MARYLAND HEALTH BENEFIT EXCHANGE

Maryland 1332 State Innovation Waiver Amendment Request

Public Comment: June 10, 2024 - July 9, 2024

Draft Prepared by the Maryland Health Benefit Exchange

Contents

Section 1: Description of Request

A. Background

The State of Maryland, through the Maryland Health Benefit Exchange (MHBE) requests approval to amend its Waiver under Section 1332 of the Patient Protection and Affordable Care Act ("section 1332 waiver") from the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services, and the Department of the Treasury ("the Departments").

Maryland currently has an approved section 1332 waiver that waives section 1312(c)(1) of the Affordable Care Act (ACA) to facilitate Maryland's State Reinsurance Program. The original waiver period was five years, beginning January 1, 2019 and ending December 31, 2023. On March 30, 2023, Maryland applied to extend its section 1332 waiver for an additional five-year period, through December 31, 2028. The Departments approved the extension request on June 28, 2023. See Appendix A for the extension application and approval letter.

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. See Appendix B for the bill text.

In a letter to the Departments submitted May 3, 2024, MHBE expressed its intent to submit an application seeking approval of a section 1332 waiver amendment that would waive section 1312(f)(3) of the Affordable Care Act (ACA) to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans (QHPs or "private plans") and Qualified Dental Plans through MHBE, thereby allowing all qualified Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. The Departments confirmed on June 4, 2024 that the application would be reviewed as a waiver amendment application.

MHBE requests to waive section 1312(f)(3) for the period January 1, 2026 through December 21, 2028, consistent with the currently approved term of Maryland's existing 1332 waiver. MHBE anticipates launching the new eligibility rules by November 1, 2025 for enrollment in 2026 plans. The waiver amendment is expected to meet all statutory guardrails.

B. Rationale for the Waiver Amendment Request

In the last ten years, Maryland's uninsured rate has fallen in half and stands at about six percent. Maryland has been a national leader in working to reduce the uninsured rate, including by implementing a state-based health insurance marketplace, launching the State Reinsurance Program which has reduced individual market premiums by more than 20 percent since 2019,

enacting the Easy Enrollment Program to allow uninsured individuals to get connected to health coverage by checking a box on their state tax return or unemployment claim, and instituting state-funded premium assistance for young adults.

Despite Maryland's efforts to reduce the uninsured rate, an estimated 112,400 Marylanders are uninsured and ineligible for on-Exchange coverage due to immigration status. This comprises about 30 percent of Maryland's uninsured population.[1] Allowing these residents to enroll in private plans on-Exchange through this waiver amendment is an important next step towards reducing Maryland's uninsured rate and could have net positive impacts, including improving the overall health of the State's population and decreasing the cost of uncompensated care. In fiscal year 2021 Maryland hospitals provided over $780 million in uncompensated care, with some hospitals paying upward of 10 percent of their total allocated budget towards uncompensated care.[2]

Currently, individuals ineligible to enroll on-Exchange due to their immigration status are able to purchase full-price health plans off-Exchange. If MHBE's request to waive section 1312(f)(3) of the ACA is approved, these individuals would be able to enroll in full-price private plans on-Exchange. Although the Access to Care Act does not allocate state funds to subsidize the cost of coverage for these individuals, allowing enrollment regardless of immigration status could promote health equity by enabling access to many other benefits available through the Exchange.

First, the Exchange offers a simplified shopping experience that allows consumers to compare plans from all individual market insurers in one place. Consumers can easily compare plan costs, check if plans include their providers and prescription drugs, and use tools available to estimate total health care costs in order to help find the right plan tailored to their needs.

The Exchange also provides extensive consumer support through its Call Center, which provides consumer support 6 days a week in more than 200 languages, and in-person assistance through the Navigator Program and authorized brokers.

Lastly, allowing enrollment regardless of immigration status would allow mixed-status families to enroll in the same plan through the Exchange, which would provide continuity of coverage and care coordination, save families money by allowing individuals in the family to share a single plan deductible and out-of-pocket maximum, and reduce the burden of managing multiple plans.

C. Provision(s) of the Law that the State Seeks to Waive

MHBE seeks to waive Section 1312(f)(3) of the ACA (42 USC §18032 (f)(3)). This section prohibits persons that are not United States citizens, United States nationals, or aliens lawfully present in the United State from being deemed a qualified individual for the purpose of qualifying for coverage in a qualified health plan offered on the exchange. MHBE is seeking a

[1]Source: MHBE analysis of American Community Survey data
[2] Health Services Cost Review Commission (HSCRC): Rate Year 2023 Uncompensated Care Report (June 2022).

complete waiver of this subsection in order to deem any individual, regardless of immigration status, a qualified individual for the purpose of enrolling in a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP), offered through Maryland Health Connection. Through this waiver, MHBE intends that 45 CFR §155.305 (a)(1) would not be used as an eligibility requirement for enrollment in a QHP or QDP through Maryland Health Connection. The other requirements of 45 CFR §155.305 (a) would apply to eligibility determinations.

Section 2: Public Notice and Comment Process

MHBE will hold two public hearings, on June 18, 2024 and July 3, 2024, during the 30-day public comment period, from June 10, 2024 to July 9, 2024, which follows posting of this application to the MHBE website on June 10, 2024. The dates, times, and locations of the public hearings were published on the MHBE website on May 10, 2024. The public was directed to submit comments to mhbe.publiccomments@maryland.gov. A summary of the public hearings and comments received will be added to the final submission of this application, and presentations, meeting minutes, and comments received will be included as appendices.

Section 3: Evidence of Sufficient Authority Under State Law

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

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), which was then signed into law by Governor Wes Moore on May 16, 2024.[3] The Access to Care Act directs MHBE to apply for an amendment to Maryland's existing 1332 waiver to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status.

In addition to various clarifying technical amendments to the MD Insurance Code, the Access to Care Act adds two sections to the MD Insurance Code:

- § 31–123, to direct MHBE to submit a state innovation waiver application amendment under § 1332 of the ACA to establish a Qualified Resident Enrollment Program; and
- § 31–124, to direct MHBE to implement a Qualified Resident Enrollment Program to facilitate the enrollment of qualified residents in qualified plans, contingent on approval from the Departments of a Section 1332 waiver amendment.

[3] https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0705

Section 4: Implementation Plan

December 2024	Receive approval of 1332 waiver amendment request
March - August 2025	Design and finalize system changes - March: Exchange begins designing system changes - Summer 2025: Finalize system updates and complete testing in advance of fall OE activities, to support waiver implementation for OE 2026
November 2025	OE 2026 begins; waiver population eligible to purchase QHPs
January 2026	OE ends Jan 15; QHP coverage begins for waiver population

Section 5: Impact on Section 1332 Guardrails

Please see Appendix C for the actuarial analysis demonstrating that the amended waiver would continue to meet the statutory guardrails.

A. Comprehensiveness

This request does not include any changes to Essential Health Benefits (EHBs) and so benefit coverage under the amended waiver will be as comprehensive as it would be without the amended waiver.

B. Affordability

The actuarial analysis shows that the waiver amendment would not change enrollees' out-of-pocket costs or raise premiums, therefore satisfying the affordability requirement. Based on limited claims data, research on the demographics and healthcare spending of individuals who are otherwise eligible for QHPs but for their immigration status, and other states' experiences, the amended waiver is expected to immaterially reduce overall premiums.

C. Coverage

The amended waiver will not impact the coverage of individuals who would be eligible regardless of whether the waiver amendment is in place, and therefore any new enrollments due to the waiver will lead to an increase in coverage, satisfying the coverage requirement.

D. Federal Deficit

Because the amended waiver is expected to lower overall premiums, the federal APTC liability would be reduced, lowering the federal deficit and meeting the requirement.

Section 6: Estimated Impact on Passthrough Funding

MHBE's actuarial consultants project that the impact of the waiver amendment on market morbidity is expected to reduce overall premiums immaterially. Research indicates that the population who would be eligible for QHP but for their immigration status are healthier and spend less on health care than the general population, controlling for age and other factors. Further, the population in Maryland who would be eligible for QHP but for their immigration status is younger than the population in the state's individual market overall. The actuarial analysis anticipates only a limited impact from anti-selection and pent-up demand due to the prior availability of off-Exchange plans for the population who would be eligible for QHP but for their immigration status. Based on these factors, premiums are expected to reduce immaterially. Although lower premiums reduce the federal APTC liability, MHBE is not requesting federal passthrough funding as a result of this waiver amendment.

Please see the actuarial analysis in Appendix C for a detailed analysis.

Appendix A: Maryland's 1332 Waiver Amendment Request Letter of Intent and Response Letter

MARYLAND HEALTH BENEFIT EXCHANGE

750 E. Pratt St., 6th floor
Baltimore, MD 21202
marylandhbe.com

May 3, 2024

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

The Honorable Janet Yellen, Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C., 20220

Dear Secretary Becerra and Secretary Yellen,

The State of Maryland, through the Maryland Health Benefit Exchange (MHBE), intends to submit an application for an amendment to its Waiver under Section 1332 of the Patient Protection and Affordable Care Act ("section 1332 waiver") to the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services, and the Department of the Treasury ("the Departments") on July 15, 2024. Through this application, MHBE will seek to waive section 1312(f)(3) of the Affordable Care Act (ACA) to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans (QHPs or "private plans") and Qualified Dental Plans through MHBE, thereby allowing all qualified Maryland residents to enroll in private plans on-Exchange, regardless of immigration status. MHBE intends to request to waive section 1312(f)(3) for the period January 1, 2026 through December 21, 2028.

Maryland currently has an approved section 1332 waiver that waives section 1312(c)(1) of the Affordable Care Act (ACA) to facilitate Maryland's State Reinsurance Program. The original waiver period was five years, beginning January 1, 2019 and ending December 31, 2023. On March 30, 2023, Maryland applied to extend its section 1332 waiver for an additional five-year period, through December 31, 2028. The Departments approved the extension request on June 28, 2023.

During its 2024 Legislative session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all Maryland residents to enroll in private plans on-Exchange, regardless of immigration status.

An estimated 112,400 Marylanders are uninsured and ineligible for coverage due to immigration status. This comprises about 30% of Maryland's uninsured population.[1] Currently, individuals

[1]Source: MHBE analysis of American Community Survey data

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ineligible to enroll on-Exchange due to their immigration status are able to purchase full-price health plans off-Exchange. If the waiver amendment is approved, these individuals would be able to enroll in full-price private plans on-Exchange. Although the Access to Care Act does not allocate funds to subsidize the cost of coverage for these individuals, allowing enrollment regardless of immigration status would enable access to many other benefits available through the Exchange, including:

- A simplified shopping experience that allows consumers to compare plans from all individual market insurers in one place. Consumers can easily compare plan costs, check if plans include their providers and prescription drugs, and use tools available to estimate total health care costs in order to help find the right plan tailored to their needs;
- Extensive consumer support through our Call Center, which provides consumer support 6 days a week in more than 200 languages, and in-person assistance through the Navigator Program and authorized brokers;
- The ability for mixed-status families to enroll in the same plan through the Exchange, which would provide continuity of coverage and care coordination, save families money by allowing individuals in the family to share a single plan deductible and out-of-pocket maximum, and reduce the burden of managing multiple plans.

MHBE does not anticipate requesting additional federal pass-through funding as a result of this amendment.

If the waiver amendment is approved, MHBE anticipates the new eligibility rules to be effective by the start of Open Enrollment for Plan Year 2026 coverage (by November 1, 2025). MHBE's desired timeline for the application process is as follows:

6/3/2024:	The Departments respond to letter of intent.
6/10/2024:	Application published on MHBE website; 30-day state public comment period; MHBE to hold two public hearings between 6/10/2024 - 7/9/2024.
7/9/2024:	Public comment period ends.
7/15/2024:	MHBE submits waiver amendment application to the Departments.
8/29/2024:	The Departments determine that the application is complete**.** 30-day Federal public comment period begins.
9/30/2024:	30-day Federal public comment period ends.
12/31/2024:	The Departments approve the waiver amendment.
11/1/2025:	Open Enrollment for Plan Year 2026 begins.
1/1/2026:	Coverage begins for Plan Year 2026; qualified residents eligible to enroll in QHPs on-Exchange, regardless of immigration status.

These dates are subject to change if substantial revisions to the draft application are required in response to the Departments' response to this LOI or in response to public comment. MHBE acknowledges that the Departments may take up to 180 days to approve a waiver amendment

MARYLAND HEALTH BENEFIT EXCHANGE

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request but is prepared to work closely with the Departments so that the request, if possible, might be reviewed and approved more quickly, ideally by the end of 2024.

Thank you for your consideration. MHBE looks forward to working with the Departments through the waiver amendment process.

Sincerely,

Michele Eberle
Executive Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

June 4, 2024

VIA ELECTRONIC MAIL: michele.eberle@maryland.gov
Michele Eberle
Executive Director
Maryland Health Benefit Exchange
750 E. Pratt St., 6th Floor
Baltimore, MD 21202

Dear Director Eberle:

Thank you for your May 3, 2024, letter of intent (LOI) to apply for an amendment to Maryland's State Innovation Waiver (section 1332 waiver) under Section 1332 of the Affordable Care Act (ACA). I am sending this letter from the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS) under the Department of Health and Human Services (HHS), as well as on behalf of the Department of the Treasury (collectively, the Departments).

The Departments acknowledge that the state informed the Departments of the state's intent to apply for an amendment to the waiver at least fifteen months prior to the waiver amendment's proposed implementation date. The Departments confirm that the state's anticipated section 1332 waiver amendment application, as described below, may be submitted and will be reviewed as a waiver amendment request. The requirements for the state's waiver amendment application are enclosed with this letter. If the amendment is approved, the Departments may determine that the waiver amendment will be subject to additional or revised requirements, which will be provided in the amendment specific terms and conditions (STCs).

The state's currently approved waiver extension of the ACA requirement for the single risk pool contained in ACA section 1312(c)(1) allows the state to operate a state-based reinsurance program for the individual health insurance market from January 1, 2024, through December 31, 2028. As described in the May 3, 2024, LOI, the state seeks to amend its currently approved section 1332 waiver extension to also waive section 1312(f)(3) of the ACA to the extent it would otherwise prohibit enrollment of residents in Qualified Health Plans and Qualified Dental Plans through the Maryland Health Benefit Exchange (MHBE), thereby allowing all qualified Maryland residents to enroll in such plans on-Exchange, regardless of immigration status, from plan years 2026 through 2028.

A waiver amendment is a change to the existing waiver plan that is not otherwise allowable under the state's STCs, or that the Departments determine could impact any of the section 1332 statutory guardrails or program design for an approved waiver. Such changes include, but are not

limited to, changes to eligibility, coverage, benefits, premiums, out-of-pocket spending, and cost sharing. Given that the state will need to waive an additional statutory provision(s) in order to implement its proposed change in eligibility, the Departments have determined that this is a substantive change in program design and is not otherwise allowable under the state's existing STCs. As such, the Departments confirm that the state may proceed with submitting an application for a waiver amendment if the state wishes to pursue making this change.

The enclosed document further outlines the application requirements for the state's waiver amendment. The state is encouraged to engage with the Departments, as the required information and process may vary based on the complexity of the proposed change. Once the Departments receive the state's waiver amendment application, the Departments will conduct a preliminary review to determine if the application is complete and, if necessary, will identify the elements that are missing from the application by written notice. Please note, the state is not authorized to implement any aspect of the proposed waiver amendment without written approval by the Departments. This letter does not constitute any pre-determination or intent to approve the state's proposed amendment application.

Please send your acknowledgement of this letter and any communications and questions regarding program matters or official correspondence concerning the waiver to stateinnovationwaivers@cms.hhs.gov.

We look forward to working with you and your staff. Please do not hesitate to contact us if you have any questions.

Sincerely,

Jeff Wu
Acting Director, Center for Consumer Information & Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)

CC: Aviva Aron-Dine, Acting Assistant Secretary, Tax Policy, U.S. Department of the Treasury
The Honorable Wes Moore, Governor, State of Maryland
Kathleen A. Birrane, Commissioner, Maryland Insurance Administration
Johanna Fabian-Marks, Director, Policy and Plan Management, MHBE
Tony Armiger, Chief Financial Officer, MHBE

Enclosure

Specific Requirements for Maryland's Waiver Amendment Application

The Departments will review Maryland's waiver amendment application and make a preliminary determination as to whether it is complete within 45 days after it is submitted to stateinnovationwaivers@cms.hhs.gov. After determining that the application is complete, the application will be made public through the HHS website, and a 30-day federal public comment period will commence while the application is under review. A final decision regarding the waiver will be issued no later than 180 days after the preliminary determination of a complete application. If the Departments determine that the application is not complete, the Departments will send the state a written notice of the elements missing from the application. The state's waiver amendment application must include the following:

(1) A detailed description of the amendment request, including:
   a. The desired time period for the amendment request;
   b. A description of the changes to the waiver plan, including whether the state seeks to waive any new provisions and the rationale for the waiver;
   c. The impact on the guardrails;
   d. An updated implementation timeline;
   e. Any activities at the state level that are outside of the waiver, but that impact the baseline; and
   f. Sufficient supporting documentation.

(2) An explanation and evidence that the state has conducted the state public notice process specified for new applications at 31 C.F.R. § 33.112 and 45 C.F.R. § 155.1312, which includes:
   a. For a state with one or more Federally-recognized Indian tribes within its borders, providing a separate process for meaningful consultation with such tribes, and providing written evidence of the state's compliance with this requirement;
   b. Publicly posting the submitted LOI on the state's website in order to ensure that the public is aware that the state is contemplating a waiver amendment request;
   c. Providing a public notice and comment period of no less than 30 days that includes a comprehensive description of the waiver amendment application; information about where the application is available for public review; and where the written comments may be submitted;
   d. Publishing the date, time, and location of the public hearings that will be convened by the state to seek public input on the waiver amendment application in a prominent location on the state's public website. The state may use its annual public forum for the dual purpose of seeking public input on a waiver amendment application;
   e. Providing a description of issues raised and comments received during the entire public notice and comment period, and how the state considered comments when developing the waiver amendment application; and

f. Publicly posting the waiver amendment application on the state's website upon its submission of the waiver amendment application to the Departments.

(3) Evidence of sufficient authority under state law(s) in order to meet the ACA section 1332(b)(2)(A) requirement for purposes of pursuing the requested amendment(s);

(4) An updated actuarial and/or economic analysis demonstrating how the proposed amended waiver will meet section 1332 statutory guardrails. Such analysis must separately identify, in the "with-waiver" scenario, the impact of the requested amendment on the statutory guardrails. Such analysis must include a "with-waiver" and "without-waiver" status on both a summary and detailed level through the proposed approval period using data from recent experience, as well as a summary of and detailed projections of the change in the "with-waiver" scenario attributable to the waiver amendment;

a. For all waiver proposals, the state should use a baseline in which there is no state waiver plan in effect, and should compare premiums, comprehensiveness, and coverage under the baseline for each year to those projected under both the currently approved waiver and the proposed, amended waiver (to allow the Departments to separately evaluate the impact of the amendment on the existing 'with-waiver' scenario). For waivers that impact the individual market, data used to produce these projections might include overall premiums (e.g., for analysis of affordability) and Second Lowest Cost Silver Plan (SLCSP) premiums (e.g., for analysis of deficit neutrality).

i. A projection of the following items separately under the 'without-waiver' scenario, the currently approved 'with-waiver' scenario, and the amended 'with-waiver' scenario:[1]

A. Number of non-group market enrollees by income as a share of the Federal Poverty Level (FPL) (0% to 99%, ≥100% to ≤150%, >150% to ≤200%, >200% to ≤250%, >250% to ≤300%, >300% to ≤400%, and greater than 400% of FPL),[2] by PTC-eligibility, and by metal level. For those projected to newly enroll in Exchange coverage under the waiver, please also provide the number of enrollees by without-waiver coverage type (uninsured, employer-sponsored, other non-group, etc.);

[1] Specifically, the without-waiver scenario refers to the baseline, the currently approved with-waiver scenario refers to the reinsurance-only scenario, and the amended with-waiver scenario refers to a combined reinsurance and amendment scenario.

[2] To the extent different income cuts are more appropriate in the context of a specific waiver, the state may use those income cuts instead.

B. Overall average non-group market premium rate (i.e., total individual market premiums divided by total member months of all enrollees);

C. SLCSP rate for a representative consumer (e.g., a 21-year old nonsmoker), by rating area and issuer-specific service area. The state needs to identify where issuers have service areas that are smaller than rating areas;

D. The state's age rating curve (or a statement that the federal default is used); and

E. Aggregate non-group market premiums and PTC.

ii. Documentation of all assumptions and methodology used to develop the projections and growth of health care spending.

(5) An explanation of the expected impact, if any, of the proposed amendment on pass-through funding, as well as any new proposed uses for pass-through funding; and

(6) The Departments may request additional information and/or analysis in order to evaluate and reach a decision on the proposed amendment.

Appendix B: Maryland Senate Bill 705/House Bill 728 (Access to Care Act)

Chapter 841

(Senate Bill 705)

AN ACT concerning

Health Insurance – Qualified Resident Enrollment Program
(Access to Care Act)

FOR the purpose of requiring the Maryland Health Benefit Exchange to establish and implement the Qualified Resident Enrollment Program to facilitate the enrollment of qualified residents in qualified plans; providing that the operation and administration of the Program may include functions delegated by the Maryland Exchange to a third party; providing that the implementation of the Program is contingent on approval of a certain waiver application amendment; and generally relating to the Qualified Resident Enrollment Program.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 31–101(a) and 31–108(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY adding to
Article – Insurance
Section 31–101(u–1), 31–123, and 31–124
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 31–107, 31–108(b)(1), and 31–115(b)(7)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

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

Article – Insurance

31–101.

(a) In this subtitle the following words have the meanings indicated.

(U–1) "QUALIFIED RESIDENT" MEANS AN INDIVIDUAL, INCLUDING A MINOR, REGARDLESS OF IMMIGRATION STATUS, WHO AT THE TIME OF ENROLLMENT:

(1) IS SEEKING TO ENROLL IN A QUALIFIED PLAN OFFERED TO INDIVIDUALS THROUGH THE EXCHANGE;

(2) RESIDES IN THE STATE;

(3) IS NOT INCARCERATED, OTHER THAN INCARCERATION PENDING DISPOSITION OF CHARGES; AND

(4) IS NOT ELIGIBLE FOR THE FEDERAL PREMIUM TAX CREDIT, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, MEDICARE, THE MARYLAND CHILDREN'S HEALTH PLAN, OR EMPLOYER–SPONSORED MINIMUM ESSENTIAL COVERAGE.

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 subtitle;

(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under this subtitle;

(iii) provide funding for the Medical Assistance Program and the Senior Prescription Drug Assistance Program;

(iv) provide funding for the establishment and operation of Health Equity Resource Communities under Title 20, Subtitle 14 of the Health – General Article; and

(v) provide funding for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Pilot Program authorized under this subtitle.

(2) The operation and administration of the Exchange, the State Reinsurance Program, **[**and**]** the State–Based Young Adult Health Insurance Subsidies Pilot Program**, AND THE QUALIFIED RESIDENT ENROLLMENT 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) income from investments made on behalf of the Fund;

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

(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;

(6) money donated to the Fund;

(7) money awarded to the Fund through grants;

(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;

(11) any funds designated by the State to provide State–based health insurance subsidies to young adults in the State;

(12) any federal funds received in accordance with § 31–121 of this subtitle for the administration of small business tax credits; and

(13) any other money from any other source accepted for the benefit of the Fund.

(f) (1) The Fund may be used only:

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

2. for the establishment and operation of the State Reinsurance Program; and

3. for appropriations to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article;

(ii) in fiscal years 2021 and 2022, for the Medical Assistance Program within the Medical Care Programs Administration of the Maryland Department of Health;

(iii) in fiscal year 2022, for the Senior Prescription Drug Assistance Program established under Title 15, Subtitle 10 of the Health – General Article; and

(iv) for the establishment and operation of the State–Based Young Adult Health Insurance Subsidies Pilot Program.

(2) In each of fiscal years 2023 through 2025, the Governor shall:

(i) transfer $15,000,000 to the Health Equity Resource Community Reserve Fund; and

(ii) include the funds transferred in accordance with item (i) of this paragraph in the annual budget bill as an appropriation to the Health Equity Resource Community Reserve Fund under § 20–1407 of the Health – General Article.

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations, for the State Reinsurance Program, and for the State–Based Young Adult Health Insurance Subsidies Pilot 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) 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 to provide reinsurance to carriers that offer individual health benefit plans in the State;

(ii) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the State;

(iii) any funds designated by the State to provide reinsurance to carriers that offer individual health benefit plans in the State; and

(iv) except as provided in subsection (f) of this section, funds received from the distribution of the assessment under § 6–102.1 of this article.

(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.

31–108.

(a) On or before January 1, 2014, the functions and operations of the Exchange shall include at a minimum all functions required by § 1311(d)(4) of the Affordable Care Act.

(b) In compliance with § 1311(d)(4) of the Affordable Care Act, the Exchange shall:

(1) make qualified plans available to qualified individuals**, QUALIFIED RESIDENTS,** and qualified employers;

31–115.

(b) To be certified as a qualified health plan, a health benefit plan shall:

(7) be in the interest of qualified individuals**, QUALIFIED RESIDENTS,** and qualified employers, as determined by the Exchange;

31–123.

(A) ON OR BEFORE JULY 1, 2025, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL SUBMIT A STATE INNOVATION WAIVER APPLICATION AMENDMENT UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ESTABLISH A QUALIFIED RESIDENT ENROLLMENT PROGRAM AND, IF AVAILABLE, SEEK FEDERAL PASS–THROUGH FUNDING RESULTING FROM THE IMPLEMENTATION OF A QUALIFIED RESIDENT ENROLLMENT PROGRAM.

(B) ON OR BEFORE DECEMBER 31, 2025, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2025 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.

31–124.

(A) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A QUALIFIED RESIDENT ENROLLMENT PROGRAM:

(1) TO FACILITATE THE ENROLLMENT OF QUALIFIED RESIDENTS IN QUALIFIED PLANS;

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

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

(B) THE QUALIFIED RESIDENT ENROLLMENT PROGRAM SHALL ~~BE DESIGNED TO MAKE INDIVIDUAL MARKET INSURANCE COVERAGE OFFERED THROUGH THE EXCHANGE AVAILABLE TO QUALIFIED RESIDENTS~~ ALLOW QUALIFIED RESIDENTS TO PURCHASE QUALIFIED PLANS ON THE INDIVIDUAL EXCHANGE.

(C) (1) THE IMPLEMENTATION OF THE QUALIFIED RESIDENT ENROLLMENT PROGRAM SHALL BE CONTINGENT ON 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 AMENDMENT UNDER § 1332 OF THE AFFORDABLE CARE ACT.

(2) WITHIN 6 MONTHS BEFORE A FISCAL YEAR IN WHICH THE EXCHANGE IMPLEMENTS THE QUALIFIED RESIDENT ENROLLMENT PROGRAM, THE EXCHANGE SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY, IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, ON ITS PLAN TO IMPLEMENT THE PROGRAM, INCLUDING:

(I) THE AMOUNT AND SOURCE OF THE FUNDING FOR THE PROGRAM;

(II) THE PARAMETERS OF THE PROGRAM;

(III) THE NUMBER OF INDIVIDUALS ANTICIPATED TO ~~BE ASSISTED THROUGH~~ PARTICIPATE IN THE PROGRAM; ~~AND~~

(IV) THE AMOUNT OF PREMIUMS ANTICIPATED TO BE PAID BY PARTICIPANTS UNDER THE PROGRAM; AND

~~(IV)~~ (V) IF THE ~~EXCHANGE IS AUTHORIZED TO PROVIDE SUBSIDIES~~ GENERAL ASSEMBLY AUTHORIZES FUNDING TO SUBSIDIZE PREMIUMS UNDER THE PROGRAM, THE PARAMETERS OF THE SUBSIDIES.

(D) ON OR BEFORE JANUARY 1, 2026, THE EXCHANGE SHALL ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2024.

Approved by the Governor, May 16, 2024.

Appendix C: Actuarial Analysis

LEWIS & ELLIS
Actuaries and Consultants

Actuarial and Economic Analysis for Maryland's 1332 Waiver Amendment

MARYLAND HEALTH BENEFIT EXCHANGE

STATE OF MARYLAND

JOSH HAMMERQUIST, FSA, MAAA
Vice President & Principal

JASON DOHERTY, ASA, MAAA
Consulting Actuary

DAVE DILLON, FSA, MAAA, MS
Senior Vice President & Principal

Submitted on:
May 30, 2024

Table of Contents

INTRODUCTION

The State of Maryland is submitting a Section 1332 Waiver amendment application ("Amendment") to allow individuals who are otherwise eligible for Qualified Health Plans (QHPs) except for their immigration status (otherwise eligible individuals ("OEI")) to enroll in Individual market QHPs on the state's exchange. The goal of the Amendment is to improve health coverage and outcomes for those with limited access to care. The Amendment is expected to be implemented for the 2026 policy year.

Lewis and Ellis, LLC (L&E) has prepared this report for the Maryland Health Benefit Exchange ("MHBE"), the Maryland Insurance Administration ("MIA"), and the Department of Health and Human Services ("HHS") to meet the requirements of 45 CFR 155.1308(f)(4)(i)-(iii) and to analyze the impact of the Amendment.

Under current federal law, OEI are not allowed to enroll in Individual health insurance offered on an exchange. As a result, OEI without employer-sponsored insurance often have no other source of health coverage. In 2021, there were approximately 113,000 uninsured OEI in Maryland. The Amendment would allow these individuals access to unsubsidized QHP coverage on the state's marketplace.

Pursuant to federal law, Section 1332 waivers must comply with four requirements:

- Provide coverage that is at least as comprehensive as the coverage provided without the waiver.
- Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver.
- Provide coverage to at least a comparable number of residents as without the waiver.
- Not increase the federal deficit[1].

Maryland's current waiver and the Amendment are both expected to meet the four compliance requirements.

The Amendment's implementation is expected to improve market morbidity and lower market premiums, albeit immaterially. No federal pass-through is being requested as part of the Amendment.

[1]https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-

WAIVER ANALYSIS

The following sections detail the processes for ensuring compliance with the four Section 1332 Waiver requirements, along with a comprehensive actuarial and economic analysis.

At the time of this report, there is uncertainty if the enhanced APTC subsidies introduced by the American Rescue Plan Act and extended by the Inflation Reduction Act will be extended beyond their current 2025 expiration. L&E has assumed these subsidies will expire as currently written into law. Their continuation or expiration is expected to have a limited enrollment impact for OEI and no impact to the four guardrails.

Maryland's current 1332 waiver is for the state-based reinsurance program. The waiver is set to expire at the end of 2028. Due to the success of the waiver, this analysis assumes it will be renewed for an additional period of five years beginning in 2029.

COMPREHENSIVENESS

The comprehensive requirement requires the waiver to have benefit coverage that is at least as comprehensive for residents of the State as coverage absent the waiver. This requirement was satisfied since the Amendment does not include any changes to Essential Health Benefits ("EHBs").

AFFORDABILITY

The affordability requirement states that coverage under the waiver must be at least as affordable for State residents absent the waiver. The Amendment does not change enrollees' out-of-pocket costs, so we will demonstrate that the premiums will not increase for the affordability requirement to be satisfied.

The Amendment's impact on market morbidity is expected to immaterially reduce overall premiums. Although other states have implemented similar 1332 waivers to allow OEI access to their exchanges, there is currently limited data on their Individual market claim utilization patterns and the corresponding morbidity outcomes. As a result, L&E relied on research that analyzed OEI and healthcare spending.

L&E projects that uninsured[2] OEI who enroll will generally be healthier than the average current enrollee in the Individual market. Research shows that OEI tend to be healthier due to the "Health Immigrant Effect" or "Immigrant Paradox"[3]. Two other studies also found that OEI anywhere from 25%[4] to at least 60%[5] less than those with recognized citizenship status, controlling for age and other factors. Additionally, the state of Washington recently applied for a similar OEI waiver. Washington assumed the relative morbidity of their enrolling population to range from 0.64 to 0.85. L&E selected a 0.75 relative health status factor based on the

[2] L&E assumed no currently insured OEI would switch coverage to purchase an unsubsidized QHP plan.
[3] Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review - PMC (nih.gov)
[4] Expanding Insurance Coverage to Undocumented Immigrants in Connecticut | RAND
[5] Medical expenditures among immigrant and nonimmigrant groups in the United States: findings from the Medical Expenditures Panel Survey (2000-2008) - PubMed (nih.gov)

previously referenced RAND study to reflect the OEI's lower acuity before age and enrollment choices are considered.

The Maryland OEI population is younger than those enrolled in the 2024 Maryland Individual market[6]. Generally, medical claim costs increase as individuals age. As a result, OEI are expected to have lower claim costs due to being younger, all else equal. Exhibit 1 below shows the expected relative morbidity based on age distribution differences using the federal age curve.

Exhibit 1 – Age Distribution of Maryland's 2024 Individual Market and Uninsured OEI Population

Age Band	Average Age Curve Factor	2024 Individual Maryland Market	2021 Maryland Uninsured OEI	Ratio
0-17	0.78	6%	11%	
18-25	0.98	11%	13%	
26-34	1.13	19%	18%	
35-44	1.29	18%	29%	
45-54	1.76	18%	16%	
55-64	2.65	24%	10%	
65+	3	5%	3%	
Average Age		42	37	
Average Age Curve Factor		**1.69**	**1.43**	**0.85**

The average age of a population does not necessarily correspond to the average age of those purchasing insurance. Older individuals are more likely to buy insurance because they often have higher health care needs. As expected, Maryland's Individual market also exhibits this trend. Consequently, the relative age factor was adjusted upward to reflect Maryland's higher average age of insurance purchasers compared to the general population. The resulting adjusted age factor is 0.92.[7]

L&E acknowledges that various factors, including health status, influence the decision to purchase coverage. It's important to note that OEI have always had the option to buy the same Individual market coverage off-exchange and demonstrate similar patterns of anti-selection, as the premiums for on-exchange plans are identical to those off-exchange. Therefore, while L&E anticipates some degree of anti-selection and pent-up demand driven by increased awareness, L&E expects these effects to be limited because these plans have been continuously available off-exchange at the same or lower costs.[8]. L&E estimates the selection load, controlling for age to be 1.20.

[6] On-exchange enrollment only, through February 2024; detailed off-exchange enrollment is not available.
[7] The average age of those insured on the Maryland Exchange is 3 years older than the general population in Maryland.
[8] Off-exchange silver plans have lower premiums than on-exchange silver plans.

Exhibit 2 below shows the relative morbidity buildup. The factors are multiplied to determine the final relative morbidity load.

Exhibit 2 – Waiver Population Relative Morbidity Buildup

Morbidity Measure	Factor
Age	0.92
Relative Health Status[9]	0.75
Selection	1.20
Relative Morbidity	**0.82**

Exhibit 3 below shows the expected enrollment and morbidity impact on premiums. The enrollment estimates are discussed in more detail in the following section and represent unique enrollment.

Exhibit 3 – Waiver Relative Morbidity and Premium Impact

	2026	2027	2028	2029	2030
Waiver Enrollment	310	385	445	485	500
Relative Morbidity	0.82	0.82	0.82	0.82	0.82
Non-Waiver Enrollment	243,671	244,680	245,740	246,808	247,885
Morbidity Impact to Premiums	**0.9998**	**0.9998**	**0.9997**	**0.9997**	**0.9997**

Since the waiver did not mandate any changes to out-of-pocket costs, the lower morbidity and resulting premium reduction achieved satisfy the affordability requirement.

COVERAGE

The coverage requirement states that the waiver must extend coverage to at least a comparable number of State residents absent the waiver. The waiver does not impact the coverage of individuals/those who would be eligible regardless of whether section 1312(f)(3) of the Affordable Care Act is waived, except for a minor reduction in premiums. Consequently, any new enrollments due to the waiver will lead to an increase in coverage.

OEI who enroll due to the Amendment will still be ineligible for any federal premium or Cost Sharing Reduction (CSR) subsidies and they must bear the full premium and cost sharing for their chosen plan. OEI also have a lower median income than individuals/those who would be eligible regardless of whether section 1312(f)(3) of the Affordable Care Act is waived[10]. As a result, the full premium and cost sharing requirement is likely to present an affordability challenge for many individuals. This population may be reluctant to engage with

[9] The age factor applied is not double counted with the health status factor as it was developed controlling for age.
[10] https://www.pewresearch.org/race-and-ethnicity/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states/

government services due to their citizenship status and unfamiliarity with the health insurance marketplace. As a result, L&E anticipates that enrollment will be modest and is expected to occur gradually over several years.

To estimate enrollment, L&E reviewed Washington's waiver's enrollment which allowed OEI to enroll on the exchange and provided a state premium subsidy for those under 250% of the federal poverty limit (FPL). A comparison to those under 250% FPL receiving the state subsidy is inappropriate due to the significant difference in net premium between the Washington and Maryland waivers. However, unsubsidized individuals above 250% FPL in Washington have more comparable net premiums to those in Maryland[11]. L&E relied on this cohort's enrollment to validate the estimated Amendment enrollment for those above 250% FPL.

During the 2024 Open Enrollment period, which was the first period Washington's waiver went into effect, 273[12] OEI over 250% FPL enrolled. The total OEI population in Washington is comparable to Maryland's[13], therefore, L&E expects a similar magnitude of enrollment as a result of the Amendment. The exhibit below shows the expected enrollment above 250% FPL by income.

Exhibit 4 – Estimated 2026 Waiver Enrollment Greater Than 250% FPL

FPL Bucket	Estimated Enrollment	Uptake Percentage
250%-300%	65	0.59%
301%-400%	110	0.64%
401%+	100	0.84%
Total	**275**	**0.73%**

Enrollment in Maryland for the under 250% FPL cohort is expected to be much lower than Washington's enrollment due to its subsidy and resulting lower net premiums. L&E assumed a significant enrollment decline for this cohort compared to those above 250% since premium and cost sharing increase as a percentage of income.

[11] The 2024 second lowest cost silver plan in Maryland is 15% lower than Washington's.

[12] 118 individuals did not report income during their enrollment. L&E assumed this cohort's income was above 250% since they voluntarily chose not to apply for a subsidy.

[13] 12.12.2022 Washington Health Benefit Exchange Waiver 1332 Information.pdf (wahbexchange.org)

Exhibit 5 – Estimated 2026 Waiver Enrollment

FPL Bucket	Estimated Enrollment	Uptake Percentage
0-138%	4	0.01%
139% - 150%	2	0.03%
151%-200%	8	0.05%
201%-250%	21	0.15%
250%+	275	0.73%
Total	**310**	**0.27%**

FEDERAL DEFICIT

The final requirement is that the implementation cost must not increase the federal deficit. Those enrolling due to the waiver will not be eligible for Advanced Premium Tax Credits or CSRs. As discussed in the Affordability section above, the relative morbidity of the enrolling population is expected to lower overall premiums. Lower market premiums reduce the federal APTC liability, lowering the federal deficit and meeting the requirement.

With the Amendment, Maryland's 1332 waiver would contain two components: the original reinsurance provision and the new on-exchange OEI population provision.

Exhibit 6 – Savings Components of Maryland's Current and Proposed Waiver/Amendment

Component	2026	2027	2028	2029	2030
Reinsurance	-33.60%	-33.39%	-33.19%	-33.00%	-32.83%
OEI	-0.02%	-0.02%	-0.03%	-0.03%	-0.03%

The data demonstrates that the reinsurance effect is the primary source of savings from the waiver. Consequently, the assumptions regarding morbidity and enrollment for the OEI population have a negligible impact on the overall savings produced by the waiver. Thus, both the existing waiver and the proposed amendment are expected to consistently result in federal savings.

RESULTS

Exhibits 7 and 8 show the projected enrollment[14], premiums, and APTCs for three scenarios: the first scenario where neither the reinsurance program nor the Amendment are active, the second scenario with the reinsurance program but without the Amendment, and the third scenario where both the reinsurance program and the Amendment are implemented.

[14] The unique enrollment values discussed in the Coverage section were converted to expected average enrollment.

Exhibit 7 – 2026 – 2030 Actuarial Analysis of Waiver/Amendment vs No Waiver

	2026	2027	2028	2029	2030
Baseline Scenario - No Reinsurance/No OEI					
Enrollment	229,051	229,999	230,996	232,000	233,011
Increase in SLCSP Premium without Reinsurance	48.9%	48.4%	47.9%	47.5%	47.0%
Premium PMPM	$828.02	$875.60	$924.81	$976.82	$1,031.86
Total Premiums	$2,276,338,092	$2,417,666,599	$2,565,315,976	$2,722,139,155	$2,888,944,407
Total APTCs	$1,211,779,346	$1,282,224,073	$1,354,906,284	$1,431,530,388	$1,512,523,273
After Reinsurance - With Reinsurance/No OEI					
Premium PMPM	$549.92	$583.45	$618.26	$655.08	$694.01
Enrollment	243,671	244,680	245,740	246,808	247,885
Total Premiums	$1,608,001,115	$1,713,088,438	$1,823,185,253	$1,940,147,630	$2,064,418,261
Total APTCs	$739,202,468	$787,938,728	$838,448,226	$891,792,450	$948,177,321
Estimated Federal Savings	$467,851,109	$489,342,492	$511,293,478	$534,340,558	$558,702,492
After Reinsurance - With Reinsurance and OEI					
Premium PMPM	$549.82	$583.31	$618.10	$654.89	$693.80
Enrollment	243,930	245,001	246,111	247,212	248,301
Total Premiums	$1,609,400,183	$1,714,931,912	$1,825,443,181	$1,942,755,056	$2,067,266,086
Total APTCs	$739,020,165	$787,508,351	$837,705,862	$890,679,057	$946,637,984
Estimated Federal Savings	$468,031,589	$489,768,565	$512,028,417	$535,442,818	$560,226,436

Exhibit 8 - 2031 – 20235 Actuarial Analysis of Waiver/Amendment vs No Waiver

	2031	2032	2033	2034	2035
Baseline Scenario - No Reinsurance/No OEI					
Enrollment	$233,976	234,990	236,011	237,040	238,074
Increase in SLCSP Premium without Reinsurance	46.6%	46.2%	45.8%	45.4%	45.0%
Premium PMPM	$1,091.15	$1,152.48	$1,217.29	$1,285.88	$1,358.34
Total Premiums	$3,068,307,130	$3,255,691,791	$3,454,719,101	$3,666,414,852	$3,891,082,739
Total APTCs	$1,600,451,236	$1,691,171,990	$1,786,812,950	$1,887,906,952	$1,994,720,633
After Reinsurance - With Reinsurance/No OEI					
Premium PMPM	$736.29	$780.21	$826.66	$875.79	$927.84
Enrollment	248,911	249,989	251,076	252,171	253,270
Total Premiums	$2,199,251,929	$2,340,528,511	$2,490,641,410	$2,650,171,589	$2,819,919,768
Total APTCs	$1,010,691,475	$1,075,480,166	$1,143,904,970	$1,216,230,021	$1,293,127,928
Estimated Federal Savings	$584,367,257	$610,580,876	$638,103,439	$667,196,184	$697,615,340
After Reinsurance - With Reinsurance and OEI					
Premium PMPM	$736.07	$779.96	$826.39	$875.50	$927.52
Enrollment	249,340	250,431	251,530	252,637	253,750
Total Premiums	$2,202,363,886	$2,343,922,137	$2,494,338,825	$2,654,196,556	$2,824,298,163
Total APTCs	$1,008,748,278	$1,073,048,108	$1,140,903,412	$1,212,583,251	$1,288,766,537
Estimated Federal Savings	$586,291,023	$612,988,614	$641,074,981	$670,806,486	$701,933,117

APPENDICES

APPENDIX A: CAVEATS

L&E performed reasonability tests on the data used; however, L&E did not perform a detailed audit of the data. To the extent that the information provided was incomplete or inaccurate, the results in this report may be incomplete or inaccurate.

L&E made several assumptions in performing the analysis. Several of these assumptions are subject to material uncertainty and it is expected that actual results could materially differ from the projections. Examples of uncertainty inherent in the assumptions include, but are not limited to:

- Data Limitations.
  - L&E relied on the data submitted from the insurers for significant portions of this analysis. To the extent that the data is inaccurate, the analysis will be impacted.
- Enrollment Uncertainty.
  - Beyond changes to premiums and market wide programs, consumer responses to these have inherent uncertainty. Therefore, actual enrollment could vary significantly.
- Political and Health Policy Uncertainty.
  - Future federal or state actions could dramatically change future premiums and enrollment.

This report has been prepared for Maryland Health Benefit Exchange, the Maryland Insurance Administration, and the Department of Health and Human Services in relation to the analysis of Maryland's 1332 Waiver. Any other use may not be appropriate.

L&E understands that this report may be distributed to other parties; however, any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

APPENDIX B: DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[15], promulgates Actuarial Standards of Practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[16], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

IDENTIFICATION OF THE RESPONSIBLE ACTUARIES

The responsible actuaries are:

- Josh Hammerquist, FSA, MAAA, Vice President & Principal
- Jason Doherty, ASA, MAAA, Consulting Actuary
- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal

The actuaries are available to provide supplementary information and explanation.

IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is May 30, 2024. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 6, 2024.

DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Maryland Health Benefit Exchange, the Maryland Insurance Administration, and the Department of Health and Human Services. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis LLC is financially and organizationally independent from the companies that participate in the Maryland Individual market. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Department of Health and Human Services with analysis of Maryland's 1332 Waiver extension.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.

[15] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conoference of Consulting Actuaries, and the Society of Actuaries.
[16] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of other subsequent events that may have a material effect on the findings.

ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions, and data used can be found in the body of this report.

ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations, and other legally binding authority.

RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuaries do not disclaim responsibility for material assumptions or methods.

DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuaries do not believe that material deviations from the guidance set forth in an applicable ASOP have been made.

Appendix D: Public Hearing Presentation

Will be added after the public comment period.

Appendix E: Public Hearing Minutes

Will be added after the public comment period.

Appendix F: Public Comments

Will be added after the public comment period.