claims information from carriers, paying carriers for eligible claims, ongoing program monitoring, and complying with federal reporting and public comment requirements. The MHBE previously administered a state supplemental reinsurance program for the 2015 and 2016 plan years and can leverage and build upon these pre-existing resources. The MHBE anticipates some additional staff costs for administering the program, including hiring a program manager and IT consultant time. These costs are estimated to be approximately \$434,000 in state fiscal year 2019, \$582,000 in 2020, and \$599,000 in 2021. The MIA may also have minor increased burden related to reviewing and approving carrier rate filings and state health insurance premium tax collection, but this can be absorbed by current staff resources.

The MHBE also requests that CMS consider whether the existing EDGE server infrastructure, utilized in the administration of the risk adjustment program and transitional reinsurance program, can be leveraged to implement the State Reinsurance Program. The MHBE has received feedback from the issuers participating in the non-group market that leveraging the EDGE server would increase program efficiency and reduce downstream administrative burden. Should the request to leverage the EDGE server be approved, the implementation costs of needed modifications to the EDGE server may be paid from the total pass-through funding amount received from waiver approval. It is expected that this would not impact the total funding in the first year of the reinsurance program. Rather Maryland would keep the total funding the same and any reduction would affect the total funding in the final year of the reinsurance program.

### **EMPLOYER MARKETS**

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

### **DEFICIT NEUTRALITY IN ALTERNATIVE SCENARIOS**

In addition, Wakely calculated the impact of the federal savings under the alternative 2019 scenarios discussed previously. As can be seen previously in Table 7, there was no 2019 scenario in which net federal savings, as a result of the reinsurance program, was less than \$262 million.

## **Appendix D**

# **5 and 10 year Projections**

The following tables show various information over the 10-year deficit period, as required under the CMS checklist. The second lowest cost silver for each rating area was calculated using a weighted average of each county’s Exchange enrollment for 2017. Future year increases aligned with the methodology outlined for the 10-year best estimate.

**Table 11A: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by Rating Area and Year**

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
<b>Baseline</b>											
1	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
2	\$587	\$687	\$735	\$772	\$812	\$854	\$897	\$942	\$990	\$1,040	\$1,093
3	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
4	\$501	\$598	\$640	\$672	\$707	\$744	\$782	\$821	\$862	\$906	\$952
<b>After Reinsurance</b>											
1		\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709
2		\$481	\$514	\$664	\$812	\$854	\$897	\$942	\$990	\$1,040	\$1,093
3		\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709
4		\$419	\$448	\$578	\$707	\$744	\$782	\$821	\$862	\$906	\$952

**Table 11B: Second Lowest Cost Silver Plan Premium PMPM, with and without Reinsurance, by County and Year**

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
<b>Baseline</b>											
Allegany	\$615	\$735	\$786	\$826	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170
Anne Arundel	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Baltimore	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Baltimore City	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Calvert	\$484	\$567	\$607	\$638	\$671	\$705	\$741	\$778	\$818	\$859	\$903
Caroline	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Carroll	\$353	\$422	\$452	\$475	\$499	\$525	\$552	\$579	\$609	\$640	\$672
Cecil	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Charles	\$484	\$567	\$607	\$638	\$671	\$705	\$741	\$778	\$818	\$859	\$903
Dorchester	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Frederick	\$484	\$579	\$619	\$651	\$685	\$719	\$756	\$794	\$834	\$877	\$921
Garrett	\$615	\$735	\$786	\$826	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170
Harford	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Howard	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Kent	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Montgomery	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Prince George's	\$353	\$446	\$477	\$501	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Queen Anne's	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Somerset	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
St. Mary's	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Talbot	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Washington	\$615	\$735	\$786	\$826	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170
Wicomico	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
Worcester	\$615	\$720	\$770	\$810	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147
<b>After Reinsurance</b>											
Allegany		\$515	\$550	\$711	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170
Anne Arundel		\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Baltimore		\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709
Baltimore City		\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709

Rating Area	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Calvert	\$397	\$425	\$548	\$671	\$705	\$741	\$778	\$818	\$859	\$903	\$903
Caroline	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Carroll	\$296	\$316	\$408	\$499	\$525	\$552	\$579	\$609	\$640	\$672	\$672
Cecil	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Charles	\$397	\$425	\$548	\$671	\$705	\$741	\$778	\$818	\$859	\$903	\$903
Dorchester	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Frederick	\$405	\$433	\$559	\$685	\$719	\$756	\$794	\$834	\$877	\$921	\$921
Garrett	\$515	\$550	\$711	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170	\$1,170
Harford	\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709	\$709
Howard	\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709	\$709
Kent	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Montgomery	\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709	\$709
Prince George's	\$312	\$334	\$431	\$527	\$554	\$582	\$611	\$642	\$675	\$709	\$709
Queen Anne's	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Somerset	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
St. Mary's	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Talbot	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Washington	\$515	\$550	\$711	\$870	\$914	\$961	\$1,009	\$1,060	\$1,114	\$1,170	\$1,170
Wicomico	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147
Worcester	\$504	\$539	\$696	\$852	\$896	\$941	\$988	\$1,038	\$1,091	\$1,147	\$1,147



**Table 12: Projected Enrollment by FPL, with and without Reinsurance, by Year**

	2018	2019	2020	2021	2022	2023
<b>Baseline</b>						
Total Non-Group Enrollment	190,607	171,526	169,776	168,525	167,273	166,069
Total Non-Group APTC Eligible	107,039	103,620	104,138	104,138	104,138	104,138
<100% of FPL	14,493	13,042	12,909	12,909	12,909	12,909
≥100% to ≤150% of FPL	19,416	18,795	18,889	18,889	18,889	18,889
>150% to ≤200% of FPL	35,641	34,502	34,675	34,675	34,675	34,675
>200% to ≤250% of FPL	23,033	22,297	22,409	22,409	22,409	22,409
>250% to ≤300% of FPL	13,079	12,661	12,724	12,724	12,724	12,724
>300% to ≤400% of FPL	15,871	15,364	15,441	15,441	15,441	15,441
>400% of FPL	69,075	54,864	52,729	51,478	50,226	49,022
<b>After Reinsurance</b>						
Total Non-Group Enrollment		181,522	179,439	172,468	167,273	166,069
Total Non-Group APTC Eligible		103,620	104,138	104,138	104,138	104,138
<100% of FPL		13,042	12,909	12,909	12,909	12,909
≥100% to ≤150% of FPL		18,795	18,889	18,889	18,889	18,889
>150% to ≤200% of FPL		34,502	34,675	34,675	34,675	34,675
>200% to ≤250% of FPL		22,297	22,409	22,409	22,409	22,409
>250% to ≤300% of FPL		12,661	12,724	12,724	12,724	12,724
>300% to ≤400% of FPL		15,364	15,441	15,441	15,441	15,441
>400% of FPL		64,860	62,393	55,421	50,226	49,022

**Table 13: Projected Enrollment by Metal Level with and without Reinsurance, by Year**

	2018	2019	2020	2021	2022	2023
<b>Baseline</b>						
Total Non-Group Enrollment	190,607	171,526	169,776	168,525	167,273	166,069
Catastrophic	7,430	6,687	6,618	6,570	6,521	6,474
Bronze	48,230	43,402	42,959	42,643	42,326	42,021
Silver	94,635	85,161	84,293	83,671	83,050	82,452
Gold	38,898	35,004	34,647	34,392	34,136	33,891
Platinum	1,413	1,271	1,258	1,249	1,240	1,231
<b>After Reinsurance</b>						
Total Non-Group Enrollment		181,522	179,439	172,468	167,273	166,069
Catastrophic		6,687	6,618	6,570	6,521	6,474
Bronze		46,947	46,386	44,041	42,326	42,021
Silver		89,271	88,265	85,292	83,050	82,452
Gold		37,264	36,832	35,283	34,136	33,891
Platinum		1,353	1,338	1,281	1,240	1,231

## **Appendix E**

# **Reliances and Caveats**

The following is a list of the data Wakely relied on for the analysis:

- Insurer submitted premium and enrollment information by metal and exchange status for 2017 and January/February/March 2018 (one insurer did not submit March data)
- Insurer submitted APTC information, including enrollment and premiums, for January/February/March 2018
- Insurer submitted paid claim continuance tables for 2016 and 2017
- A complete set of 2016 EDGE Server XML data was collected from the primary insurers in the non-group market, including:
  - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each insurer to the EDGE Server
  - The corresponding response files that apply an accept/reject status to the claims in the inbound files
  - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports
- The June 30th Risk Adjustment and Reinsurance Report for the 2016 benefit year produced by CMS<sup>19</sup>
- The 2016 , 2017, and 2018 Open Enrollment Report PUF produced by HHS<sup>20 21 22</sup>
- Effectuated Enrollment Reports released by CMS<sup>23</sup>

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<sup>19</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>

<sup>20</sup> <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

<sup>21</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan\\_Selection\\_ZIP.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html)

<sup>22</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018\\_Open\\_Enrollment.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html)

<sup>23</sup> <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

- Kaiser Family Foundation Survey<sup>24</sup>
- CBO Analysis on Impact of Repeal of the Mandate<sup>25</sup>
- OACT Analysis on Impact of Repeal of the Mandate<sup>26 27</sup>
- Inertia analysis including research on Prospect Theory and Loss Aversion,<sup>28 29 30 31</sup> research on Individual Market Churn,<sup>32</sup> data from Maryland’s Health Benefit Exchange on churn rate, and actuarial judgement
- Additional data and feedback from Maryland’s insurers, Maryland Insurance Administration, and the Maryland Health Benefit Exchange. This includes 2018 enrollment, premium data, and the second lowest cost silver plan estimates.
  - In particular, Wakely relied on Maryland calculation on the increase of the SLCSP relative to overall premiums

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Maryland for reasonability.

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<sup>24</sup> <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

<sup>25</sup> <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>

<sup>26</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf>

<sup>27</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf>

<sup>28</sup> Kahneman, Daniel and Amos Tversky (1979) Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, Vol 47 No 2.

<sup>29</sup> [https://www.worldscientific.com/doi/abs/10.1142/9789814417358\\_0006](https://www.worldscientific.com/doi/abs/10.1142/9789814417358_0006)

<sup>30</sup> <https://link.springer.com/article/10.1007/BF00122574>

<sup>31</sup> Handel, Benjamin (2011) “Adverse Selection and Switching Costs in Health Insurance Markets: When Nudging Hurts” NBER Working Paper. 17459

<sup>32</sup> Sommers, Ben and Sara Rosenbaum (2011). “Issuers in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges”. Health Affairs

The following are additional reliances and caveats that could have an impact on results:

- **Data Limitations.** Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering non-group market ACA-compliant plans. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.
- **Political Uncertainty.** There is significant policy uncertainty. Future federal actions or requirements in regards to short-term duration plans, association health plans, reinsurance funds, income verification, and / or CSR payments could dramatically change premiums and enrollment in 2019 or future years. In particular, CSR funding or changes to rules about how CSR requirements are accounted for in premium (i.e., “silver-loading”) could dramatically decrease the pass-through percentage relative to what was estimated in this report.
- **Enrollment Uncertainty.** Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. This includes implementation of new income verification policy as encapsulated in the 2019 Notice of Benefit and Payment Parameters, which could influence APTC enrollment. All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Premium Uncertainty.** Given that several regulations (association plans, short-term duration plans, etc.) have not been finalized, there is uncertainty in how insurers may respond in their 2019 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Pass-Through Uncertainty.** Ultimately, the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely’s models, differences in the pass-through amounts are possible.
- **Reinsurance Operations.** If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely’s analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results. Furthermore, if less than amount specified is spent, for example because some funds are used for reinsurance operations, then effects may be different.

## **Appendix F**

# **Disclosures and Limitations**

**Responsible Actuary.** Julie Peper and Danielle Hilson are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

**Intended Users.** This information has been prepared for the sole use of the management of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

**Risks and Uncertainties.** The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Wakely used conservative pass-through assumptions. The extent to which the enrollment experience for 2018 or 2019 is different than expected could affect results. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Maryland will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

**Conflict of Interest.** The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Maryland.

**Data and Reliance.** We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

**Subsequent Events.** These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2018 experiences. Change in emerging 2018 enrollment and experience could impact the results. Additional changes in regulations (e.g., association health plans, short-term limited duration plans) could impact findings. For example, since neither of the proposed regulations on these topics have been finalized, they were not included in the analysis.

**Contents of Actuarial Report.** This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.



**Deviations from ASOPs.** Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

***Addendum to the Maryland 1332 State Innovation Waiver Application  
to Establish a State Reinsurance Program.***



# **Addendum to the Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program**

**Maryland Health Benefit Exchange  
August 4, 2018**

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## Addendum Overview

The Maryland Health Benefit Exchange (“MHBE”) respectfully submits this Addendum to the Maryland 1332 State Innovation Waiver to Establish a State Reinsurance Program (“Addendum”) to the United States Department of the Treasury and the United States Department of Health and Human Services. This Addendum provides application reviewers an update on the state action taken to address public concern received during the 30-day state public comment period.

Several commenters cautioned the MHBE on the potential for duplicative payments under both the Federal Risk Adjustment and State Reinsurance Program for the same risk. During an MHBE Board of Trustees session on May 21, 2018, the MHBE Board resolved to potentially take regulatory action to address the interaction between the Federal Risk Adjustment and State Reinsurance Programs based on analysis of the issue that would be performed by the Wakely Consulting Group (“Wakely”), the same actuarial firm that performed the actuarial and economic analysis for Maryland’s waiver application.<sup>1</sup>

Wakely submitted a model of the interaction between the Federal Risk Adjustment and Reinsurance programs to the MHBE on June 30, 2018.<sup>2</sup> The model identified a material degree of interaction between the two programs for enrollees with greater than \$20,000 in claims, which is the estimated attachment point for the State Reinsurance Program in 2019. The degree of interaction was indicated through an estimated -1.57 claims to premiums ratio, meaning that issuers might receive payments under both programs that are greater than the enrollee claims experience by 157% of premium. Wakely estimated that Risk Adjustment payments would need to be reduced by 30% (a .70 dampening factor) to remove this interaction.

The Maryland Insurance Administration (“MIA”) performed its own analysis of the issue and is in agreement with Wakely that there is interaction between the Federal Risk Adjustment and State Reinsurance Programs for enrollees with a claims experience above \$20,000. The MIA estimates that Risk Adjustment payments would need to be reduced by 16.5% (a .835 dampening factor) to normalize the claims to premiums ratio between risk adjustment payers (generally healthier enrollees who “pay” into the risk adjustment program) and receivers (generally sicker enrollees who “receive” from the risk adjustment program).

At the July 16, 2018 session, in a joint presentation before the MHBE Board of Trustees, the MHBE and the MIA presented the findings of the analyses performed by both Wakely and the MIA.<sup>3</sup> At the session, the MHBE Board approved a recommendation that MHBE Staff take action to account and adjust for any potential duplication in payments from both risk adjustment and reinsurance through regulation for the State Reinsurance Program.<sup>4</sup>

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<sup>1</sup>The MHBE Board of Trustees resolution from the May session was included in the May 31, 2018 waiver application submission.

<sup>2</sup>The methodology utilized for the 2019 model is included in this Addendum as Attachment 2.

<sup>3</sup> The joint presentation is included in this Addendum as Attachment 3.

<sup>4</sup> The motion approved by the MHBE Board of Trustees is included in this Addendum as Attachment 4.

The MHBE Board of Trustees was not prescriptive of the degree of adjustments to reinsurance payments, to account for the determined risk adjustment premium reduction, to allow for additional public input through the regulatory process for the State Reinsurance Program. The MHBE Board agreed to rejoin on August 20, 2018, after the public hearing on Federal Risk Adjustment/State Reinsurance Program on August 2, 2018, to determine a final adjustment factor for 2019.<sup>5</sup>

It is important to stress that any Maryland action to address the Federal Risk Adjustment/State Reinsurance Program interaction (1) will not affect the estimated 30% reduction in average premiums the State Reinsurance Program would have; (2) will not adversely impact any of the guardrails detailed in Section 1332 of the Affordable Care Act; and (3) does not impact the findings of the actuarial and economic analysis submitted in the Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program on May 31, 2018.

Accordingly, Maryland does not believe that any analysis submitted as a part of the waiver application on May 31, 2018 needs to be revisited.

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<sup>5</sup> The MHBE Board of Trustees minutes for the July 16, 2018 session are included in this Addendum as Attachment 5.

## I. Summary of the Maryland 1332 Waiver Request

On May 31, 2018, the MHBE submitted a 1332 state innovation waiver application to the United States Department of the Treasury and the United States Department of Health and Human Services. In the submission, Maryland requested to waive Section 1312(c)(1) of the Affordable Care Act (“ACA”) for a period of five years (2019 through 2023) to implement a state reinsurance program.

The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, which will decrease premiums and federal payment of advance premium tax credits (“APTCs”). The waiver will not affect any other ACA provisions and does not adversely impact any of the guardrails detailed in Section 1332.

Maryland estimates that the state reinsurance program would reduce average premiums by approximately 30% in 2019 from what they would be absent the waiver. This premium reduction is projected to result in an increase in individual market enrollment by 5.8% in 2019 and federal savings of \$302 million. The actuarial analyses estimates federal savings of \$325 million and \$148 million in 2020 and 2021, respectively.

**Table 1. Potential Impact of the Maryland Reinsurance Waiver on 2019 Premiums, Enrollment, and Federal Deficit.**

	<b>Premium Impact</b>	<b>Non-Group Enrollment</b>	<b>Federal Savings</b>
Effects of Reinsurance	-30.0%	+5.8%	\$302 million

## II. Summary of Public Comment on Federal Risk Adjustment and State Reinsurance Program Interaction

The MHBE received a robust and comprehensive response during the state public comment period (April 20, 2018 – May 20, 2018) for the waiver application. While each of the respondents expressed support to establish the State Reinsurance Program through the waiver, many also expressed concern on the potential for interaction between the Federal Risk Adjustment and State Reinsurance Programs.

Respondents, including an issuer, consumer advocate organizations, the state medical society, a Maryland state senator, and other advocacy groups, cautioned that such an interaction could have a distortive impact on the marketplace where members with the highest claims/risk would also be the most profitable, creating a disincentive for issuers to broaden the risk pool to attract healthier enrollees. In contrast, another issuer participating in the marketplace cautioned against consideration of duplicative payments as, at the federal level, the Risk Adjustment and Transitional Reinsurance Programs were intended to address different issues. Both issuer respondents concurred that the concern warranted additional study and urged the MHBE to take action.

Several respondents, including an issuer, the state medical society, and the state hospital association, also urged the MHBE to express the State’s intent to explore the program interaction issue in the waiver application.

### **III. MHBE Response on Federal Risk Adjustment and State Reinsurance Program Interaction**

In response to the public concern on the potential interaction between the Federal Risk Adjustment and State Reinsurance Program, the MHBE commissioned Wakely (the same firm that delivered the actuarial and economic analysis for Maryland’s waiver application) to provide analysis on the issue. Further, at the May 21, 2018 MHBE Board of Trustees session, the Board resolved to consider regulatory action based on the outcome of the analysis. In response to the Board’s action, the MHBE modified the waiver application to reflect the MHBE’s consideration of the potential program interaction, and noted that the MHBE would provide waiver application reviewers with the analysis. Wakely supplied the MHBE with the program interaction analysis on June 30, 2018.

This section discusses the outcomes of the program interaction analysis, and the action the MHBE has taken, and will take, to address stakeholder concerns on the issue.

#### ***Federal Risk Adjustment and State Reinsurance Program Interaction Analysis***

As a first step to model the interaction between the Federal Risk Adjustment and State Reinsurance Program, Wakely projected 2017 issuer EDGE server data into an estimated 2019 enrollee population. Wakely then applied three scenarios to the estimated 2019 population:

1. 2019 Federal Risk Adjustment only (RA);
2. 2019 Federal Risk Adjustment and State Reinsurance Program (RA + RI); and
3. Dampened 2019 Federal Risk Adjustment and State Reinsurance Program (*d*RA + RI);

It is important to note that Wakely’s assumptions match those utilized in the submitted waiver application as closely as possible. These include premium increases, enrollee attrition, morbidity changes, etc. Additional information on the assumptions and methodology Wakely utilized for the analysis can be found in Attachment 2.

Wakely utilized claims to premium ratios as the indicator for the analysis. With the inclusion of the premium stabilization programs, the claims to premium ratio (CPR) equation is modified as below:

$$CPR = \frac{Claims - (RA + RI)}{Premium}$$

Where RA means “Risk Adjustment” and RI means “Reinsurance.”



Table 2 below details the results of Wakely’s analysis.

**Table 2. Estimated 2019 CPRs for RA, RA +RI, and  $dRA + RI$  Scenarios for the Estimated 2019 Enrollee Population with a Greater than \$20,000 Claims Experience.<sup>6</sup>**

Claims Experience	RA	RA + RI	$dRA + RI$ ( $d = .64$ )
Above \$20,000	1.05	-1.57	.56

The claims experience category highlighted in Table 2 reflects the population whose claims would be eligible for payments under the estimated parameters for the State Reinsurance Program.<sup>7</sup> With a MLR of -1.57, the Risk Adjustment and State Reinsurance Program scenario is estimated to result in issuers receiving payments under both programs that is much greater than the costs incurred by claims. The degree to which issuers are estimated to receive payments under both programs, as evidenced by the -1.57 MLR, indicate material program interaction.

Wakely modeled several scenarios for a dampening of risk adjustment program payments to calibrate for the degree of overlap ( $dRA + RI$ ). Wakely determined that a .64 dampening factor in the Risk Adjustment payment would produce the minimal variation among cost categories based on the assumptions used in the analysis. Additionally, this degree of dampening would prevent potential for overpayment received by issuers under the Risk Adjustment and State Reinsurance Program.

The MIA also performed analysis on program interaction in parallel with the Wakely analysis. The MIA concurred with Wakely’s finding that there is program interaction. In contrast to the .64 dampening factor (36% reduction) to Federal Risk Adjustment payments determined by Wakely, the MIA recommended that a dampening factor of .835 (16.5% reduction) be utilized to coordinate the interaction with the State Reinsurance Program. The MIA noted that this dampening factor would (1) not eliminate overpayment for the above \$20,000 in claims population, but would (2) normalize claims to premiums ratios for Risk Adjustment “payers” and “receivers.” While the basis for the MIA’s recommendation is for a different policy outcome, the concurrence with Wakely on the program interaction adds confidence to Wakely’s finding. Additional information on the analysis performed by the MIA on program interaction is included in Attachment 8.

### ***State Action to Address Federal Risk Adjustment and State Reinsurance Program Interaction***

The findings of Wakely’s analysis was presented to the MHBE Board of Trustees at the July 16, 2018 session.<sup>8</sup> The MIA also presented their analysis in a joint-presentation with MHBE staff. At the session, MHBE staff presented a recommendation that the Board move to require that the State Reinsurance Program be structured, through regulation, to account and adjust for any

<sup>6</sup> This table highlights the specific category of interest from Wakely’s model. The Risk Adjustment and State Reinsurance Program interaction for other claims/risk groups is available in Attachment 1.

<sup>7</sup> The Maryland waiver application submitted on May 31, 2018 reflected an estimated attachment point of \$20,000.

<sup>8</sup> See Attachment 3.

potential duplication in payment from both risk adjustment and reinsurance.<sup>9</sup> The Board unanimously approved of the motion. The Board also concurred with MHBE Staff that the public should be provided the opportunity to supply testimony on the degree of dampening to Federal Risk Adjustment transfers that should be accounted for through modified State Reinsurance Program payments. In response to the Board action, the MHBE included Federal Risk Adjustment and State Reinsurance Program interaction as the primary topic for the August 2, 2018 public hearing for State Reinsurance Program regulations.

The MHBE Board agreed to rejoin August 20, 2018, after the public hearings, to consider public testimony on program interaction and determine a final Risk Adjustment dampening factor (reduction percentage) that should be accounted for through modified State Reinsurance Program payments.

### ***State Approach to Address Program Interaction through Rate Review***

Maryland plans to address Federal Risk Adjustment and State Reinsurance Program interaction through the yearly qualified health plan rate review process. Payments from the 2019 State Reinsurance Program will be modified to account for any dampening that would have been applied to Federal Risk Adjustment transfers. Program interaction will be accounted for through adjustment to the reinsurance factor on issuer market index rates.

At a high level, Maryland will utilize a two-step process to account for program interaction:

1. Issuers will apply a factor to their market index rates that accounts for reinsurance payments under the estimated State Reinsurance Program parameters without any adjustment.
2. The MIA will apply an additional factor on each issuer's reinsurance-adjusted market index rate that will account for the MHBE-determined degree of dampening to Federal Risk Adjustment program transfers.

Modifications to the reinsurance factor in step 2 will maintain the deficit neutrality of the Federal Risk Adjustment Program. This approach will not impact the State Reinsurance Program's estimated impact of a 30% premium reduction on average premiums. Additional information on the specific methodology Maryland will take to address program interaction is available in Attachment 8.

### ***Impact of State Approach to Address Program Interaction on Market Premiums and Waiver Application Analysis***

Adjustments to payments from the State Reinsurance Program, to account for Federal Risk Adjustment program interaction, would have a differential impact on issuers dependent on the issuer's risk adjustment experience. Issuers that receive risk adjustment payments would experience a reduced rate offset due to a reduced reinsurance payment. Issuers that pay into the risk adjustment program would experience a magnified rate offset due increased reinsurance payments. Table 3 details the estimated impact of Maryland's approach on 2019 issuer rate

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<sup>9</sup> See Attachment 5.

filings.<sup>10</sup> It should be noted that the rate review process is ongoing. The estimates are preliminary and are not rate decisions.

**Table 3. Estimated 2019 Premium Impact of the State Reinsurance Program (SRP) with Federal Risk Adjustment Interaction Modification.**

Issuer	Market Share	Rate Impact				
		SRP-only	Modified SRP (Wakely)	Modification Impact (Wakely)	Modified SRP (MIA)	Modification Impact (MIA)
Issuer 1 HMO	58%	-34%	-27%	7%	-32%	2%
Issuer 1 PPO*	7%	-65%	-39%	26%	-59%	6%
Issuer 2	35%	-10%	-30%	-20%	-15%	-5%
Total	100%	-30%	-30%	0%	-30%	0%

\*Issuer 1 PPO accounts for two PPO licenses operated by Issuer 1. Together, the two licenses function as one state-wide PPO network.

The methodology Maryland will use to address program interaction will not impact the estimated 30% reduction in average premiums the State Reinsurance Program is expected to achieve. Further, Maryland’s approach does not require either the actuarial and economic analysis or the Section 1332 guardrail impact analysis, which was submitted in Maryland’s 1332 waiver application on May 31, 2018, to be redone.

### ***Opportunity for Public Input and Next Steps***

The public will have the opportunity to provide testimony on program interaction, and the appropriate degree of dampening to take into account, through the regulatory process. The MHBE will hold a public hearing on State Reinsurance Program/Federal Risk Adjustment interaction on August 2, 2018. Members of the public who are unable to attend the hearing in person will be able to participate through an operator-assisted teleconference line. The MHBE will also receive written public comments on State Reinsurance Program regulations via its dedicated public comment email account.

Following the August 2, 2018 hearing, the MHBE Board of Trustees will convene on August 20, 2018, to determine the degree of dampening to be accounted for through modified State Reinsurance Program payments.

<sup>10</sup> Presented by the MIA at the July 16, 2018 MHBE Board of Trustees Session. Please see Attachment 3.

## **Attachments**

1. Wakely Consulting Group RA/RI Interaction Model 2019
2. Wakely Consulting Group State Flexibility for ACA Risk Adjustment in Maryland's Individual Market
3. Maryland Insurance Administration Analysis (MIA) RA/RI Interaction for 2019
4. MHBE/MIA Presentation to the MHBE Board of Trustees on RA/RI Interaction – July 16, 2018
5. MHBE Board of Trustees Motion to Address RA/RI Interaction – July 16, 2018
6. MHBE Board of Trustees Minutes from July 16, 2018 Session
7. State Reinsurance Program Regulation Public Hearings and Agenda

## ***Attachment 1. Wakely Consulting Group RA/RI Interaction Model 2019***

- Extracts from Wakely Consulting Group's RA/RI Interaction Model – 2019 with .70 dampening factor.

**Model Inputs**

	Kaiser 90296	CareFirst 28137	CareFirst 45532	CareFirst 94084
<b>Premium Increases</b>				
<b>Silver</b>				
2017 to 2018	42.1%	53.5%	53.5%	53.5%
2018 to 2019	18.0%	12.0%	25.0%	25.0%
<b>Other</b>				
2017 to 2018	29.8%	54.0%	54.0%	54.0%
2018 to 2019	18.0%	12.0%	25.0%	25.0%

	Kaiser 90296	CareFirst 28137	CareFirst 45532	CareFirst 94084
<b>Premium Adj.</b>				
Due to RI	0.901	0.664	0.388	0.275

	Kaiser 90296	CareFirst 28137	CareFirst 45532	CareFirst 94084
<b>Raw Claim Trend</b>				
2017 to 2018	5.0%	8.0%	8.0%	8.0%
2018 to 2019	5.0%	8.0%	8.0%	8.0%

**Risk Adjustment Dampening Factor**

0.640
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**Morbidity Change**

1.207
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Bucket Migration Source Category	Dest. Category		Continued Enrollment					Leaving	Check
	HIOS	Description	90296	28137	45532	94084	ALL		
No Claims	90296	Kaiser	55.0%	0.0%	0.0%	0.0%	45.0%	OK	
	28137	Carefirst HMO	20.0%	45.0%	0.0%	0.0%	35.0%	OK	
	45532	Carefirst PPO	10.0%	30.0%	30.0%	0.0%	30.0%	OK	
	94084	Carefirst PPO	10.0%	40.0%	0.0%	20.0%	30.0%	OK	
1st Quartile	90296	Kaiser	60.0%	0.0%	0.0%	0.0%	40.0%	OK	
	28137	Carefirst HMO	20.0%	50.0%	0.0%	0.0%	30.0%	OK	
	45532	Carefirst PPO	10.0%	35.0%	35.0%	0.0%	20.0%	OK	
	94084	Carefirst PPO	10.0%	45.0%	0.0%	25.0%	20.0%	OK	
2nd Quartile	90296	Kaiser	65.0%	0.0%	0.0%	0.0%	35.0%	OK	
	28137	Carefirst HMO	25.0%	55.0%	0.0%	0.0%	20.0%	OK	
	45532	Carefirst PPO	10.0%	30.0%	40.0%	0.0%	20.0%	OK	
	94084	Carefirst PPO	10.0%	40.0%	0.0%	30.0%	20.0%	OK	
3rd Quartile	90296	Kaiser	70.0%	0.0%	0.0%	0.0%	30.0%	OK	
	28137	Carefirst HMO	25.0%	65.0%	0.0%	0.0%	10.0%	OK	
	45532	Carefirst PPO	5.0%	20.0%	65.0%	0.0%	10.0%	OK	
	94084	Carefirst PPO	5.0%	50.0%	0.0%	35.0%	10.0%	OK	
4th Quartile	90296	Kaiser	90.0%	0.0%	0.0%	0.0%	10.0%	OK	
	28137	Carefirst HMO	5.0%	90.0%	0.0%	0.0%	5.0%	OK	
	45532	Carefirst PPO	5.0%	10.0%	80.0%	0.0%	5.0%	OK	
	94084	Carefirst PPO	5.0%	10.0%	0.0%	80.0%	5.0%	OK	
Same Reinsurance	90296	Kaiser	99.5%	0.0%	0.0%	0.0%	0.5%	OK	
	28137	Carefirst HMO	0.0%	99.5%	0.0%	0.0%	0.5%	OK	
	45532	Carefirst PPO	0.0%	0.0%	99.5%	0.0%	0.5%	OK	
	94084	Carefirst PPO	0.0%	0.0%	0.0%	99.5%	0.5%	OK	

State of Maryland  
 Estimated Experience After Migration  
 Experience by Issuer ID and Cost Quantile

TOTAL - ALL	2019 Estimated Results based on Input Assumptions (No Dampening)										2019 Estimated Results based on Input Assumptions (Dampening Applied)			
	Premium PMPM	Premium (No RI) PMPM	Unadjusted Claims PMPM	RA Transfer PMPM	RA Transfer (No RI) PMPM	Reinsurance PMPM	High Risk Pool PMPM	Average Members	Distribution of Members	Claim (Adj. for RA and HRP) to Premium Ratio	Claim (Adj. for RI, RA and HRP) to Premium Ratio	RA Transfer PMPM	Claim (Adj. for RA and HRP) to Premium Ratio	If apply total ratios to distribution
Total	\$524.65	\$744.07	\$590.75	\$0.00	\$0.00	\$219.42	\$0.58	174,560	100%	0.71	0.71	\$0.00	0.71	0.71
No Claims	\$459.16	\$598.35	\$0.00	-\$394.01	-\$544.61	\$0.00	\$0.00	17,990	10%	0.84	0.84	-\$245.77	0.54	
1st Quartile	\$475.01	\$666.35	\$8.35	-\$355.38	-\$504.00	\$0.00	\$0.00	27,896	16%	0.77	0.77	-\$227.44	0.50	
2nd Quartile	\$455.06	\$619.83	\$46.45	-\$343.69	-\$487.71	\$0.00	\$0.00	34,444	20%	0.86	0.86	-\$220.09	0.59	
3rd Quartile	\$599.32	\$720.98	\$156.54	-\$310.48	-\$440.33	\$0.00	\$0.00	35,073	22%	0.80	0.80	-\$198.71	0.62	
4th Quartile	\$601.18	\$894.91	\$641.21	\$34.05	-\$48.29	\$0.00	\$0.00	45,384	26%	1.01	1.01	\$21.79	1.03	
Some Reinsurance	\$610.83	\$1,031.99	\$6,218.69	\$3,615.09	\$5,126.97	\$5,555.57	\$9.40	10,772	6%	-1.57	-1.57	\$2,313.66	0.56	

**Model Inputs**

Premium increases	Kaiser		CareFirst		CareFirst	
	90296	28137	45532	94084	94084	94084
<b>Silver</b>						
2017 to 2018	42.1%	53.5%	53.5%	53.5%	53.5%	53.5%
2018 to 2019	18.0%	12.0%	25.0%	25.0%	25.0%	25.0%
<b>Other</b>						
2017 to 2018	29.8%	54.0%	54.0%	54.0%	54.0%	54.0%
2018 to 2019	18.0%	12.0%	25.0%	25.0%	25.0%	25.0%

Premium Adj. Due to RI 2019	Kaiser		CareFirst		CareFirst	
	90296	28137	45532	94084	94084	94084
	0.901	0.664	0.388	0.275		

Raw Claim Trend 2017 to 2018	Kaiser		CareFirst		CareFirst	
	90296	28137	45532	94084	94084	94084
2017 to 2018	5.0%	8.0%	8.0%	8.0%	8.0%	8.0%
2018 to 2019	5.0%	8.0%	8.0%	8.0%	8.0%	8.0%

**Risk Adjustment Dampening Factor**

0.835
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**Morbidity Change**

1.207
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Bucket Migration Source Category	Dest. Category		Continued Enrollment				Leaving ALL	Check
	HIOS	Description	90296	28137	45532	94084		
No Claims	90296	Kaiser	55.0%	0.0%	0.0%	0.0%	45.0%	OK
	28137	Carefirst HMO	20.0%	45.0%	0.0%	0.0%	35.0%	OK
	45532	Carefirst PPO	10.0%	30.0%	30.0%	0.0%	30.0%	OK
	94084	Carefirst PPO	10.0%	40.0%	0.0%	20.0%	30.0%	OK
1st Quartile	90296	Kaiser	60.0%	0.0%	0.0%	0.0%	40.0%	OK
	28137	Carefirst HMO	20.0%	50.0%	0.0%	0.0%	30.0%	OK
	45532	Carefirst PPO	10.0%	35.0%	35.0%	0.0%	20.0%	OK
	94084	Carefirst PPO	10.0%	45.0%	0.0%	25.0%	20.0%	OK
2nd Quartile	90296	Kaiser	65.0%	0.0%	0.0%	0.0%	35.0%	OK
	28137	Carefirst HMO	25.0%	55.0%	0.0%	0.0%	20.0%	OK
	45532	Carefirst PPO	10.0%	30.0%	40.0%	0.0%	20.0%	OK
	94084	Carefirst PPO	10.0%	40.0%	0.0%	30.0%	20.0%	OK
3rd Quartile	90296	Kaiser	70.0%	0.0%	0.0%	0.0%	30.0%	OK
	28137	Carefirst HMO	25.0%	65.0%	0.0%	0.0%	10.0%	OK
	45532	Carefirst PPO	5.0%	20.0%	65.0%	0.0%	10.0%	OK
	94084	Carefirst PPO	5.0%	50.0%	0.0%	35.0%	10.0%	OK
4th Quartile	90296	Kaiser	90.0%	0.0%	0.0%	0.0%	10.0%	OK
	28137	Carefirst HMO	5.0%	90.0%	0.0%	0.0%	5.0%	OK
	45532	Carefirst PPO	5.0%	10.0%	80.0%	0.0%	5.0%	OK
	94084	Carefirst PPO	5.0%	10.0%	0.0%	80.0%	5.0%	OK
Some Reinsurance	90296	Kaiser	99.5%	0.0%	0.0%	0.0%	0.5%	OK
	28137	Carefirst HMO	0.0%	99.5%	0.0%	0.0%	0.5%	OK
	45532	Carefirst PPO	0.0%	0.0%	99.5%	0.0%	0.5%	OK
	94084	Carefirst PPO	0.0%	0.0%	0.0%	99.5%	0.5%	OK



State of Maryland  
 Estimated Experience After Migration  
 Experience by Issuer ID and Cost Quartile

2019 Estimated Results based on Input Assumptions (Dampening Applied)

RA Transfer PMPM	Claim (Adj. for RA and HRP) to Premium Ratio	Claim (Adj. for RA and HRP) to Premium Ratio
\$0.00	0.71	0.71
-\$320.65	0.70	0.70
-\$296.74	0.64	0.64
-\$287.15	0.73	0.73
-\$259.25	0.73	0.73
\$28.43	1.02	1.02
\$3008.60	-0.60	-0.60

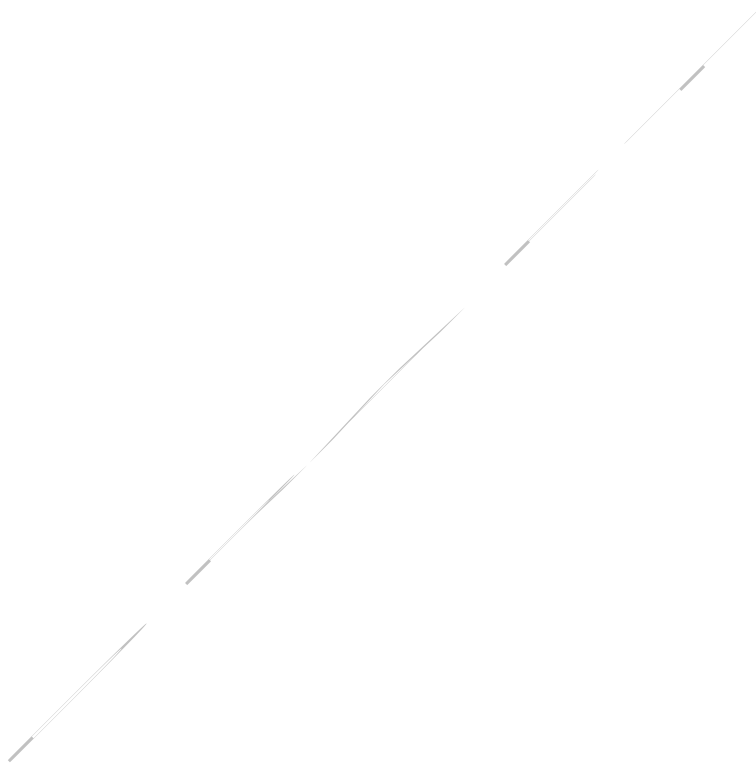
If apply total ratios to distribution

2019 Estimated Results based on Input Assumptions (No Dampening)

Premium (No RI) PMPM	Unadjusted Claims PMPM	RA Transfer PMPM	RA Transfer (No RI) PMPM	Reinsurance PMPM	High Risk Pool PMPM	Average Members	Distribution of Members	Claim (Adj. for RA and HRP) to Premium Ratio	Claim (Adj. for RI, RA and HRP) to Premium Ratio
\$274.65	\$590.75	\$0.00	\$0.00	\$219.42	\$0.58	174,560	100%	0.79	0.71
\$459.16	\$0.00	-\$384.01	-\$544.61	\$0.00	\$0.00	17,990	10%	0.91	0.84
\$475.01	\$8.35	-\$355.38	-\$304.00	\$0.00	\$0.00	27,896	16%	0.77	0.77
\$495.06	\$46.45	-\$943.89	-\$487.71	\$0.00	\$0.00	34,444	20%	0.86	0.86
\$593.32	\$720.98	-\$310.48	-\$440.33	\$0.00	\$0.00	36,073	22%	0.80	0.83
\$601.18	\$894.91	\$34.05	\$48.29	\$0.00	\$0.00	45,384	26%	0.66	1.01
\$610.83	\$6,218.69	\$3,615.09	\$5,126.97	\$3,555.57	\$9.40	10,772	6%	1.05	-1.57

TOTAL - ALL	Total
	No Claims
	1st Quartile
	2nd Quartile
	3rd Quartile
	4th Quartile
	Some Reinsurance

***Attachment 2. Wakely Consulting Group State Flexibility for ACA Risk Adjustment in Maryland's Individual Market***



# State Flexibility for ACA Risk Adjustment in Maryland's Individual Market

State of Maryland  
Maryland Health Benefit Exchange

7/17/2018

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## Introduction

The State of Maryland Health Benefit Exchange (“Maryland”) retained Wakely Consulting Group, LLC (“Wakely”), through Bolton Partners, to analyze Affordable Care Act (ACA) risk adjustment in the individual market and if allowable changes to the statewide average premium calculation may improve the appropriateness of risk adjustment transfers. Maryland is currently applying for a 1332 waiver, which would allow for a state-based reinsurance program. In 2018, the Department of Health and Human Services (“HHS”) granted states flexibility to apply for an adjustment to the risk adjustment methodology to best meet their own needs, especially if unique market circumstances produce a misalignment between risk adjustment transfers and actuarial risk. This flexibility could first affect the 2020 benefit year. States also have flexibility in altering risk adjustment methodology under state authority. States also have authority to alter reinsurance payments to account for potential overlap between reinsurance and risk adjustment payments. This paper will outline the basics of ACA risk adjustment, what flexibilities HHS granted states to alter the methodology, how risk adjustment has historically aligned with actuarial risk in Maryland’s individual market, and finally, how allowable adjustments to risk adjustment may affect financial results for individuals grouped by their cost category.

## Summary

In the 2019 Notice of Benefit and Payment, HHS allowed states to request a reduction in the calculated risk adjustment transfer amounts of up to 50% if state-specific market dynamics warrant an adjustment. Maryland is planning to implement a state-based reinsurance program for the 2020 benefit year, contingent on 1332 waiver approval. We have modeled these reinsurance payments and considered them in our analysis for consideration for either an HHS reduction or a state adjustment to the reinsurance payments.

Maryland asked Wakely to model different potential reduction percentages to the statewide average premium in the risk adjustment methodology and to quantify the impact for the different cost quartiles. Maryland also asked Wakely to identify an estimated reduction in the statewide average premium to address the potential for double counting in the reinsurance and risk adjustment programs, which might distort financial results.

**Wakely has estimated that a reduction in transfers of 30% would result in closer alignment of relative actuarial risk and risk adjustment transfers for the 2020 benefit year.** This recommendation was significantly influenced by the presence of the 2020 reinsurance program. Our results would change materially if that program were not implemented or were changed in material ways. Table 1 below summarizes financial results by cost category grouping before and after the proposed reduction in statewide average risk adjustment premium:

**Table 1: Claims to Premium Ratios<sup>1</sup>  
Impact of 30% Risk Adjustment (RA) Premium Dampening  
Estimated 2020 Individual Market Using the 2019 Risk Adjustment Model  
Maryland Reinsurance (RI) Program Reflected**

Claims Category	Claims to Premium Ratio (Adj for RA and RI)	Claims to Premium Ratio (Adj for RA and RI) – 30% RA Dampened	Member Distribution
No Claims	1.15	0.80	10%
1 <sup>st</sup> Quartile	1.04	0.73	16%
2 <sup>nd</sup> Quartile	1.18	0.86	20%
3 <sup>rd</sup> Quartile	1.13	0.89	22%
4 <sup>th</sup> Quartile	1.36	1.38	26%
Above \$20,000	-1.54	0.83	6%
Total	1.00	1.00	100%
Standard Deviation	0.85	0.29	n/a

As shown above, the Claims to Premium Ratios by claims category are more uniform after dampening the statewide average risk adjustment premium by 30%. We modeled other reduction percentages as well. The 30% reduction produced favorable results under various other combinations of assumptions although other reduction percentages may be appropriate and still produce improved results as compared to no change.

We relied on information from the issuers and the state and used historic data to model these results. Actual results may vary from our estimates for many reasons, including, but not limited to, issuer premium increases, enrollment and morbidity changes due to the recent regulatory changes, and details surrounding the actual 2020 risk adjustment methodology which are not yet available.

This document has been prepared for the sole use of and reliance by Maryland. Other uses may be inappropriate. Wakely understands that the report will be made public. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial

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<sup>1</sup> The Claims to Premium ratio is defined as: (Claims – Risk Adjustment Amounts – High Risk Pooling Payment – Reinsurance Receipts) / Premium

Standard of Practice (ASOP) 41 reporting requirements. Anyone receiving this report should rely on their own experts in interpreting the results.

## Background: ACA Risk Adjustment

Starting in 2014, the Affordable Care Act ushered in a number of commercial market reform rules. Plans in the individual and small group markets were no longer allowed to deny coverage based on pre-existing conditions and were generally required to rate enrollees via adjusted community rating. Risk adjustment was included as one of the key program features that was intended to provide for a stable market. As HHS outlined in their 2016 white paper on risk adjustment:

*“The intent of risk adjustment is to allow a plan enrolling a higher proportion of high-risk enrollees to charge the same average premium (other factors being equal) as a plan enrolling a higher proportion of low-risk enrollees, shifting the focus of plan competition to plan benefits, quality, efficiency, and value”<sup>2</sup>*

In essence, the policy goal is to reduce the incentives for issuers to avoid high-risk enrollees and instead incentivize issuers to maximize profitability through improvements in efficiency and quality. HHS finalized the ACA risk adjustment methodology in the 2014 Notice of Benefit and Payment Parameters regulation. The methodology is designed to compensate issuers for enrolling members with excess actuarial risk. The risk adjustment transfer formula, which determines payments and charges for issuers, measures the difference between the revenue requirement given the health status of the plan’s enrollees and the pre-risk adjustment premium revenue generated by the plan’s enrollees. The difference between the actuarial risk the plan takes on and the revenue the plan receives is the risk adjustment transfer. All of the calculations and transfers occur within a market and state. For example, risk adjustment calculations and budget neutral transfers occur within Maryland’s non-catastrophic individual market separate from Maryland’s small group market. While the transfers and calculations occur within a state, the overall HHS risk adjustment model is calibrated on a national data set and the same methodology is applied across every state in the country, as of 2018.<sup>3</sup>

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<sup>2</sup><https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>

<sup>3</sup> States that operate their own Exchange have the option of operating their own risk adjustment program. As of 2018 HHS operates risk adjustment in all 50 states and DC.

## 2019 Payment Notice Changes

In the 2019 Payment Notice<sup>4</sup> finalized in April 2018, HHS granted states the flexibility to dampen the level of risk adjustment transfers between plans. The HHS risk adjustment methodology uses the state average premium to scale risk adjustment transfers (i.e., make them state specific). In the 2019 Payment Notice, HHS admits that the current methodology may require some adjustment to risk adjustment transfers to more accurately account for unique state-specific factors. HHS is allowing states to apply for a modification to the historical risk adjustment methodology to improve the accuracy of the resulting transfers. States may request that risk adjustment transfers be dampened by up to 50% in their individual, small group, or merged markets.

To receive approval for the reduction, states must first identify the state-specific rules (e.g., rating rule) or market dynamic that warrants an adjustment to risk adjustment transfers. Then, the state must identify the reduction percentage requested (i.e., any value up to 50%) that is appropriate given the state-specific rule or market dynamic. This can be done either through analysis that demonstrates how the transfer adjustment is warranted given the state specific factors or it must show that the adjustment is estimated to have an impact so small that it will have a de minimis effect (less than 1%) on issuers who receive risk adjustment payments.

In addition to the above mentioned change, the 2019 Payment Notice reiterated that states to retain authority to make adjustments under state law. Under state law, states are generally able to take action to make state-specific adjustments without HHS approval. This means that if a state were to pass a state law they could effectively alter what an issuer would be paid through risk adjustment (albeit the adjustments would happen post hoc).

## Requirements for Submission

To gain approval for a state-specific adjustment as outlined in the 2019 Payment Notice, states must submit analysis demonstrating why the adjustment will more precisely account for risk differences in a state or that the change will have a de minimis impact. It must submit this evidence no later than August 1 for two calendar years into the future (e.g. August 1, 2018 is the submission deadline for the 2020 benefit year). The request and supporting evidence will be published in future years' proposed Payment Notices to seek public comment. HHS will publish its approval or denial in the applicable year's final Payment Notice.

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<sup>4</sup> <https://www.gpo.gov/fdsys/pkg/FR-2018-04-17/pdf/2018-07355.pdf>



## 2017 View of Maryland’s Individual Market

The first step to understanding if an adjustment is necessary for the 2020 benefit year is to examine the historical data. Wakely examined the 2017 benefit year and how effective the ACA risk adjustment methodology was at compensating issuers for actuarial risk. To do this, Wakely collected EDGE data (i.e., claim costs and premiums) alongside the risk adjustment transfer amounts. For a fuller description of the methodology, please see Appendix A. Wakely “bucketed” claim costs into 6 separate categories. The first category is members who had no claims in 2017. The last category is members with claims in excess of \$20,000 (which is the attachment point for the reinsurance program in 2019). For the remaining four categories, members were allocated equally to four cost groups based on their claims costs in 2017. While the number of unique members is the same for each quartile, the average members in the four quartiles vary because of each category’s members’ duration of coverage in 2017.

Table 2 below shows claims to premium ratios without risk adjustment amounts included under the 2017 model, with risk adjustment included under the 2017 model, and with risk adjustment amounts included under the 2019 model. Each Claims to Premium Ratio column shows the ratio for each claims category, normalized to an overall 1.00.

**Table 2: Claims to Premium Ratios  
With and Without 2017 Risk Adjustment and Impact of 2019 Model**

Claims Category	Claims to Premium Ratio - Without RA	2017 Claims to Premium Ratio - Adj for 2017 RA Model	2017 Claims to Premium Ratio - Adj for 2019 RA model	Average Members Distribution
No Claims	0.00	0.82	0.73	13%
1 <sup>st</sup> Quartile	0.02	0.71	0.65	18%
2 <sup>nd</sup> Quartile	0.10	0.78	0.74	20%
3 <sup>rd</sup> Quartile	0.27	0.73	0.72	21%
4 <sup>th</sup> Quartile	1.13	0.87	0.94	22%
Above \$20,000	9.54	4.03	4.21	5%
Total	1.00	1.00	1.00	100%
Standard Deviation	2.70	0.96	1.01	n/a

As can be seen in Table 2 above, risk adjustment (RA) transfers correlate strongly with actuarial risk. As actuarial risk increases, so do risk adjustment transfers, which levels the ratios once risk adjustment is taken into account. The standard deviation of the financial results decreases notably

under risk adjustment. While there is some variation in between levels of claims cost and levels of risk adjustment, generally the tiers align. The exception is the “Above \$20,000” category where the claims to premium ratio is significantly higher than the other categories even after risk adjustment.

Wakely additionally updated the 2017 experience with the 2019 risk adjustment model. The fourth column of Table 2 captures an estimate of what the 2017 ACA individual market could have experienced if the 2019 risk adjustment methodology had been used rather than the 2017 risk adjustment model. This includes the high cost pooling program, which is scheduled to start for 2018 transfers. The 2019 model affects the results and increases the standard deviation in claims to premium ratios, although not significantly.

## 2020 Market Dynamics

The state of Maryland has applied for a reinsurance based 1332 waiver. If approved, Maryland would operate a claims cost based reinsurance program that would expend an estimated \$459 million dollars of reinsurance in 2020. Wakely estimates that this program would directly result in a premium reduction of 30% (due to the funding and additional premium reduction due to morbidity improvements). While Maryland has not yet officially solidified the payment parameters for the 2020 benefit year, comparable reinsurance parameters for the 2019 benefit year produce reinsurance parameters of a \$20,000 attachment point, cap of \$250,000, and coinsurance of 80%. Given the large amount of reinsurance dollars expended and the low attachment point, there is potential for an issuer being compensated beyond their actuarial risk in risk adjustment.

To estimate the 2020 premium and enrollment in the individual market, Wakely used similar assumptions as in the analysis for Maryland’s 1332 waiver application.<sup>5</sup> Wakely collected 2017 EDGE data specific for this analysis, which allows for a detailed allocation of risk adjustment transfers, but also creates a slightly different starting point than used in the waiver analysis. Risk adjustment transfers were calculated and allocated to a member under both the 2017 and estimated 2019 risk adjustment methodology. 2018 emerging issuer data, Kaiser Family Foundation estimates on the impact of the effective mandate repeal, and other actuarial assumptions were used to estimate Maryland’s individual market, including the effects of reinsurance. Please note the estimates included in this report differ slightly from those included in the 1332 report, but any differences are small and not expected to impact the results of this analysis. The differences are primarily due to the starting data being slightly different and that

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<sup>5</sup>[https://www.marylandhbe.com/wp-content/uploads/2018/06/Final\\_Maryland%201332%20State%20Innovation%20Waiver%20to%20Establish%20a%20State%20Reinsurance%20Program%20-%20May%2031%202018.pdf](https://www.marylandhbe.com/wp-content/uploads/2018/06/Final_Maryland%201332%20State%20Innovation%20Waiver%20to%20Establish%20a%20State%20Reinsurance%20Program%20-%20May%2031%202018.pdf)

some assumptions in this analysis are at a more granular level. In addition, the catastrophic members have been removed from the risk adjustment analysis so that only the non-catastrophic single risk pool is included in the analysis.

Table 3 below includes Wakely’s estimates from the waiver on the key characteristics of the 2020 individual market, including the effects of reinsurance.

**Table 3: 2020 Baseline Estimates and Effects of Reinsurance**

2020	
<b>Baseline</b>	
Total Non-Group Enrollment	169,776
Total Non-Group Premium PMPM	\$776.34
Total Premiums	\$1,581,638,554
<b>After Reinsurance</b>	
Reinsurance Funding	\$459,000,000
Reduction in Premiums (Reinsurance Funding)	-29.0%
Reinsurance Assessment	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%
Total Reduction in Premiums	-30.0%
Total Non- Group Premium PMPM	\$543.36
Change in Total Non-Group Enrollment	5.7%
Total Non-Group Enrollment	179,439
Total Premiums	\$1,169,998,256

## Impact of Reinsurance by Claim Category and Proposed Adjustment

Table 4 shows the change in the claims to premium ratios for estimated 2020 data after risk adjustment (using the estimated 2019 risk adjustment model), after risk adjustment and reinsurance, and with the risk adjustment dampened by 30%. As with Tables 1 and 2, all ratios are normalized so that the overall ratio is 1.00.

**Table 4: Claims to Premium Ratios  
Impact of Reinsurance and 30% Reduction in Statewide Average Premium**

Claims Category	Claims to Premium Ratio (Adj for RA only)	Claims to Premium Ratio (Adj for RA and RI)	Claims to Premium Ratio (Adj for RA and RI) – 30% RA Dampened	Member Distribution
No Claims	1.14	1.15	0.80	10%
1 <sup>st</sup> Quartile	0.96	1.04	0.73	16%
2 <sup>nd</sup> Quartile	1.08	1.18	0.86	20%
3 <sup>rd</sup> Quartile	1.00	1.13	0.89	22%
4 <sup>th</sup> Quartile	0.83	1.36	1.38	26%
Above \$20,000	1.40	-1.54	0.83	6%
Total	1.00	1.00	1.00	100%
Standard Deviation	0.19	0.85	0.29	n/a

The ratios for the 2020 data without reinsurance are notably different than the ratios seen in the 2017 base experience. The primary driver of this is the large increase in premiums experienced and estimated from 2017 to 2020. These large increases in premium result in significantly larger risk adjustment transfers per member per month (PMPM) for the reinsurance category, which improves the financial results of this cohort of members. The variation by claim cohort has also lessened significantly.

While the premium increases evened out the variability by cohort, the introduction of reinsurance dramatically changes the adjusted claims to premium ratios. This change in dynamics comes from two sources. First, for enrollees who are eligible for reinsurance payments, the combination of risk adjustment payments and reinsurance payments makes this cohort of individuals far more profitable on average than any other cohort. The second source is that the reduction in state average premium due to reinsurance reduces transfers for all individuals and categories. The result is enrollees who are sicker on average but not eligible for reinsurance tend to be under-compensated. The combination of both these factors means that, in effect, the combination of risk adjustment and reinsurance in Maryland, without adjustment, produces risk adjustment transfers that do not consistently reflect actuarial risk across the different cost categories.

As also shown in Table 4, enrollees receiving reinsurance have drastically adjusted claims to premium ratios compared to a no reinsurance scenario. The cost category of those receiving

reinsurance payments has an estimated relative claims to premium ratio of negative 1.54 which indicates that reinsurance and risk adjustment receipts exceed claims.

The impacts of the reinsurance program can be moderated by reducing risk adjustment transfers by a fixed percentage. As can be seen in Table 4, adjusted premium to claims ratios exhibit far less variation with the reduction in transfers of 30%. This factor was selected because it produces the minimal variation among cost categories based on the assumptions used in the analysis (different assumptions will produce different reduction factors). Additionally, adjusted claims to premium ratios (i.e., actuarial risk) maintain a strong correlation to risk transfers using this method.

We relied on information from Maryland, CMS, the Maryland issuers, and other outside information. The 2020 risk adjustment methodology has not yet been released. There is inherent, significant uncertainty regarding how premium increases, market enrollment decreases, and member migration will affect market dynamics and morbidity, and risk adjustment transfers. We made simplifying assumptions and adjustments given available information and practical considerations. Financial results may vary considerably from our estimates and the results we have modeled may not materialize for the market as a whole, and especially for each issuer.

While the potential reinsurance program will lower premiums in the individual market, it produces unique, Maryland-specific distortions to the financial results when the risk adjustment and reinsurance programs are combined. To maintain the proper correlation of risk transfers to actuarial risk, regardless of enrollees cost level, Wakely's analysis and estimates support a reduction in transfers of 30%. Given the uncertainties of the 2020 market and resulting risk adjustment transfers, other reduction values may be appropriate.

## Appendix A: Data and Methodology

The following outlines the methodology used to develop the analysis included in this report.

### Data Collection

The data collected for this study was provided by the health insurance companies in the state of Maryland. Detailed encounter and high-level summary data was collected from CareFirst and Kaiser. The detailed encounter data was provided in the 2017 EDGE server files from the issuers. The high-level summary data included 2018 premium and enrollment experience by month by HIOS ID, metal level and other breakouts. In addition, Cigna provided their 2017 RATEE (EDGE server) file to provide Wakely with the means of calculating the risk transfers for 2017.

Wakely processed the provided 2017 detailed encounters to calculate member level claims, premiums, and risk transfer amounts. This information was then summarized to create the baseline data for the analysis. No adjustments were made to the EDGE data. For example, prescription drug rebates and other potential claim adjustments were not made.

Since claims and premium information was not available for Cigna, all Cigna members are assumed to have experience and risk profile similar to the CareFirst PPO plans. This was done since the risk transfers per member most closely aligned with the CareFirst PPO plans.

### 2017 Risk Transfer Methodology

The 2017 risk transfers were calculated using RATEE files provided by each issuer at the rating area and 14-digit plan identifier level. Geographic cost factors were calculated using the information provided in the RATEE files. At the time this analysis was performed, the final risk transfers were not yet published by CMS.

### 2019 Risk Transfer Methodology

The 2019 risk transfer methodology (2019 risk weights and 2019 age rating factors) was calculated using the encounter data provided by the issuers. The plan liability risk score and age rating factors were then used to calculate the 2019 risk transfers based on 2017 experience. Note that for the purpose of the historic 2017 risk transfer calculations, the statewide average premium was held flat from 2017 to understand the impact solely from the change in the risk adjustment model from 2017 to 2019. The exception to this is that the state average premium was reduced by 14% reduction to account for variable administrative expenses and aligns with the 2019 risk adjustment methodology that will be applied. The geographic cost factors were not adjusted for any premium changes. The key reason for not updating these factors is that premiums were not adjusted for the new factors. In addition, Cigna's ARF values remain constant with no adjustment

made for the 2019 allowable rating factor (ARF), and a trended risk score factor was applied to their plan liability risk score (PLRS). Finally, the amount of high risk pool claims that will be covered under the 2019 risk adjustment methodology were removed. This includes 60% of claims over \$1,000,000.

## Claims and Reinsurance Allocation

Claims were aggregated at the member level from the provided EDGE encounter medical and claims files. Claims and enrollment spans from the encounter file were only included if they were active on the EDGE server (accepted and non-orphaned). Cross-year medical claims were included in the paid amounts for members who had these types of claims.

Reinsurance based on the 2017 experience and 2019 parameters was calculated for each member based on the aggregation of paid amounts for each member. An attachment point of \$20,000, a coinsurance amount of 80%, and a reinsurance cap of \$250,000 were used to calculate each member's reinsurance amount.

## Quartile Category Determination

Six different claim cost groupings were developed for the purpose of this analysis. Catastrophic members were removed from this grouping so that the analysis was based solely on members in the non-catastrophic single risk pool.

1. No Claims - The members in this category have no claims attributed to them in 2017.
2. Quartile Categories - Four quartiles were created based on a member's paid amount if the member had incurred a claim and had less than \$20,000 total paid in 2017 (not hitting the reinsurance attachment point). These categories have the same amount of unique members in each quartile. However, given the duration of members with less claims are lower than the duration of members with higher claim costs, the average members increases from the 1<sup>st</sup> to 4<sup>th</sup> quartile.
  - 1st Quartile: Members with total claim less than \$184.50
  - 2nd Quartile: Members with total claims between \$184.50 and \$659.00
  - 3rd Quartile: Members with total claims between \$659.00 and \$2,028.90
  - 4th Quartile: Members with total claims between \$2,028.90 and \$20,000
3. Above \$20,000 - Any member eligible for reinsurance payments, with above \$20,000 of paid claims, is included in this category.



## Estimating 2020 Enrollment, Claims and Premiums

The 2020 data was estimated with the following adjustments that are consistent with the waiver application. One primary difference is that catastrophic members, claims and premiums were removed from the analysis.

All estimates for 2020 were made at the claim cost category level. Some assumptions were made in more detail and the weighted assumptions were applied at the claim cost category level.

1. **Enrollment and migration.** Non-catastrophic enrollment was estimated to decrease from 2017 to 2020 by approximately 21%. It was assumed that more members in the “No Claims and 1<sup>st</sup> Quartile” dropped coverage compared to the higher cost members, although all claim cost categories assumed some level of enrollment losses. Based on 2018 enrollment, there was also some migration assumed between HIOS IDs. In our analysis, for simplicity, we assumed that the distribution of enrollment by demographic, rating area, and metal level remained constant within a cost grouping. We also assumed, that members who migrated to a different issuer would take on the premium and claims of the members is the same quartile as the new issuer but the risk adjustment transfers followed the member.
2. **Claims costs.** Claims per member per month (PMPM) were trended approximately 7.5% annually, although the trend varied by issuer.
3. **Premiums.** Actual premium increases were used for the 2017 to 2018 premium increase. Given the de-funding of cost sharing reduction plans, we included different premium increases for silver and non-silver plans. For 2018 to 2019, consistent with the waiver we used an overall premium increase of 15% (prior to the impact of reinsurance) although the increase varied by issuer. Note that the carriers have filed larger rate increases, on average, for 2019 but the actual rate increase that will be approved is not known. If larger premium increases are passed on, it could impact the results of the analysis. For 2020, an assumption was made that premiums will increase approximately 6% for all issuers. This includes a trend increase, adjusts for the removal of the 2019 reinsurance assessment, and adjusts for the addition of the provider insurer fee for 2020 (there was a moratorium on the fee for 2019).
4. **Reinsurance.** The reinsurance PMPM was adjusted from 2017 to match the waiver application funding amount of \$462 million. Since only the non-catastrophic single risk pool is included in the analysis, the \$462 million was targeted for the non-catastrophic plans. In reality there were some members who would have been eligible for reinsurance in the catastrophic plans in 2017 but the amount of reinsurance would have been small and ignoring these catastrophic plan reinsurance claims is not expected to impact the analysis. Similarly, some members in the 4<sup>th</sup> quartile would likely be eligible for reinsurance in 2020 given claim cost trends. For simplicity the total reinsurance amounts were kept in the reinsurance category. For



any analyses that includes the impact of reinsurance, the premiums were adjusted for the impact of reinsurance. This is around 30% overall but varies by issuer.

5. **High risk pool.** For simplicity, the high risk pool PMPMs were trended similar to the claim trends. Also for simplicity, the estimated national fee of 0.3% for the high risk pool was not explicitly included but assumed to be included in the premiums.

## Risk Transfer Adjustments

Once the estimates were made for the 2020 individual market, Wakely re-calculated the risk adjustment transfers for multiple scenarios: with risk adjustment only, with risk adjustment and reinsurance, and with a dampened risk adjustment and reinsurance.

Transfers were scaled based on the changes in premiums. For a change in overall transfers due to members leaving the market, the difference in transfers were allocated back to the various cost categories. The risk adjustment modification factor applies uniformly to all assumed transfer amounts, and is applied prior to the reallocation of funds to “force” projected risk transfers to be net \$0. We made simplifying assumptions and adjustments to the transfers given available information and practical considerations.

No changes were made to the premium assumptions based on the changes in risk adjustment transfers.

## Claim to Premium Ratios

Once the estimates for 2020 were calculated, premium to claim ratios were developed for the three scenarios mentioned: adjusting only for risk adjustment, adjusting for risk adjustment and reinsurance, and adjusting for damped risk adjustment and reinsurance. Administration costs, taxes, or additional expenses that could affect profitability were not included in the analysis. For each claim cost grouping, the claims were adjusted for risk adjustment transfers, high risk pool claims, and reinsurance (if appropriate) and then divided by the premium. For scenarios with reinsurance, the premiums and related risk adjustment transfers were adjusted for the lower premium expected due to the reinsurance program. For the last scenario, different dampening factors were tested to understand the various impacts of each factor. Finally, for comparison purposes all ratios were adjusted so that the overall claims to premium ratio for all claim cost categories was a 1.00.

## Appendix B: Reliance and Caveats

Wakely performed high-level reasonability tests on the data but did **not** audit the data. To the extent that the information provided to us is incomplete or inaccurate, the results in this report and the corresponding model will need to be revised accordingly. This report may only be used for discussion purposes in relation to the risk adjustment dampening analysis. Any other use may not be appropriate.

The following is a list of the data Wakely relied on for the analysis:

- A complete set of 2017 EDGE Server XML data was collected from the primary insurers in the non-group market, including:
  - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each insurer to the EDGE Server
  - The corresponding response files that apply an accept/reject status to the claims in the inbound files
  - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports
  - 2017 RATEE files for the carrier that did not submit EDGE data (carrier has small enrollment in 2017 and no longer offers a product in the individual market)
- Issuer submitted 2018 premium and enrollment information by metal and exchange status
- The 2016 , 2017, and 2018 Open Enrollment Report PUF produced by HHS<sup>6 7 8</sup>
- Effectuated Enrollment Reports released by CMS<sup>9</sup>

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<sup>6</sup> <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

<sup>7</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan\\_Selection\\_ZIP.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html)

<sup>8</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018\\_Open\\_Enrollment.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html)

<sup>9</sup> <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

- Kaiser Family Foundation Survey<sup>10</sup>
- Additional data and feedback from Maryland's insurers, Maryland Insurance Administration, and the Maryland Health Benefit Exchange.

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Maryland for reasonability.

The following are additional caveats that could have an impact on results:

- **Data Limitations.** Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering non-group market ACA-compliant plans. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.
- **Political Uncertainty.** There is significant policy uncertainty. Future federal actions or requirements in regards to short-term duration plans, association health plans, reinsurance funds, income verification, and / or CSR payments could dramatically change premiums and enrollment in 2020.
- **Enrollment Uncertainty.** Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. All of these uncertainties result in limitations in providing point estimates on enrollment estimates in 2020.
- **Premium Uncertainty.** Given the impact of several regulations (mandate repeal, association plans, short-term duration plans, etc.), there is uncertainty in how insurers may respond in their 2020 premiums and the enrollment and morbidity impact on costs. These uncertainties result in limitations in providing point estimates. Additionally, changes to premiums based on changes to expected risk adjustment transfers were not included in the calculations. In theory, reduced risk adjustment payments could increase premiums for plans receiving risk adjustment payments and reduced risk adjustment charges could decrease premiums for plans having risk adjustment charges. Wakely did not account for issuer's changing premiums as a result of changes to risk adjustment.
- **Risk Adjustment Transfers.** The details of the 2020 risk adjustment model are not yet available. In addition, given the large enrollment changes between 2017 and 2020, estimates of risk adjustment transfers by cost category is uncertain. Simplifying

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<sup>10</sup> <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

assumptions and adjustments to the transfers were made given available information and practical considerations.

- **Reinsurance Operations.** This analysis assumes that Maryland's 1332 reinsurance waiver will be approved and that the impact to premiums and claims will be as estimated in the waiver. If actual operations of the reinsurance program differ from the data configurations used in this analysis or if the actual reinsurance dollars differ significantly from those assumed, Wakely's analysis would need to be adjusted to match actual reinsurance results.
- **Reinsurance/1332 Funding.** Maryland's reinsurance program, as currently structured, is contingent on approval by the Departments of Health and Human Services and Department of Treasury. Any alterations to reinsurance funding, issuer estimates of reinsurance payments in rate filings (as those estimates influence pass-through amounts and total available reinsurance funding), or other material changes to the reinsurance program including reinsurance payments or 1332 funding would influence the findings in this report.

## Appendix C: Disclosures and Limitations

**Responsible Actuaries.** Julie Peper is the actuary responsible for this communication. She is a Member of the American Academy of Actuaries and Fellow of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report.

**Intended Users.** This information has been prepared for the sole use of Maryland. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. Wakely understands that this report may be shared with CMS, the general public, or other relevant stakeholders. The parties receiving this report should retain their own actuarial experts in interpreting results.

**Risks and Uncertainties.** The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Maryland will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

**Conflict of Interest.** The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of the state of Maryland.

**Data and Reliance.** We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and reliances.

**Subsequent Events.** These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report, including actions in regards to mandate enforcement by the state of Maryland. Additionally, final federal regulations on short-term limited duration plans have not yet been released. Material changes as a result of Federal or state regulations change on short-term limited duration plans or association plans may also have a material impact on the results. In addition, any changes in issuer actions as well as emerging 2018 enrollment and experience could impact the results. Changes to current Maryland practice of loading CSR amounts to Silver plans only could also impact the results. The 2020 risk adjustment methodology has not yet been released. Changes to the risk adjustment model or transfer formula could have an impact. Finally, this paper assumes

that Maryland's reinsurance program, which is contingent on approval of its 1332 waiver, will operate in 2020. Disapproval of the 1332 waiver or spending of amounts different than what was estimated in the report could have a material impact. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

**Contents of Actuarial Report.** This document (the report, including appendices) constitutes the entirety of the actuarial report and supersedes any previous communications on the project.

**Deviations from ASOPs.** Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

***Attachment 3. MHBE/MIA Presentation to the MHBE Board of Trustees  
on RA/RI Interaction – July 16, 2018***

# Risk Adjustment and State Reinsurance Program Interaction: Analysis from Wakely Consulting Group - July 16, 2018





# Background

- On May 31, 2018, MHBE submitted a State Innovation Waiver Application to implement a State Reinsurance Program (“SRP”) in Maryland.
- The SRP was modeled to result in a 30% premium offset for 2019 and 2020. The estimated size of the SRP is \$462 million and \$459 million, respectively.
- During the public comment period stakeholders expressed concern over potential duplicative payments issuers might receive under the risk adjustment and reinsurance programs.
- At the May board meeting, the MHBE Board of Trustees authorized MHBE to commission the Wakely Consulting Group to perform analysis on this potential program interaction for Plan Years 2019 and 2020. The Board also resolved to potentially take regulatory action based upon the outcome of the Wakely analysis.

# Background

- The federal risk adjustment program operates by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees, thereby encouraging insurers to compete based on the value and efficiency of their plans rather than by attracting healthier enrollees. The risk adjustment program is federally administered but transfers are budget neutral to state markets.
- The State Reinsurance Program will operate by transferring funds to plans with high claim enrollees to exert downward pressure on premiums.
- The 2019 risk adjustment program is estimated to transfer +/- \$132 million across issuers in the individual market, and the SRP is estimated to pay out \$462 million in reinsurance payments.
- Total premiums for the individual market in 2019 are estimated at approximately \$1.1 billion.

# Assumptions & Methods

- Wakely's assumptions for its analysis matched those included in the waiver as closely as possible (e.g., premium increases, etc.).
- Wakely leveraged the most recently available data (2017) from the EDGE server, a repository where carrier enrollee data used to determine risk adjustment program payments are stored and analyzed.
- Wakely then grouped the enrollee data into six "buckets," according to their 2017 claims experience. After the enrollees were grouped, Wakely adjusted the enrollee data to estimate the 2019 experience (Table 1).

**Table 1 – Risk Adjustment/Reinsurance Analysis Categories – 2019 Estimates**

Category	Claims Range (2017)*	Population Estimate	Distribution
No claims	--	17,990	10%
1 <sup>st</sup> Quartile	less than \$184.50	27,896	16%
2 <sup>nd</sup> Quartile	\$184.50 - \$659.00	34,444	20%
3 <sup>rd</sup> Quartile	\$659.00 - \$2,028.90	38,073	22%
4 <sup>th</sup> Quartile	\$2,028.90 - \$20,000	45,384	26%
Some Reinsurance	above \$20,000	10,772	6%
TOTAL	--	174,560	100%

# Assumptions & Methods

After data for 2019 was estimated, Wakely then identified three scenarios for analysis:

- 2019 Risk Adjustment only;
- 2019 Risk Adjustment and State Reinsurance Program; and
- Dampened 2019 Risk Adjustment and State Reinsurance Program.

## Analysis – Claims to Premium Ratios

- In order to determine the degree of overlap between the risk adjustment and reinsurance programs, Wakely leveraged the claims-to-premiums ratio, also known as the “Medical Loss Ratio” or MLR.

$$MLR = \frac{Claims}{Premiums}, \quad \text{Average MLR} = .80$$

- Incorporation of premium stabilization programs, however, modifies the equation:

$$MLR = \frac{Claims - (RA + RI)}{Premium}$$

### Analytical Framework:

- If  $MLR > .80$ , then it can be assumed the issuer is eating into its allowable administrative margin.
- If  $MLR < .80$ , then it can be assumed the issuer is increasing its margin by the difference between the MLR and .80.

### Example:

- An MLR of .70 indicates that the issuer is collecting an additional 10% of premiums above the administrative load that is not attributable to claims.

# Report Outcomes

**Table 2 - MLRs for RA, RA + RI, and RA with dampening + RI.\***

Category	RA-only	RA + RI	RA (-30%) + RI	RA (-40%) +RI
No claims	.91	.84	.59	.50
1 <sup>st</sup> Quartile	.77	.77	.54	.47
2 <sup>nd</sup> Quartile	.86	.86	.63	.56
3 <sup>rd</sup> Quartile	.8	.83	.66	.60
4 <sup>th</sup> Quartile	.66	1.01	1.03	1.03
Some reinsurance	1.05	-1.57	.20	.79
Total	.79	.71	.71	.71

\* MLRs assume a 15% premium increase from 2018 to 2019.

# Report Outcomes

- With an MLR of -1.57, payments received by issuers for enrollees above \$20,000 in claims under the risk adjustment and reinsurance programs would result in issuers receiving payments greater than the costs incurred by claims.
- Under normal medical loss ratio distributions for issuers, enrollees with lower claims would subsidize losses experienced by enrollees with higher claims. The interaction between the risk adjustment and reinsurance programs, when applied without any calibration, distorts this experience, and results in enrollees with higher claims subsidizing enrollees with lower claims.
- Wakely modeled scenarios for a dampening of risk adjustment program payments to calibrate for the degree of overlap (column RA (-30%) + RI).
- Wakely determined that a 30% reduction in the Risk Adjustment payment would result in bringing this population to a non-negative MLR.

# MIA Insights on Risk Adjustment and Reinsurance Interactions

- Todd Switzer, Chief Actuary, and Bradley Boban, Sr. Actuary



## RA/RI Interaction - INM ACA Market - MIA/OCA

1. A guiding principle in measuring achievement of the state's goal of the RI program is the principle expressed in HHS' white paper of 2016 regarding RA. That is, the result should be that insurers compete based on "benefits, quality, efficiency, and value" and not "risk selection." Members also self-select making RA necessary to prevent risk selection.
2. Analysis has led to the conclusion that an appreciable amount of interaction is expected, warranting an adjustment. Quantitatively, 2019 estimates of interaction range from \$26M to \$44M. Preliminary estimates of 2019 RA and RI are +/- \$158M and +\$460M, respectively. Therefore, the interaction as a percentage of RA ranges from 17% to 28% (6% and 10% of RI).
3. For the two remaining insurers, the \$26M scenario would impact CFI and KP premiums by ~+2% (HMO & PPO) and -12%, respectively. The \$44M scenario would have impacts of +4% and -20%.
4. For the first time CMS will allow states to submit by 08/01/18 for 2020 a "scalar" to mute the impact of RA. The volatility of our estimates thus far is ~+/-20%. Therefore the leaning is to utilize RI to adjust for RA interaction for both 2019 and 2020.
5. Two methods were examined to measure the "interaction." To start, members were split into six categories of rising annual claims costs from \$0 claims to \$20K+ (i.e., \$0 claims, four quartiles, then reinsured claims > \$20K). These six categories could be further bifurcated into "paying RA transfers/healthy" and "receiving RA transfers/unhealthy." The first method sought to minimize the volatility of loss ratios in the six categories. It had the "pro" of having none of the six categories with subsidies greater than claims. It had the "con" that the "payers/healthy" were transformed from unprofitable to very profitable and the converse for "receivers/unhealthy." The second method sought to make the profitability exactly equal for payers and receivers. The "pro" is that this is consistent with the ACA RA objective, and insurers would be indifferent to the morbidity of the insured. The "con" is that the loss ratio volatility, while reduced, is greater than the first method and for the reinsured members, subsidies exceed claims.
6. It is maintained that the RI coinsurance of 80% is sufficient motivation for an insurer to actively manage care towards appropriate cost containment.
7. In practical terms the RI process would have two steps: 1) the paid claim amounts corresponding to the program's parameters would be calculated, and 2) the RI dampening factor would be applied at the legal entity level to determine the final payment to insurers. First, this would be estimated prospectively in rate filings in, for example, September 2018 for calendar 2019 rates. Finally this would be done again retrospectively in May 2020 for calendar 2019 to compute actual payments. As with Federal transitional reinsurance from 2014-2016, there will inevitably be a variance from the estimate to actual.

## RA/RI Interaction – Federal RA and RI Impact

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
<b>1) Undampened RA, w/o RI</b>																
	PMPY		Average								RA					
	Claims		Annual				Raw				Scalar/			Adj.		
	Amt.		Paid	2019			Paid	Raw	Raw		Factor/			Loss		
			Claim	Members	%		Claims	Income	Loss Ratio	Δ	Dampening	RA	RI	Ratio	Δ	
1	No Claims	\$0	\$0	17,990	10%		\$0	\$129,174,406	0%		n/a	(\$117,572,393)	\$0	91%		
2	1st Quartile	\$1-\$185	\$8	27,896	16%		\$2,793,683	\$223,063,978	0%		n/a	(\$168,716,111)	\$0	77%		
3	2nd Quartile	\$186-\$659	\$46	34,444	20%		\$19,200,122	\$256,197,839	7%		n/a	(\$201,585,036)	\$0	86%		
4	3rd Quartile	\$660-\$2029	\$137	38,073	22%		\$62,380,534	\$329,395,962	19%		n/a	(\$201,175,094)	\$0	80%		
5	4th Quartile	\$2030-\$19999	\$641	45,384	26%		\$349,210,399	\$487,380,500	72%		n/a	\$26,301,159	\$0	66%		
6	Some Reinsurance	\$20000+	\$6,219	10,772	6%		\$803,871,083	\$133,401,855	603%		n/a	\$662,747,475	\$0	106%		
7	<b>Total SRP</b>		<b>\$591</b>	<b>174,560</b>	<b>100%</b>		<b>\$1,237,455,821</b>	<b>\$1,558,614,540</b>	<b>79%</b>		<b>n/a</b>	<b>\$0</b>	<b>\$0</b>	<b>79%</b>		
8																
9	No Claims + Quartiles 1-3	RA Payers	Healthy	\$59	118,403	68%	\$84,374,339	\$937,832,185	9%		n/a	(\$689,048,634)	\$0	82%		
10	4th Quartile/Reinsured	RA Receivers	Unhealthy	\$1,711	56,156	32%	\$1,153,081,482	\$620,782,355	186%	177%	n/a	\$689,048,634	\$0	75%	-8%	
11	<b>Total SRP</b>		<b>\$591</b>	<b>174,559</b>	<b>100%</b>		<b>\$1,237,455,821</b>	<b>\$1,558,614,540</b>	<b>79%</b>		<b>n/a</b>	<b>\$0</b>	<b>\$0</b>	<b>79%</b>		
12																
13	<b>2) Undampened RA, w/ RI</b>															
14			Average								RA					
15	PMPY		Annual				Raw				Scalar/			Adj.		
16	Claims		Paid	2019			Paid	Raw	Raw		Factor/			Loss		
17	Amt.		Claim	Members	%		Claims	Income	Loss Ratio	Δ	Dampening	RA	RI	Ratio	Δ	
18	No Claims	\$0	\$0	17,990	10%		\$0	\$99,125,376	0%		1.000	(\$82,901,685)	\$0	84%		
19	1st Quartile	\$1-\$185	\$8	27,896	16%		\$2,793,683	\$159,012,330	2%		1.000	(\$118,963,725)	\$0	77%		
20	2nd Quartile	\$186-\$659	\$46	34,444	20%		\$19,200,122	\$188,090,189	10%		1.000	(\$142,139,993)	\$0	86%		
21	3rd Quartile	\$660-\$2029	\$137	38,073	22%		\$62,380,534	\$246,401,845	25%		1.000	(\$141,850,937)	\$0	83%		
22	4th Quartile	\$2030-\$19999	\$641	45,384	26%		\$349,210,399	\$327,407,230	107%		1.000	\$18,545,258	\$0	101%		
23	Some Reinsurance	\$20000+	\$6,219	10,772	6%		\$803,871,083	\$78,960,571	1018%		1.000	\$467,311,082	\$459,616,999	-156%		
24	<b>Total SRP</b>		<b>\$591</b>	<b>174,560</b>	<b>100%</b>		<b>\$1,237,455,821</b>	<b>\$1,098,997,541</b>	<b>113%</b>		<b>1.000</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>		
25																
26	No Claims + Quartiles 1-3	RA Payers	Healthy	\$59	118,403	68%	\$84,374,339	\$692,629,740	12%		0.705	(\$485,856,340)	\$0	82%		
27	4th Quartile/Reinsured	RA Receivers	Unhealthy	\$1,711	56,156	32%	\$1,153,081,482	\$406,367,801	284%	272%	0.705	\$485,856,340	\$459,616,999	51%	-31%	
28	<b>Total SRP</b>		<b>\$591</b>	<b>174,559</b>	<b>100%</b>		<b>\$1,237,455,821</b>	<b>\$1,098,997,541</b>	<b>113%</b>		<b>0.705</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>		

Please note that the 71% & 79% loss ratios do not reflect 1) NAIC MLR adjustments, 2) operating expenses, and 3) final approved rates. The filed NAIC MLR for 2019 is ~82%.

## RA/RI Interaction – Options Toward State Objective

30	3) Dampened RA (Thru RI), WAKELY Approach (Get Loss Ratios of 6 Categories as Close as Possible, No Subsidies > Claims, Remove All "Interaction \$s", Healthy More Profitable)										
31		1	2	3	4	5	11	12	13	14	15
32				Average			RA				
33		PMPY		Annual			Scalar/			Adj.	
34		Claims		Paid	2019		Factor/			Loss	
35		Amt.		Claim	Members	%	Dampening	RA	RI	Ratio	Δ
36		No Claims		\$0	17,990	13%	0.720	(\$59,689,213)	\$0	60%	
37		1st Quartile		\$1-\$185	27,896	19%	0.720	(\$85,653,882)	\$0	56%	
38		2nd Quartile		\$186-\$659	34,444	20%	0.720	(\$102,340,795)	\$0	65%	
39		3rd Quartile		\$660-\$2029	38,073	21%	0.720	(\$102,132,675)	\$0	67%	
40		4th Quartile		\$2030-\$19999	45,384	22%	0.720	\$13,352,586	\$0	103%	
41		Some Reinsurance		\$20000+	10,772	5%	0.720	\$336,463,979	\$459,616,999	10%	
42		<b>Total SRP</b>			<b>\$591</b>	<b>174,560</b>	<b>100%</b>	<b>0.720</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>
43											
44		No Claims + Quartiles 1-3	RA Payers	Healthy	\$59	118,403	68%	0.720	(\$349,816,565)	\$0	63%
45		4th Quartile/Reinsured	RA Receivers	Unhealthy	\$1,711	56,156	32%	0.720	\$349,816,565	\$459,616,999	85% 22%
46		<b>Total SRP</b>			<b>\$591</b>	<b>174,559</b>	<b>100%</b>	<b>0.720</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>
47											
48	4) Dampened RA (Thru RI), OCA1 Approach (Get Loss Ratios of 2 Categories as Close as Possible (Healthy & Unhealthy), Healthy & Unhealthy Equally Profitable, Some Subsidies > Claims)										
49											
54		No Claims		\$0	17,990	13%	0.834	(\$69,140,005)	\$0	70%	
55		1st Quartile		\$1-\$185	27,896	19%	0.834	(\$99,215,747)	\$0	64%	
56		2nd Quartile		\$186-\$659	34,444	20%	0.834	(\$118,544,754)	\$0	73%	
57		3rd Quartile		\$660-\$2029	38,073	21%	0.834	(\$118,303,681)	\$0	73%	
58		4th Quartile		\$2030-\$19999	45,384	22%	0.834	\$15,466,745	\$0	102%	
59		Some Reinsurance		\$20000+	10,772	5%	0.834	\$389,737,442	\$459,616,999	-58%	
60		<b>Total SRP</b>			<b>\$591</b>	<b>174,560</b>	<b>100%</b>	<b>0.834</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>
61											
62		No Claims + Quartiles 1-3	RA Payers	Healthy	\$59	118,403	68%	0.834	(\$405,204,188)	\$0	71%
63		4th Quartile/Reinsured	RA Receivers	Unhealthy	\$1,711	56,156	32%	0.834	\$405,204,188	\$459,616,999	71% 0%
64		<b>Total SRP</b>			<b>\$591</b>	<b>174,559</b>	<b>100%</b>	<b>0.834</b>	<b>\$0</b>	<b>\$459,616,999</b>	<b>71%</b>

## RA/RI Interaction - Premium Impact

	1	2	5	6	7	9	10
			Actual		Filed	RI	Δ/ Premium
1		Legal	Members		Insurer	Premium	Impact/ "Dampening"
2	Insurer	Entity	03/31/18	%	Renewal	Impact	
3						<b>No Dampening</b>	
4	CF	BC	123,188	58%	18.5%	-28%	n/a
5	CF	GHMSI	5,666	3%	91.4%	-46%	n/a
6	CF	CFMI	9,215	4%	91.4%	-46%	n/a
7	Kaiser	KP	73,704	35%	37.4%	-30%	n/a
8	<b>TOTAL</b>		<b>211,773</b>	<b>100%</b>	<b>30.2%</b>	<b>-30%</b>	<b>n/a</b>
9							
10						<b>Wakely (0.720, +/- \$44M)</b>	
15	CF	BC				-25%	3%
16	CF	GHMSI				-34%	12%
17	CF	CFMI				-34%	12%
18	Kaiser	KP				-50%	-20%
19						<b>-30%</b>	<b>0%</b>
20							
21						<b>OCA 1 (0.834, +/- \$26M)</b>	
26	CF	BC				-26%	2%
27	CF	GHMSI				-39%	7%
28	CF	CFMI				-39%	7%
29	Kaiser	KP				-42%	-12%
30						<b>-30%</b>	<b>0%</b>

# MHBE Staff Recommendation

## *MHBE Staff Recommendation:*

MHBE staff take action, as necessary, to structure through regulation the State Reinsurance Program to account and adjust for any potential duplication in payment from both risk adjustment and reinsurance as independently analyzed by the Maryland Insurance Administration and by the Wakely Consulting Group model provided to MHBE on June 30, 2018.

***Attachment 4. MHBE Board of Trustees Motion to Address RA/RI Interaction – July 16, 2018***



<p style="text-align: center;"><b>BOARD OF TRUSTEES MEETING July 16, 2018</b></p> <p style="text-align: center;"><b>2:00pm - 4:00pm</b></p> <p style="text-align: center;"><b>MHCC, 4160 Patterson Avenue, Baltimore, MD 21215</b></p>	<p><b>§ 31-102. Maryland Health Benefit Exchange established.</b></p> <p>(c) Purpose. -- The purposes of the Exchange are to:</p> <ol style="list-style-type: none"> <li>1) Reduce the number of uninsured in the State;</li> <li>2) Facilitate the purchase and sale of qualified health plans in the individual market in the State by providing a transparent marketplace;</li> <li>3) Assist qualified employers in the State in facilitating the enrollment of their employees in qualified health plans in the small group market in the State and in accessing small business tax credits;</li> <li>4) Assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and</li> <li>5) Supplement the individual and small group insurance markets outside of the Exchange.</li> </ol>
<p><b>Core Principles: Accessibility, Affordability, Sustainability, Stability, Health Equity, Flexibility, Transparency</b></p>	

OPEN MEETING AGENDA			
Topic	Presenter	Time Allotted with questions	Vote Required?
Welcome & Introductions Meeting call to order	Robert R. Neall, Board Chair	5 minutes	No
Approval of Minutes June 18, 2018 open meeting	Robert R. Neall, Board Chair	5 minutes	<b>Yes Motion 1</b>
Executive Update	Michele Eberle, Executive Director	10 minutes	No
MITA 3.0 Presentation	Dennis Schrader, COO and Medicaid Director, Maryland Department of Health	20 minutes	No
Risk Adjustment and Reinsurance	JP Cardenas, Policy Director	45 minutes	<b>Yes Motion 2</b>
Indefinite Delivery Indefinite Quantity Procurement Presentation	Tony Armiger, Chief Financial Officer Venkat Koshanam, Chief Information Officer	15 minutes	No
Corticon Maintenance & Operations Procurement	Tony Armiger, Chief Financial Officer Venkat Koshanam, Chief Information Officer	10 minutes	<b>Yes Motion 3</b>

**CLOSED MEETING STATEMENT: No Closed Meeting required today**

***MOTIONS FOR ITEMS REQUIRING A VOTE LOCATED ON BACK OF AGENDA***



**MOTION #1**

I move to [approve/defer/reject] the Board of Trustees minutes from **June 18, 2018** [as presented] or [as amended].

**MOTION #2**

I move to [approve/defer/reject] the recommendation that MHBE staff take action, as necessary, to structure through regulation the State Reinsurance Program to account and adjust for any potential duplication in payment from both risk adjustment and reinsurance as independently analyzed by the Maryland Insurance Administration and by the Wakely Consulting Group model provided to MHBE on June 30, 2018. ... [as presented] or [as amended].



***Attachment 5. MHBE Board of Trustees Minutes from July 16, 2018  
Session***



## Maryland Health Benefit Exchange Board of Trustees

July 16, 2018

2:00 p.m. – 4:00 p.m.

Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

### Members Present

Robert R. Neall, Chair	Ben Steffen, MA
S. Anthony (Tony) McCann, Vice Chair	Dana Weckesser
Linda S. (Susie) Comer (by phone)	Alfred W. Redmer, Jr.
Rondall E. Allen	

### Members Absent

K. Singh Taneja	Sastry Dara
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### Also in Attendance

Lourdes Padilla, Secretary, Maryland Department of Human Services  
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)  
Andrew Ratner, Chief of Staff, MHBE  
Venkat Koshanam, Chief Information Officer, MHBE  
Tony Armiger, Chief Financial Officer and Acting Procurement Officer, MHBE  
Caterina Pañgilinan, Chief Compliance Officer, MHBE  
John-Pierre Cardenas, Director, Policy & Plan Management, MHBE  
Betsy Plunkett, Director, Marketing & Web Strategies, MHBE  
Aaron Jacobs, Director, Organizational Effectiveness and Human Resources, MHBE  
Sharon Stanley Street, Principal Counsel, Office of the Attorney General  
Juliana Bell, Assistant Attorney General, Office of the Attorney General  
Raelene Glasgow, Procurement Manager, MHBE  
Kris Vallecillo, Senior Health Policy Analyst, MHBE

### Welcome & Introductions

Secretary Neall welcomed everyone to the Board meeting.

### Approval of Meeting Minutes

The Board reviewed the minutes for the June 18, 2018 open meeting. Mr. McCann moved to approve the minutes. Ms. Weckesser seconded the motion. The Board voted unanimously to approve the minutes of the June 18, 2018 open meeting.

### Executive Update

*Michele Eberle, Executive Director, MHBE*

Ms. Eberle began by welcoming new Board member Dr. Allen and offered a brief biographical summary of his career and accomplishments.

Next, Ms. Eberle announced that the MHBE has completed moving all staff from the former Linthicum office to the Pratt Street office. She noted that having all 180 personnel on one floor helps the agency fulfill its mission more effectively.

Ms. Eberle then gave an update on staffing. The MHBE has several new hires including a new Quality Assurance Specialist, Webmaster, Procurement Manager, and two summer interns.

Next, Ms. Eberle stated that the MHBE's 1332 State Innovation Waiver application was deemed complete by the Centers for Medicare & Medicaid Services (CMS), which triggered the beginning of a month-long federal public comment period ending August 4, 2018.

Ms. Eberle then described efforts to update and revise training materials for the more than 1,700 consumer assisters. She noted that all such materials must be made current and consistent well in advance of the next open enrollment period.

Next, Ms. Eberle announced that the MHBE has completed four regional forums wherein the agency gathered feedback from community stakeholders. She noted that comments received in both southern and far western Maryland underlined the importance of using local radio and newspapers as the foundation of any outreach strategy in those areas.

Ms. Eberle also described a recently completed strategy session with the MHBE's marketing vendor. The session focused on how to increase enrollment in the next open enrollment session, assuming the approval of the 1332 waiver.

Next, Ms. Eberle stated that the agency is nearing completion of its managing-for-results (MFR) effort along with its budget submission for fiscal year (FY) 2020. She added that they expect to complete that effort by the end of August. Secretary Neall asked whether the MHBE identified any changes through the MFR process, to which Ms. Eberle replied in the negative, noting that they had made changes last year.

Ms. Eberle finished her update by describing some of the components in the next major software release scheduled for July 27. The release will include "pay direct url" functionality that allows consumers to make a binder payment to their selected insurance carriers immediately after selecting their plan. Also included are updates to the producer "Tango" process, Medicaid managed care organization (MCO) auto-assignment, a new training compliance check for worker portal provisioning, a new marketing portal into the exchange systems that will allow workers to perform outreach to consumers that is customized to their progress through the application for coverage, and a range of improvements to data transmissions between the MHBE and carriers.

### **MITA 3.0 Presentation**

*Dennis R. Schrader, Chief Operating Officer & Medicaid Director, Maryland Department of Health*

*Craig Smalls, Assistant Chief Information Officer for Medicaid, Maryland Department of Health*

Mr. Schrader presented the results of the Maryland Medicaid Information Technology Architecture (MITA) State Self-Assessment effort recently undertaken by his office. He described a recent summit wherein leaders at Medicaid began to roll out the future vision of Maryland's Medicaid information technology architecture, explaining that continued access to federal matching funds at the 90/10 rate is contingent upon completing this work. CMS requires Maryland to develop an assessment of current overall architecture, as well as advance planning documents—all of which will be the product of close partnerships between Medicaid, the MHBE, and the Maryland Department of Human Services' (DHS') Total Human-services Information Network (MD THINK).

Next, Mr. Schrader laid out the approach his team has taken and will continue to employ in fulfilling the requirement. Details presented included the timing, stakeholders, and output of the project.

Mr. Schrader then presented CMS' MITA Maturity Level framework, a five-level schema that rates the IT architecture of a Medicaid agency. He explained that Maryland is currently at Level 1, which is the national average, but intends to reach Level 3 within ten years as part of this effort. He noted that Levels 4 and 5 remain aspirational at this time.

Next, Mr. Schrader further explained Maryland's current Level 1 score, noting that in some areas including Business Relationship Management, Maryland is very nearly at Level 2. In other areas, including Financial Management, the state has room for improvement. He added that the goal is to reach Level 2 across the board within five years.

Mr. Schrader then presented a diagram representing the MDH Enterprise Module Strategy Design, characterizing it as an important component of succession planning that will allow anyone who comes to work on the project to be oriented quickly.

Next, Mr. Schrader described the four phases of the program. He explained that all four phases would unfold in the coming decade. He concluded his presentation by laying out the process by which modules developed during the project would be certified by CMS.

Secretary Neall asked whether the end result of completing all four phases laid out by Mr. Schrader would be the achievement of Maturity Level 2. Mr. Schrader replied in the affirmative.

Mr. Steffen, noting that the module certification process presented appears to have the Independent Verification & Validation (IV&V) vendor reporting directly to CMS, asked Mr. Schrader to confirm his impression and to explain to which organization the IV&V vendor is contracted. Mr. Schrader replied that the MD THINK project has the IV&V vendor reporting to the governing bodies rather than the program managers and that the IV&V vendor uses the standard CMS template. Mr. Smalls added that the artifacts created by the IV&V vendor will go to state and federal authorities at the same time. Mr. Steffen cautioned that IV&V sometimes becomes misaligned from project goals and urged Mr. Schrader to remain vigilant in this regard.

### **Risk Adjustment and Reinsurance**

*John-Pierre Cardenas, Director, Policy & Plan Management, MHBE*

*Todd Switzer, Chief Actuary, Maryland Insurance Administration (MIA)*

*Bradley Boban, Senior Actuary, MIA*

Mr. Cardenas gave the board an overview of the likely interaction between federal risk adjustment and state reinsurance in the individual market. He thanked the Board for their engagement on the topic and noted that this interaction issue is one of the most complicated in the entire effort.

Mr. Cardenas began by explaining the background of the issue, including those events leading to the Board's having authorized the MHBE to commission a study by the Wakely Consulting Group (Wakely) to analyze the interaction between risk adjustment and reinsurance with a view toward avoiding duplicative payments to issuers under the two programs. He detailed the assumptions and methods employed by Wakely in the study, noting that the analysis incorporates as closely as possible those assumptions included in the 1332 State Innovation Waiver application recently submitted by the MHBE to CMS.

Next, Mr. Cardenas described how Wakely forecasted the likely distribution of 2019 individual market enrollees among various claims cost categories. He underscored that Wakely estimated that the size of the 2019 individual market would decrease by 25 percent from 2017 and that only six percent of all those enrolled would have claims reaching the reinsurance attachment point. In response to a question from Secretary Padilla, Mr. Cardenas clarified that the population under consideration is the individual market, regardless of whether the plan was purchased through the MHBE or on the off-Exchange market, and that the analysis does not consider Medicaid enrollees.

Mr. Cardenas then laid out the three scenarios analyzed by Wakely: a 2019 plan year with risk adjustment only, 2019 with risk adjustment and state reinsurance, and 2019 with "dampened" risk adjustment and state reinsurance. Mr. McCann asked when federal authorities would allow the state to dampen risk adjustment payments, to which Mr. Cardenas replied that such dampening could not take place before the 2020 plan year. Mr. McCann then asked why Wakely analyzed the dampening scenario for 2019. Mr. Cardenas replied that the MHBE can replicate the effects of dampening of risk adjustment through adjustments to reinsurance payments.

Next, Mr. Cardenas explained how medical loss ratios (MLRs) are calculated when taking into account premium stabilization programs such as risk adjustment and reinsurance. He noted that in the early years of the Affordable Care Act (ACA), MLRs were typically above 0.80, indicating that issuers were using some of their allowable overhead to pay claims.

Mr. Cardenas then displayed the analysis results, with MLRs for each scenario and claims cost category. He pointed out that the negative MLR displayed indicates a duplicative payment under the scenario that combines un-dampened risk adjustment and reinsurance.

Mr. McCann asked why, if the MHBE cannot employ dampening in 2019, the analysis includes two scenarios with dampened risk adjustment in 2019. He also asked why the analysis does not include modifying the reinsurance attachment point to move more individuals into the 4<sup>th</sup> quartile category. Mr. Cardenas replied that the only dampening tool available to the MHBE for 2019 is the reinsurance program. For that reason, he explained, the agency must modify the reinsurance parameters by estimating the risk adjustment payments. He added that modifications to the reinsurance program will only directly affect those consumers whose claims exceed the attachment point.

Commissioner Redmer asked how consumers with no claims could have a 0.91 MLR. Mr. Cardenas explained that a portion of the premiums paid by those with no claims is paid into the risk adjustment program.

Mr. Steffen asked about the implications of the proposed reinsurance parameters, including the \$20,000 attachment point. He stated that several common procedures such as childbirth, hip and knee replacement, and gastric bypass surgery would likely exceed that threshold, and commented that these are not catastrophic losses. Mr. Cardenas replied that Mr. Steffen had a good point, and that the agency is conducting hearings in order to gather such feedback. He added, however, that a combination of factors led to the \$20,000 attachment point. The Board felt very strongly that the reinsurance program should have a cap of \$250,000 with an 80 percent coinsurance rate, and the agency requires a 30 percent premium offset to stabilize the market. The combination of those requirements results, mathematically, in the \$20,000 attachment point. Raising the attachment point would increase premiums.

Mr. Cardenas then presented the report's conclusion that risk adjustment dampening of 30 percent would result in no duplicative payments to issuers. He then introduced Mr. Switzer and Mr. Boban of the MIA who presented in more technical detail aspects of Wakely's analysis.

Mr. Boban noted that the perfect solution to the problem would be for Maryland to control the risk adjustment program, allowing the state to address the duplicative payments in a highly targeted fashion. He added that Minnesota evaluated creating their own state-run risk adjustment program and found it to be infeasible—a conclusion shared by MIA for Maryland.

Mr. Cardenas underlined the urgency of coming to a decision, as a supplementary submission under the 1332 waiver application that is to address these matters is due by August 4, 2018. To that end, he presented the MHBE staff recommendation that the Board “instruct MHBE staff to take action to calibrate the overlap of payments from the risk adjustment and reinsurance programs through regulations for the State Reinsurance Program.”

Secretary Neall asked whether the regulations referred to in the staff recommendation would be subject to public hearings. Mr. Cardenas replied in the affirmative, adding that while the policy tool has been identified, the agency needs to hear insight as to how best to use that tool.

Mr. McCann asked whether the issue would ever again come before the Board. Mr. Cardenas replied that any proposed regulations resulting from this process would be presented for Board review. Secretary Neall, noting that the Board does not meet in open session again before September, announced that there would be a telephone conference for the Board on these issues sometime in August.

Secretary Neall stressed the importance of keeping the retail price of insurance premiums at the forefront of considerations throughout this process. Mr. Cardenas agreed, noting that the salient question is how to get the lowest premium for the greatest number of people.

Secretary Neall underlined the fact that Maryland has just signed a new total cost of care agreement with CMS, meaning that if the MHBE's actions increase uncompensated care in the state, it would become necessary for the state to save money somewhere else in the system. Mr. Cardenas replied that reducing the uninsured population in

Maryland is critical to reducing the incidence of uncompensated care.

Mr. Steffen asked the MIA staff whether there is any differential impact on off-Exchange versus on-Exchange plans and whether they were confident in the accuracy of the federal financial data, given that they are not audited. Mr. Switzer replied that they are confident in the federal data, but that the entire issue involves a great deal of volatility. Mr. Boban added that there is no difference in price between on- and off-Exchange plans, and thus no difference in policy impact.

Commissioner Redmer moved to adopt the staff recommendation. Mr. Steffen seconded the motion. The motion was carried with no opposition.

### **IT Procurements**

*Tony Armiger, Chief Financial Officer, MHBE*

*Venkat Koshanam, Chief Information Officer, MHBE*

*Raelene Glasgow, Procurement Manager, MHBE*

Mr. Armiger began by introducing Ms. Glasgow, the MHBE's new Procurement Manager. Ms. Glasgow gave the Board a brief overview of her background and accomplishments.

Mr. Armiger then gave notice that the MHBE will request the Board's approval at their next open meeting of a contract award to renew maintenance support for RedHat Linux Operating System & Application Servers.

Next, Mr. Armiger discussed the current contract log for FY 2018. He noted that, at a previous meeting, a Board member asked why so many contracts with zero dollars were present on the list. He clarified that the list included master contracts that have no dollar amounts associated with them.

Ms. Eberle asked how many hours are outstanding under the indefinite delivery indefinite quantity (IDIQ) contract. Mr. Koshanam replied that the agency has received nearly 1,000 resumes and has filled 105 positions. He added that 27 vendors have received at least one task order and that no single vendor has more than 15 or 16 task orders, making the total complement of vendors a healthy mix of high and low volume. Mr. Koshanam stated that they expect to fill three or four more positions.

Mr. Armiger then presented the list of FY 2019 IDIQ awarded task orders, noting that the list is current through July 9, 2018. He noted that there are 96 task orders on the list and that future versions of the list will include the dollar amounts spent.

### **Adjournment**

Commissioner Redmer moved to adjourn the meeting. Mr. McCann seconded the motion. The Board voted unanimously to adjourn the meeting.

***Attachment 6. Standing Advisory Committee Agenda – July 12, 2018***



## AGENDA

### Standing Advisory Committee Meeting (SAC)

Maryland Department of Transportation (MDOT)  
Ground Floor (Lower Level) 7201 Corporate Center Drive, Hanover, MD 21076  
July 12, 2018  
2:00 PM – 3:30 PM

Dial-In: 877-620-6892 Code: 106 126 3325

2:00 – 2:05pm	Welcome & Introductions Robyn Elliott & Al Helfenbein, SAC Co-Chairs
2:05 – 2:10pm	Call Meeting to Order / Approval of June 14th Minutes Robyn Elliott & Al Helfenbein, SAC Co-Chairs
2:10 – 2:20pm	MHBE Executive Update Michele Eberle, MHBE Executive Director
2:20 – 3:15pm	Discussion on Wakely Consulting Group's Report on Risk Adjustment and Reinsurance in Maryland's Individual Market John-Pierre Cardenas, MHBE Director of Policy and Plan Management
3:15 – 3:30pm	Public Comment
3:30pm	Adjournment



***Attachment 7. State Reinsurance Program Public Hearings and Agenda***



## State Reinsurance Program Regulations

### Meeting Schedule and Agenda

To: Interested Parties

Pursuant to House Bill 1795 / Senate Bill 1267, the Maryland Health Benefit Exchange (“MHBE”) shall, in consultation with the Commissioner of the Maryland Insurance Administration (“MIA”) and as approved by the MHBE Board of Trustees (“Board”), establish and implement a State Reinsurance Program. The State Reinsurance Program will provide reinsurance to carriers that offer individual health benefit plans in order to mitigate the impact of high-risk individuals on rates in the individual insurance market, both inside and outside of the Health Benefit Exchange. As part of its requirement to establish and implement a State Reinsurance Program (“SRP”), MHBE is required to adopt regulations implementing the State Reinsurance Program on or before January 1, 2019.

A Notice of Public Hearing on Regulations was published in the Maryland Register on July 20, 2018, advising that the hearings for the above regulations would be held on July 26, August 2, August 9, and August 16, 2018. It also advised that an agenda would be posted prior to the first hearing on the MHBE website at [marylandhbe.com](http://marylandhbe.com).

Please note that the federal government has not yet approved Maryland’s Section 1332 State Innovation Waiver, but is currently in the process of accepting public comments. Accordingly, MHBE is holding these hearings on the assumption that the federal government will ultimately approve the waiver.

Below, please find the agenda for each meeting.

#### **Hearing #1: Administration & Priorities**

**July 26, 2018, 2:00 P.M. – 4:00 P.M.**

**Maryland Health Benefit Exchange | 750 E. Pratt St., 6<sup>th</sup> Fl., Baltimore, MD 21202**

**Dial-in: (833) 640-6816 / Conference ID: 5877647**

Topics to be discussed:

- Administration
  - As the administering agency for the SRP, how can MHBE minimize the burden of administering the SRP on issuers?
  - Assuming claims data is collected through the EDGE Server, what issues might arise from using this data source?
    - For example, what concerns exist regarding timeliness, completeness, and data aggregation?
  - What other options are available if the EDGE server cannot be leveraged for the SRP?



- Can the All-Payers Claim Database submissions be accelerated? If so, could this data source be leveraged for the SRP?
- What other data options would parties recommend?
- Priorities
  - What priorities/objectives should be addressed by the State Reinsurance Program?
    - For example, delivery system alignment, quality improvement, cost containment, etc.

### **Hearing #2: Risk Adjustment/Reinsurance Interaction & Incentive Funding\***

**August 2, 2018, 2:00 P.M. – 4:00 P.M.**

**Maryland Health Benefit Exchange | 750 E. Pratt St., 6<sup>th</sup> Fl., Baltimore, MD 21202**

**Dial-in: (833) 640-6816 / Conference ID: 2454605**

#### Topics to be discussed:

- Federal Risk Adjustment Program / State Reinsurance Program (SRP) Interaction
  - What objectives should modifications to payments from the SRP accomplish when taken to account for interaction with the federal risk adjustment program?  
Should MHBE:
    - Target lowest premiums possible?
    - Equalize the medical loss ratio across issuers?
    - Remove all reinsurance/risk adjustment interaction?
    - Other objective(s)?
- Incentive Funding
  - How should incentive funding be determined from the State Reinsurance Program allocation?
    - For example, MHBE could raise the attachment point and use the difference to fund incentive payments.
  - Should a set amount be separated from the initial allocation?
  - Should incentives be funded through any remaining reinsurance allocation?
  - How might incentive payments be incorporated into issuer rate requests?

**\*Note:** For the purpose of this hearing, respondents should assume that the State will take action to address the Federal Risk Adjustment program and the SRP interaction. Respondents should also assume incentives will take effect for 2020 SRP payments.

### **Hearing #3: Incentives I: Utilization Management & Quality Improvement\***

**August 9, 2018, 1:00 P.M. – 3:00 P.M.**

**Maryland Department of Transportation | 7201 Corporate Center Dr., Hanover, MD 21076**

**Dial-in: (833) 640-6816 / Conference ID: 5675147**

#### Topics to be discussed:

- Existing Incentives
  - What incentives currently exist for issuers to better manage high risk enrollees?  
What demonstrated effectiveness have they achieved?



- How might existing incentives be included in the State Reinsurance Program?
- Utilization Management
  - How could the State Reinsurance Program best measure issuer utilization management performance?
  - What methodology would be appropriate to measure performance?
  - Should network type/network management factor into utilization management performance?
- Quality Improvement
  - How could the State Reinsurance Program best measure improvement on clinical efficiency, plan administration, and enrollee experience indicators?
  - Which indicators should be measured?
- Disincentives
  - Should MHBE contemplate the use of modifiers to reduce program payments for underperformance on incentive measures?
- Other Utilization Management/Quality Improvement Incentives

**\*Note:** Respondents should provide justification for the universal attainability of their recommendations in their comments. Respondents should assume incentive payments will take effect for the 2020 SRP payments.

#### **Hearing #4: Incentives II: Value Based Performance Measures - Chronic Diseases & Population Health\***

**August 16, 2018, 2:00 P.M. – 4:00 P.M.**

**Maryland Health Benefit Exchange | 750 E. Pratt St., 6<sup>th</sup> Fl., Baltimore, MD 21202**

**Dial-in: (833) 640-6816 / Conference ID: 9285299**

Topics to be discussed:

- Chronic Disease
  - How can the State Reinsurance Program be leveraged to address the utilization management of high claims chronic diseases?
  - Which diseases might be included for such measures?
  - Which methodology should be utilized to select included diseases?
  - Which metrics should be utilized to measure performance on chronic disease management?
- Population Health
  - How can the State Reinsurance Program be leveraged to expand access to health care for under-served populations?
  - How can the State Reinsurance Program be leveraged to expand preventive care to their enrolled populations?
  - Which metrics should be utilized to measure performance on preventive care/wellness?
- Other Value Based Performance Measures for Chronic Diseases/Population Health
- Value-Based Benefit Design



- Should MHBE implement a value-based benefit design to address chronic disease management and population health to help achieve the goals of the State Reinsurance Program?
- Additional testimony not previously discussed.

**\*Note:** Respondents should provide justification for the universal attainability of their recommendations in their comments. Respondents should assume incentive payments will take effect for the 2020 SRP payments.

***Attachment 8. Theoretical and Practical Considerations in  
Adjusting for Interaction Between Risk Adjustment and the  
Proposed, Maryland Reinsurance Program***



**TO:** Mr. John-Pierre Cardenas, MSPH  
Director, Policy and Plan Management  
Maryland Health Benefit Exchange (MHBE)

**FROM:** Mr. Bradley Boban, A.S.A., M.A.A.A.  
Senior Actuary

Mr. Todd Switzer, A.S.A., M.A.A.A.  
Chief Actuary

Maryland Insurance Administration (MIA)  
Office of the Chief Actuary (OCA)

**DATE:** August 3, 2018

**RE:** Theoretical and Practical Considerations in Adjusting for Interaction Between  
Risk Adjustment and the Proposed, Maryland Reinsurance Program

## **Section 1: Background**

During the State Innovation Waiver process, stakeholders express concerns on the potential for duplicative payments for the same risk under the risk adjustment and reinsurance programs. The potential for such duplication was first noted by CMS when the federal transitional reinsurance program was implemented for 2014. But no action was taken by CMS to quantify or address the issue.

In 2016, Minnesota performed a “State-Based Risk Adjustment System Assessment Feasibility Study” in which they concluded that “A Minnesota-based reinsurance strategy that is aligned with risk adjustment necessitates implementation of a state-based risk adjustment mechanism. Because it did not interact with the federal risk adjustment model, the federal transitional reinsurance program likely resulted in overcompensating insurers that enrolled high-cost members. The federal program expires at the end of 2016, but if Minnesota creates a permanent state-based reinsurance program, a state-based risk adjustment program could be designed to specifically account for the level of reinsurance protection provided, resulting in a risk adjustment transfer that more accurately aligns with the insurers’ actual liability and limits the impact on premiums from both programs.”

However, despite this conclusion, Minnesota did not proceed with implementing a state risk adjustment program. This is because the report also concluded a lead time of at least 18 months would be necessary, with considerable staff and financial resources needed. A state risk adjustment program requires considerable resources because it would require gathering and analyzing a large volume of medical claims data at a very detailed level, to enable the development of state-specific coefficients to replace the federal coefficients. There are several thousand coefficients that would need to be replaced.

In the “2019 Notice of Benefit and Payment Parameters,” CMS introduced a new option for state flexibility, which enabled states to submit a state-specific dampening factor between 0.50 and 1.00 which would be applied to the risk adjustment transfer formula. This option was not available during the Minnesota analysis. If it had been, it would have been an attractive way to accomplish the same goal as a state-run risk adjustment program, but without all the administrative complexity. A state-run program that accounts for reinsurance ends up with lower coefficients than the federal coefficients and leads to less money being transferred between carriers. A dampening factor applied to the federally-run program can achieve the same results.

This option for state flexibility was available for 2020 plan years or later. States are required to submit proposed dampening factors for 2020 by 8/1/18, and must submit an analysis demonstrating that the adjustment will more precisely account for risk differences.

Wakely Consulting Group was commissioned to perform an analysis on the potential reinsurance/risk adjustment program interactions for both 2019 and 2020. The analysis for both years was performed consistently, with the goal of computing a needed risk adjustment dampening factor to more appropriately align transfers with risk differences. Since CMS could not implement a dampening factor for 2019, the intent was to translate the needed 2019 dampening factor into carrier-specific reinsurance adjustment factors.

## **Section 2: Comments on Wakely Conclusion for 2020**

For both 2019 and 2020, the MIA found the data and the methodology used by Wakely to be reasonable. However, the MIA disagrees with the final conclusion drawn from that data.

For 2020, the conclusion was: “Wakely has estimated that a reduction in transfers of 30% would result in closer alignment of relative actuarial risk and risk adjustment transfers to the 2020 benefit year.” The 30% was selected “because it produces the minimal variation among cost categories based on the assumptions use in the analysis”

The MIA has concluded that the needed reduction is 12.5% for 2020.

Replicating Table 4 from the Wakely analysis, with some additional detail added, demonstrates the driver behind the different conclusions.



**Table 4 Claims to Premium Ratios  
Impact of Reinsurance and 30% reduction in Statewide Average Premium**

Claims Category	Claims to Premium Ratio - Without RA	Claims to Premium Ratio - (Adj for RA Only)	Claims to Premium Ratio - (Adj for RA and RI)	Claims to Premium Ratio - (Adj for RA and RI) - 30% RA Dampened	Claims to Premium Ratio - (Adj for RA and RI) - 12.5% RA Dampened	Average Members Distribution
No Claims	0.00	1.14	1.15	0.8	1.01	10%
1st Quartile	0.02	0.96	1.04	0.73	0.92	16%
2nd Quartile	0.10	1.08	1.18	0.86	1.04	20%
3rd Quartile	0.24	1	1.13	0.89	1.03	22%
4th Quartile	0.92	0.83	1.36	1.38	1.37	26%
Above \$20,000	7.75	1.4	-1.54	0.83	-0.62	6%
Total	1.02	1.00	1.00	1.00	1.00	100%
3rd Quartile and Lower	0.11	1.03	<b>1.13</b>	<b>0.83</b>	<b>1.00</b>	68%
4th Quartile and Higher	2.20	0.94	<b>0.82</b>	<b>1.28</b>	<b>1.00</b>	32%

The first column shows the actual claims/premium ratios before any risk adjustment or reinsurance. The healthiest four claims categories together have an average claims/premium ratio of only 0.11 while the unhealthiest two categories are at 2.20. This demonstrates the very significant risk differences requiring adjustment.

The second column shows that the federal risk adjustment program by itself slightly over-transfers. Ideally, the ratios for both the healthiest and unhealthiest would converge to 1.00. That’s the core goal of the risk adjustment program, to remove the incentive for carriers to target the healthiest. As stated in the 2016 CMS White Paper “The HHS risk adjustment methodology developed by the Centers for Medicare & Medicaid Services (CMS) and its contractor, RTI International, is based on the premise that **premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population.** The HHS risk adjustment methodology includes the risk adjustment model and the payment transfer formula.”

The third column clearly demonstrates the problem that the stakeholders raised about duplicative payments. The -1.54 ratio for those >\$20,000 means that the sum of their risk adjustment and reinsurance receivables are (significantly) greater than actual claims. The healthiest four categories combined have a very bad ratio of 1.13 while the sickest two categories fall to 0.82. Carriers would have the incentive to try to avoid healthy members and attract sick ones.

The fourth column is the Wakely recommendation of 30% dampening. The 30% dampening factor is successful at bringing the -1.54 for >\$20,000 all the way to 0.83, completely removing any and all duplicative payments. The problem with this approach is that it leaves the healthiest and sickest portions of the pool just as unbalanced as without dampening. The ratios flip under the Wakely proposal, with the healthiest having a ratio of 0.83. This gives carriers the incentive to target the healthy and avoid the sick.

The fifth column shows the 12.5% dampening factor which the MIA advocates as being most appropriate. The MIA dampening factor was derived specifically to equalize the ratios of the healthiest and unhealthiest categories. This approach should make carriers indifferent as to whether they attract the healthy or unhealthy portion of the pool. The drawback of this approach is that the ratio for >\$20,000 remains negative. This means that a portion of the duplicative payments would be left in place. This is a necessary compromise to offset the 1.36 ratio of the 4<sup>th</sup> quartile and bring the combined ratio for the bottom two categories up to 1.00.

On a high level, the difference between the Wakely and MIA recommendations is a question of how to deal with the imperfection inherent in any dampening factor method. The ideal solution to the issue of overpayment would be one which took the entire amount of the overpayment away from the reinsured and distributed that amount fairly amongst all the members without reinsurance. The only way to achieve this ideal is to run a state risk adjustment program with coefficients that are developed from post-reinsurance claims projections. With a dampening factor, the ideal cannot be achieved. This is because the 4<sup>th</sup> quartile deserves a significant amount of the overpayment, but the dampening factor cannot transfer any money to them (it actually takes some away).

So when using a dampening factor, a choice must be made about what to do with the overpayment that should have been transferred to the 4<sup>th</sup> quartile. Wakely's choice was to distribute the amount owed to the 4<sup>th</sup> quartile to the 1<sup>st</sup> through 3<sup>rd</sup> quartiles. This has the advantage of removing all the overpayment from the reinsured, but the disadvantage of making the healthiest quartiles much more profitable. The MIA's choice was to leave the amount owed to the 4<sup>th</sup> quartile with those collecting reinsurance. This has the advantage of not making the healthy quartiles excessively profitable, but has the disadvantage of leaving some of the overpayment with the reinsurance. Given the correlation between 4<sup>th</sup> quartile and reinsured members (carriers who have a disproportionate share of one are likely to have a disproportionate share of the other), the excess profit left with the reinsured and the excess loss left with the 4<sup>th</sup> quartile should be roughly offsetting.

The difference between the 12.5% and 30.0% dampening estimates for 2020 is solely attributable to different optimization goals. This difference could equate to ~\$20M in absolute dollar terms. There is significant potential volatility in that estimate. The \$20M is approximately 4% of the total 2019 reinsurance dollars of \$462M and approximately 1% of the total 2019 projected revenue of \$1.6B, prior to the -30% revenue reduction due to reinsurance. Each was derived with identical sets of assumptions for 2020. The single most impactful assumption is the average statewide premium for 2020. The amount of dampening as computed by either goal could swing +/- 10% from these estimates given more pessimistic or optimistic assumptions about the 2020 premium. The 2020 premium is strongly dependent upon the 2019 premium which is strongly dependent on the approval of the State Innovation Waiver. Given that the approval status of the State Innovation Waiver for 2019 won't be known until 8/4/18 at the earliest, it was decided that submitting a dampening factor to CMS for 2020 by the 8/1/18 deadline was inadvisable. The revised intent is that for both 2019 and 2020, the same process will take place which will convert a dampening factor that would be theoretically necessary on the risk adjustment side, and translate the impact of that dampening to the reinsurance receivables.

### Section 3: Comments on Wakely Analysis for 2019

For 2019, the same dynamic plays out as in 2020. Expanding on Table 2 of the MHBE policy brief dated 7/16/18, the MIA recommends a dampening of 16.5% for 2019, compared to a value of 36% derived using the Wakely methodology. (The MHBE policy brief presented 30% and 40% reductions, based on the following rationales: “Wakely determined that a 30% reduction in the Risk Adjustment payment would result in bringing this population to a non-negative MLR” and that “A 40% reduction in Risk Adjustment models would result in an MLR of 0.79 for this category.” The MIA has computed a point estimate of 36% as the dampening factor which most precisely mirrors the 2020 Wakely conclusion and “produces the minimal variation among cost categories”).

Table 2 - Projected Claims/Premium ratios for RA, RA + RI, and RA with dampening + RI.\*

Category	% Members	Raw/No RA or RI	RA-Only	RA + RI	RA (-30%) + RI	RA (-40%) + RI	RA (-36) + RI	RA (-16.5%) + RI
No Claims	10%	0.00	0.91	0.84	0.59	0.50	0.54	0.70
1st Quartile	16%	0.02	0.77	0.77	0.54	0.47	0.50	0.64
2nd Quartile	20%	0.10	0.86	0.86	0.63	0.56	0.59	0.73
3rd Quartile	22%	0.25	0.80	0.83	0.66	0.60	0.62	0.73
4th Quartile	26%	1.07	0.66	1.01	1.03	1.03	1.03	1.02
Some reinsurance	6%	10.18	1.05	-1.57	0.20	0.79	0.56	-0.60
<b>Total</b>	<b>100%</b>	<b>1.13</b>	<b>0.79</b>	<b>0.71</b>	<b>0.71</b>	<b>0.71</b>	<b>0.71</b>	<b>0.71</b>
<b>Standard Deviation:</b>		<b>4.06</b>	<b>0.13</b>	<b>1.00</b>	<b>0.27</b>	<b>0.21</b>	<b>0.20</b>	<b>0.57</b>

3rd Quartile and lower	68%	0.12	0.83	0.83	0.61	0.54	0.57	0.71
4th Quartile and higher	32%	2.84	0.73	0.52	0.87	0.98	0.94	0.71

Note that in the 2020 Wakely report, all claims/premium ratios were normalized to 1.00 for the pool. The above ratios are raw ratios from the Wakely model and have not been normalized.

### Section 4: Mechanics of Translating Dampening Factor into Equivalent Reinsurance Adjustments

Once the dampening factor has been finalized, the steps in computing the equivalent reinsurance adjustments are as follows:

**Step 1)** Project/Measure the unadjusted federal risk adjustment transfers by carrier.

For 2017, the actual CMS risk adjustment transfers were:

	Risk Adjustment Transfer
Kaiser	(\$76,072,410)
BlueChoice	\$3,194,767
CareFirst PPO	\$70,958,667
Cigna	\$1,918,976
<b>MD Total</b>	<b>\$0</b>

**Step 2)** Computed the dampened \$ amount.

With the formula “Dampened \$ = % Dampening x Unadjusted Risk Adjustment Transfer.” Using the 16.5% dampening factor that the MIA recommends for 2019 as an illustrative example would give the following:

	Dampened \$ Amount
Kaiser	(\$12,551,948)
BlueChoice	\$527,137
CareFirst PPO	\$11,708,180
Cigna	\$316,631
MD Total	\$0

**Step 3)** Project/Measure the reinsurance receivables of each carrier.

This is a measure of the base reinsurance amount, computed by adjudicating each member’s claims against the \$20,000 attachment point, 80% coinsurance, \$250,000 cap.

For 2017, the Wakely model projects the following:

	Reinsurance Projection*
Kaiser	\$37,381,014
BlueChoice	\$217,623,336
CareFirst PPO	\$86,493,341
Cigna	\$2,381,685
MD Total	\$343,879,376

\*Estimated cost of \$20k/80%/\$250k cap, if program had been run in 2017

**Step 4)** Compute a carrier-specific reinsurance adjustment factor.

The formula is “Reinsurance Adjustment = (Reinsurance - Dampened \$ Amount)/Reinsurance.”

Plugging in the numbers from above, gives the following factors:

Reinsurance Adjustment	
Kaiser	1.336
BlueChoice	0.998
CareFirst PPO	0.865
Cigna	0.867
MD Total	1.000

Note that:

- All carriers who are net risk adjustment payers will have an adjustment factor greater than 1.00.
- All carriers who are net risk adjustment receivers will have an adjustment factor < 1.00.
- The closer a carrier’s risk adjustment transfer is to \$0, the closer the adjustment factor is to 1.00 (no adjustment).
  - This is because the risk adjustment transfer for a carrier is the sum of its individual member’s risk adjustment transfer amounts. Every carrier has a majority of members who are healthier than (state) average and pay into the program, and a minority of members who are sicker than (state) average and receive money. If those balance exactly to \$0 with no dampening factor, they will still balance to zero when each side gets multiplied by the dampening factor.
- The computed reinsurance adjustments will be revenue-neutral and not increase or decrease the total amount of reinsurance payables for the state, as long as the calculation is performed after both the reinsurance adjudication and the risk adjustment transfers are finalized.
  - CMS generally releases final risk adjustment transfers on or around June 30<sup>th</sup>, so this would mean that the reinsurance adjustment factors could not be finalized until July.

**Section 5: Timing and Potential Future Refinements to Dampening Calculation (Years 2020+)**

To ensure that the carrier-specific reinsurance adjustments redistribute the total amount of statewide reinsurance dollars and do not raise or lower the amount being distributed, it is necessary to have three finalized numbers; 1) base reinsurance amounts by carrier, 2) net risk adjustment transfers by carrier, and 3) the dampening factor.

Risk adjustment is dependent on CMS. The “Summary Report on Permanent Risk Adjustment Transfers” is generally released on the last few days of June. They were delayed in 2018 until 7/9, but that was due to ongoing litigation and is not expected to be a recurrent event.

Reinsurance amounts can be computed any time after 5/1, when the carriers submit their claims data for 2019.

With respect to the dampening factor, there are two options. The first option is for the factor to be set prospectively in August of 2018 by the MIA. The second is for the factor to be set retrospectively in July of 2020. There are pros and cons to each method.

Setting the factor prospectively means that the carriers do not have any additional uncertainty or complexity to the rate filings. Carriers already have a process to project risk adjustment transfers, and with a dampening factor locked in advance, they will project the transfers as usual and simply have to multiply their projections by a factor. If they accurately project the pre-dampened transfers, the post-dampened transfers will also be accurate. In the federal formula, both the factor to account for admin (0.84 nationwide) and the factor to account for state flexibility (0.50 to 1.00) are locked in prospectively in advance of carriers setting rates.

However, the drawback of setting the factor prospectively is that there is a possibility of either over or under-dampening, due to 2019 actuals coming in differently than projected.

As Wakely notes in their report, the analysis is relatively sensitive to the statewide average premium. That's because all risk adjustment transfers pivot off that premium. The projected statewide average premium depends on both a) projecting the final approved 2019 rates by metal and carrier and then b) projecting member lapse rates by metal and carrier and then c) projecting "buy-downs."

In general, every open enrollment sees members buying down to cheaper plans to help alleviate their rate increase. This involves both shifting from high metal levels to low metal levels, and shifting from high premium carriers to lower premium carriers. Predicting the movement that will take place in the 2019 open enrollment period is particularly challenging, because if the State Innovation Waiver is approved, a significant number of plans are likely to see rate decreases. This means that members may reasonably "buy-up" to a richer plan that they were priced out of last year. And that we might have "negative lapse" rates with members coming back into the pool instead of leaving the pool. These dynamics mean that there's more uncertainty than usual in predicting the statewide average premium for 2019.

To ensure that the amount of dampening achieves the theoretical ideal, the dampening factor would need to be finalized on a retrospective basis after the actual risk adjustment and reinsurance results are known. In the federal formula, carriers must project a variable, the statewide average P, which is finalized retrospectively by CMS. This approach would add a new variable "d," which carriers would have to project but which would not be finalized retrospectively by the MHBE.

The issue with this approach is that this adds additional uncertainty and complexity to the rate filings. Carriers would need to develop a new process to project the dampening factor. In general, the risk adjustment transfer is the most uncertain part of a carrier's rate filing projection because a carrier must accurately project not only their own risk accurately, but the risks of the rest of the market. The projection of the dampening factor has this uncertainty, but compounded. It requires projecting not just the average risk of competitors accurately, but the risk by the six health status cohorts upon which the dampening factor relies.

From a practical perspective, given the complexity of the new analysis that would be required, it may be advisable to set the factor prospectively for 2019. Both carriers have expressed concerns about the amount of additional uncertainty and the unreasonableness of being asked to model such a complex projection on a short time frame. Carriers have noted that using a prospectively locked-in dampening factor will produce more equitable results by health status than using no dampening factor at all, even if there is some degree of over/under-dampening due to actuals deviating from projections.

For future consideration for years after 2019, two refinements to the analysis may be worthwhile to consider. The first refinement that the MIA would suggest is to slightly alter the way members are categorized by health status. The suggested alteration would be as follows:

Wakely	MIA
No Claims	No Claims
1st Quartile*	1st Tertile**
2nd Quartile*	2nd Tertile**
3rd Quartile*	3rd Tertile**
4th Quartile*	Risk Adj Receivers, <\$20k
>\$20k	>\$20k
*of those between \$0.01	**of risk adjustment
and \$19,999.99 in claims	payers w/ >\$0.01 in claims

This change enhances the analysis, assuming the goal is set to equalize the claims/premium ratio of healthier-than-average and sicker-than-average membership. Right now, the Wakely 4<sup>th</sup> quartile is mainly the risk adjustment receivers <\$20k, but has some portion of the 3<sup>rd</sup> tertile of risk adjustment payers. The analysis would be cleaner if all the payers and receivers were separated. This is because the dampening factor fundamentally impacts payers and receivers in opposite directions. For a payer, any dampening will cause their claims/premium ratio to improve and get lower. For a receiver, any dampening will cause the claims/premium ratio to increase. For risk adjustment receivers >\$20k, increasing the claims/premium ratio from its negative value is the goal. But for risk adjustment receivers <\$20k, the claims/premium ratio is already too high and can only get higher with the use of dampening. More precisely isolating this segment of members that are adversely impacted by dampening will improve the analysis.

Another possible refinement would address concerns that have been raised about using premium ratios as the metric. In general, the goal of risk adjustment is to equalize the claims PMPMs, for the portion of risk differences that are not permitted to be built into premiums. But, to the extent that different groups of members have differences in allowable rating factors, like age or metal level, the post-risk adjustment claims PMPMs should vary in proportion to those allowable rating factors. If the claims PMPMs and premium PMPMs are proportional regardless of health status, that means the same claims/premium ratio.

However, while the premium primarily varies based on allowable rating factor differences, it also varies based on how carriers price. The concern has been raised that if one carrier is significantly underpriced

(meaning high claims/premium ratios) then the analysis which focuses on equalizing claims/premium ratios by health status could inadvertently end up over-dampening to partially offset that carrier's underpricing. The MIA agrees that to some extent this would happen on a theoretical basis, but thinks that the carrier market shares for healthy vs. the carrier market shares for unhealthy are similar enough that the magnitude of any such offset of underpricing would be di minimis.

However, to remove this concern, the MIA suggests that a parallel analysis be prepared which focuses on claims PMPMs instead of claims/premium ratios. The goal would be to achieve equal, normalized claims PMPMs for the healthy vs. unhealthy. The ARF/IDF/AV values from the EDGE files could be used to compute the average allowable rating factors for the state as a whole and for each cohort, and that could be used to solve for the un-normalized claims PMPM that needs to be achieved to equalize the normalized PMPM. And then that can in turn be used to solve for the dampening factor that will achieve those PMPMs.

In summary, Wakely and the MIA have concluded from analyses that an adjustment for the interaction of risk adjustment and Maryland's proposed state reinsurance program for 2019 and 2020 is warranted. A method has been devised that adheres to the principles and objectives of the ACA, specifically related to risk adjustment. The current prospective best estimate of a risk adjustment dampening factor for 2019 is 0.835. Support has been expressed for both methods at a public hearing. The choice of a method will be made by the MHBE Board via a vote on Monday, 08/20/18. The vote will allow the MHBE to submit regulations for the RI program. Once a method is chosen, this factor will be re-calculated one more time by Fri., 08/31/18 by the MIA based on a clearer picture of final, approved 2019 rates. The pros and cons of a retrospective re-derivation of the 0.835 factor in 2020 have been discussed. This led to a proclivity to not retroactively adjust the original 2019 factor for the sake of predictability.



***Maryland Response to Application Reviewer Questions from the  
Federal Public Comment Period***



To: The U.S. Department of Health and Human Services & the U.S. Department of the Treasury

From: The Maryland Health Benefit Exchange

Date: August 10, 2018

Re: Maryland Response to Application Reviewer Questions from the Federal Public Comment Period.

The Maryland Health Benefit Exchange respectfully provides the below responses to questions received from State Innovation Waiver Application reviewers on August 10, 2018.

“The comment letter from Kaiser Permanente outlined that ‘Maryland should fully account for the federal risk adjustment program in structuring its reinsurance program and avoid duplicating payments for the same high-risk membership beginning with the start of the program in 2019.’ Could the MHBE please explain their approach and how they choose this approach? Could the MHBE describe its public process for developing the dampening factor and if it plans to engage in a public process for future years?”

1. With respect to the first question, the Maryland approach to account for duplicative payments under risk adjustment and reinsurance is through a modification of receivables under the reinsurance program to reflect the degree of dampening that would have been applied to risk adjustment transfers such that, on net, no duplicative payments would occur. Issuers would then apply this modified-reinsurance factor to their market index rate. Because the risk adjustment program is budget neutral receivables under the reinsurance program would modified upward or downward depending on whether the issuer is a payer or receiver under the risk adjustment program. We choose this approach because, for 2019, MHBE has the flexibility to utilize payments under the reinsurance program to account for the duplicative payment. Given the uncertainties of marketplace dynamics under year 1 of the waiver, MHBE determined that continued utilization of this approach for 2020 and beyond would provide MHBE with the most flexibility to react to any changes.

2. With respect to the second question, MHBE has engaged in a robust process to gather public input on this matter. At the May Board of Trustees Session, in response to public concern, the MHBE Board resolved to investigate the matter through commissioning an independent actuary to perform the analysis and then potentially take regulatory action to address the issue depending on the outcome of the analysis. After the analysis was completed and submitted to MHBE on June 30, 2018, MHBE first presented the analysis to MHBE's Standing Advisory Committee - with a membership representing diverse stakeholder groups. Then at the July MHBE Board session, MHBE recommended to the MHBE Board that MHBE leverage the State Reinsurance Program regulatory process to gather additional public input on the dampening factor. The MHBE Board agreed to the recommendation and MHBE held a public hearing on the matter on August 2, 2018. MHBE will incorporate the received testimony into final recommendations for the MHBE Board to vote on at the August 20, 2018 session.

MHBE plans to engage in a public process for the dampening recommendation for every year of the reinsurance program.

UPDATE: On August 14, 2018 the MHBE Board meeting for August 20, 2018 was postponed to allow for additional review of the information. MHBE will provide reviewers with the updated date as soon as it is rescheduled.

