Maryland Health Benefit Exchange
Board of Trustees

February 18, 2025
2 p.m. – 4 p.m.
Meeting Held via Video Conference

Members Present:
Laura Herrera Scott, M.D., Chair
Ben Steffen, Vice Chair
Aika Aluc
Laura Crandon (joined at 3pm)
Marie Grant
Katherine Rodgers
Maria Pilar Rodriguez
K. Singh Taneja
Dana Weckesser

Also in Attendance:
Michele Eberle, Executive Director, MHBE
Tony Armiger, Chief Financial Officer, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Shirelle Green, Procurement Officer, MHBE
Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE
Greg Yaculak, Deputy Chief Information Officer, MHBE
Makeda (Mimi) Hailegeberel, Manager, Small Business Programs, MHBE
Scott Brennan, Director of Compliance & Privacy, MHBE
Tamara Cannida-Gunter, Director of Consumer Assistance & Eligibility, MHBE
Sharon Merriweather, Assistant Attorney General, MHBE
Tisha Payne, Director of Human Resources & Organizational Effectiveness, MHBE
Tracey Gamble, Procurement Manager, MHBE

Meeting Call to Order
Sec. Herrera Scott called the meeting to order.

Approval of Minutes
Mr. Steffen moved to approve the minutes from the January 21, 2024, Board meeting.

Ms. Grant moved to approve the minutes as presented. Ms. Rodgers seconded. The Board voted unanimously to approve the minutes. Sec. Herrera Scott and Mr. Taneja abstained from the vote because they did not attend the January Board meeting.

Public Comment

None offered.

Board Committee Reports

K. Singh Taneja, Board Member
Kat Rodgers, Board Member

Mr. Taneja reported that he was unable to attend the last Finance Committee meeting on January 21. He noted that there was a presentation at the meeting on the finance report as well as the audit findings from the Office of Legislative Audits (OLA) with the management response. Mr. Taneja will provide more details at the next Board meeting.

Ms. Rodgers reported that during the last Policy Committee meeting they discussed possible upcoming changes under the new administration and whether reinsurance funds would be used to cover lost Medicaid funds. She also mentioned that they discussed a policy regarding the utilization of AI.

Executive Director Update

Michele Eberle, Executive Director

Ms. Eberle began her update by noting that changes at the federal level are having a huge impact on the exchange. Robert F. Kennedy Jr. has been appointed as the Secretary of Health and Human Services (HHS) and is starting to implement changes. Dr. Mehmet Oz is waiting to be confirmed as the administrator of the Centers for Medicare & Medicaid Services (CMS). Peter Nelson is the new director of the Center for Consumer Information and Insurance Oversight (CCIIO), which is the agency the MHBE reports under. Ms. Eberle commented that not much is known about Mr. Nelson other than that he was in the prior administration and is favorable to section 1332 waivers. Drew Snyder is set to be the deputy director of the CMS Medicaid division. Ms. Eberle reported that the Department of Government Efficiency (DOGE) has come into HHS and some staff have been let go.

Ms. Eberle noted that the MHBE is keeping a close eye on the executive orders being released. On February 14, an executive order was issued that reduced navigator funding for the federal marketplace to $10 million. Ms. Eberle explained that, since Maryland is a state-based marketplace, the navigator program is funded by the state and will not be impacted by this executive order. There has been interest in reducing federal Medicaid funding, which would have a significant impact on the state and consumers especially if the state is unable to backfill the lost funding. The exchange receives some Medicaid funding from CMS for the MHBE's Medicaid work which includes information technology (IT). Any cuts to that federal funding will likely result in a reduction of staffing levels, mostly for contracted staff, and will impact the MHBE's ability to complete their work in same amount of time as previously. A bill which was recently passed in the House, HR 77, the Midnight Rules Relief Act, would reverse any rulemaking done in the previous sixty days. This would impact the expansion of coverage through the exchange to deferred action for childhood arrivals (DACA) recipients and the 2026 Notice of Benefit and Payment Parameters, which sets out the landscape for the individual

insurance market and carriers for 2026. Other threats being monitored by MHBE include potential impacts on the state reinsurance program, the reduction or elimination of the expanded tax credits which are set to expire at the end of 2025 and could affect the reinsurance program and enrollment, and a potential federal government shutdown beginning on March 14.

Ms. Eberle then provide the state update. She noted that it is a tight budget season as expected and the MHBE is working with the state in different areas including adopting a Department of Budget and Management (DBM) initiative, called Results for America, which examines how the MHBE can do what it does better with objective measures. The MHBE worked with DBM to ensure that the MHBE's services are evidence-based and outcome-oriented. The MHBE also worked with another initiative from the Governor's Office to explore possible efficiencies with the MHBE's call center and other call centers. The Governor's Office was impressed by the MHBE's demonstration of their call center efficiency with current funding. Ms. Eberle commented that the MHBE is liked and respected in Annapolis and thanked the Board for their governance.

Ms. Eberle reported that the Office of Legislative Audits (OLA) recently finished their triannual audit of the MHBE which took 18 months to complete. The audit had several findings which the MHBE is addressing in collaboration with OLA. The largest finding is that during the audit period of 2020 through 2023, which coincided with the COVID public health emergency (PHE) and Medicaid continuous enrollment requirements, the MHBE allowed attestation of income for Medicaid eligibility. The MHBE drafted a response collectively with the Maryland Department of Health, that the federal law required the acceptance of income attestation. Other findings were less serious and are being mitigated. Ms. Eberle noted that the audit report is publicly available.

Ms. Eberle explained that the "check the box" initiative for tax filings is in process so that individuals filing their tax returns who don't have health coverage can check a box to be contacted by the MHBE for assistance enrolling in coverage. Ms. Eberle expressed best wishes to three individuals who are moving on: Sharon Merriweather is moving to a new role in the Attorney General's office, Ben Steffen is retiring in the next month, and Sec. Laura Herrera Scott will be leaving at the end of the month.

Sec. Herrera Scott commended Mr. Steffen for his years of service to the state.

Standing Advisory Committee Member Approval

Aika Aluc, Board Member,
Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE

Ms. Aluc, Board Liaison for the Standing Advisory Committee (SAC) reported that the new member application period ended on January 31, 2025. The SAC is charged with addressing a broad range of policy issues on which the Board may seek their input or advice. The SAC should be reflective of the gender, racial, ethnic, and geographic diversity of the state. SAC members serve a three-year term. Ms. Aluc explained that the application and member recruitment process was consistent with MHBE SAC policy and procedure. MHBE staff identified goals for recruiting new members to maintain the SAC's reflection of the diversity of the state and add expertise to the SAC, by targeting recruitment in the Eastern Shore and Capital regions. This resulted in two applicants from the Eastern Shore and four from the Capital region.

Ms. Aluc noted that there were eleven applicants for the SAC for 2025 including representatives from community organizations, health care providers, public health researchers, brokers, navigators, and insurers. The MHBE usually aims to recruit six to eight new SAC members each year but there were a lot of SAC members whose terms end early so the MHBE had a larger recruitment goal for 2025. The SAC traditionally includes representation from each carrier active on Maryland Health Connection (MHC). In 2024, the SAC terms for the current representatives from CareFirst and United Healthcare ended and WellPoint was invited to join the SAC as they entered the individual market in 2025. As a result, there were three applicants from these carriers. The Board Liaison and SAC recommend that the Board appoint ten applicants to the SAC. There were two broker applicants with one from the Central Maryland region which is already heavily represented in SAC and the other broker applicant was from the Eastern Shore, so the MHBE is recommending the broker applicant from the Eastern Shore. Ms. Aluc showed a list of the eleven applicants with name, location, affiliation, and specialty; the list identified the ten applicants being recommended to join the SAC.

Sec. Herrera Scott asked for a motion to approve the appointment of the applicants to the 2025 Standing Advisory Committee as presented. Mr. Steffen moved to approve the motion and Mr. Taneja seconded. The Board voted unanimously to approve the appointment of the new SAC members. Ms. Crandon was absent for the vote.

Final 2026 Plan Certification Standards

Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE

Ms. Fabian-Marks reported that the MHBE did not receive any comments on the proposed plan certification standards for 2026, so no changes were made for the final plan certification standards. She provided an overview of the timeline for the certification standards. Ms. Fabian-Marks explained that carriers are required to offer a value plan at each of the metal tiers. The MHBE establishes the plan design for the value plans which is essentially the cost sharing that applies to each benefit because the benefits are standardized.

Ms. Fabian-Marks provided an overview of the proposed changes for 2026 value plans driven by workgroup input and compliance with federal actuarial value requirements. The changes include reducing the copay associated with laboratory procedures in the Bronze, Base Silver, and Silver 75 plans; making coinsurance rates equal for Class III and IV major pediatric dental services, as is generally done in the market; increasing the maximum out-of-pocket amount for all Value Plans; increasing the specialist copay from $100 to $110 in the Bronze, Base Silver, and Silver 73 plans; raising the lab copay from $5 to $10 in the Silver 94 plan; and raising the copay for outpatient rehabilitation and habilitative services from $2 to $5 for the Silver 94 plan, bringing it in line with other occupational therapy (OT) copays in the same way that all other plans have the same copay for all OT services. Ms. Fabian-Marks then showed a table of the copays for all services under each proposed 2026 Value Plan design, included in full in the presentation for this meeting. Ms. Fabian-Marks showed a list of commonly used services for diabetes patients with $0 cost-sharing.

Ms. Fabian-Marks explained that the other 2026 plan certification standard for which the MHBE is asking the Board's approval would mandate that cost sharing for mental health and substance use disorder (MHSUD) office visits for every MHC plan be set equal to that of primary care visits. Carriers would be encouraged, but not required, to use a copay structure for MHSUD office visits. This standard would simplify cost sharing across these service types.

Ms. Fabian-Marks explained that state and federal parity laws generally physical health and mental health treatment cost sharing be equivalent, but plans may still differ in their copays for MHSUD office visits versus primary care office visits due to technicalities of the law. The MHBE thought that making the cost sharing amounts equivalent would be easier for consumers to understand and promote access to MHSUD services.

Ms. Eberle asked for more information regarding how many consumers hit the maximum out-of-pocket and the significant enrollment in gold and platinum plans due to the plan certification standards. Ms. Fabian-Marks responded that the MHBE worked with the Maryland Insurance Administration (MIA) and carriers to examine how many enrollees hit their maximum out-of-pocket amount and found that 2-5% of enrollees do so. She explained that when the MHBE and carriers are adjusting the plans' cost sharing to stay within the federal actuarial value requirements that they will increase the maximum out-of-pocket amount because it impacts a small portion of enrollees. The federal government sets a maximum limit for the maximum out-of-pocket amount which increases slightly each year. Ms. Fabian-Marks explained that, in terms of enrollment distribution across metal levels, almost 75% of enrollees are in gold or gold-equivalent plans or better. Some of the silver plans have variants that make them equivalent to or better than gold plans. Very few people are enrolled in a base silver plan. Roughly 25% of enrollees are in a bronze plan. These may be healthy individuals who have made a calculated decision to select a plan with low monthly costs because they expect to have low health needs.

Sec. Herrera Scott moved to approve the final plan certification standards for plan year 2026 as presented. Ms. Weckesser and Ms. Aluc seconded. The Board voted unanimously to approve the final plan certification standards for 2026. Ms. Crandon was absent for the vote.

2026 Estimated Reinsurance Parameters

Johanna Fabian-Marks, Director of Policy & Plan Management, MHBE

Ms. Fabian-Marks explained that, under Maryland regulations, the Board must set the estimated payment parameters for the state reinsurance program (SRP) for the following plan year by April 1 every year so carriers can include these payment parameters in their rate filings. She then provided an overview of the key dates for the SRP. The Board will set the estimated payment parameters for the SRP today and will set the final payment parameters at the July Board meeting. Between now and July, the carriers will submit claims data for 2024 to the federal government and the MHBE so the MHBE will know the SRP payouts for 2024, and the amount of pass-through federal funding being received. After the MHBE receives these data then they will do more modeling and consult with the MIA to determine the final SRP parameters for 2026.

Ms. Fabian-Marks explained that the MHBE operates the SRP under a waiver granted by the federal government which allows the reimbursement of insurers for a portion of their claims costs and has resulted in insurance rates that are more than 20% lower than they were before the SRP. When an enrollee's claims cost exceeds a certain amount, called the attachment point, the SRP begins reimbursing the carrier for a portion of claims costs. The portion of claims costs reimbursed by the SRP is called the coinsurance rate. The SRP stops reimbursing the carrier for claims costs once they exceed a certain amount, called the reinsurance cap.

Ms. Fabian-Marks then showed a table displaying the SRP payment parameters from 2019 through 2025 with the estimated 2026 parameters. From 2019 through 2022 the parameters stayed the same with a $20,000 attachment point, 80% coinsurance rate, $250,000 reinsurance cap, and a .760-.805 dampening factor. The attachment point increased to $21,000 in 2025 and the MHBE's modeling assumes a thousand dollar increase each year moving forward to keep the SRP consistent with inflation and medical cost trends. Ms. Fabian-Marks noted that the Board does not set the dampening factor but determines if it is necessary and then the Insurance Commissioner sets the dampening factor, which is an adjustment factor to SRP payments to account for the interaction between the SRP and the federal risk adjustment program that moves money between carriers to equalize risk. The dampening factor is used to minimize the impact of double payments when an insurer is eligible for both a federal risk adjustment payment and SRP payment. The SRP has had a dampening factor in place every year of the SRP and MHBE recommended that the Board again determine that a dampening factor, to be provided by the Insurance Commissioner, is required.

Ms. Fabian-Marks then showed a snapshot of the funding outlook for the SRP based on data collected last summer, included in full in the presentation for this meeting. She will share an updated version of the projection based on updated data with the Board in July. Ms. Fabian-Marks explained that the SRP received more funding than it spent each year since the program began in 2019, which has allowed the MHBE to save some funds for future years. It is projected that, in 2026, federal funding will decrease and that the cost of the SRP will exceed the funding in 2026 through 2028 so the MHBE will be drawing down on the reserve. The MHBE still anticipates ending the five-year waiver period in 2028 with a balance of $263 million so the SRP will remain solvent. Ms. Fabian-Marks noted that the projections assume that the attachment point will continue to increase annually by $1,000 and that the enhanced federal subsidies will end in 2025 resulting in the significant decrease in federal funding.

Ms. Fabian-Marks explained that, once the estimated parameters are set during this meeting, there will be a 30-day public comment period and the MHBE will collect additional data and will come back to the Board with the final 2026 SRP parameters in July.

Ms. Grant asked for more information regarding the projection that shows that, in 2026, the SRP cost will be almost $100 million less than 2025. Ms. Fabian-Marks responded that, in 2026, the projections show both a drop in the federal funding and the SRP spending which ties back to an assumed change in the enrollment mix as the MHBE expects some individuals who receive enhanced federal subsidies will drop coverage, so declining enrollment will reduce SRP costs.

Ms. Grant commented that the SRP projections will be an ongoing process over the next few months as they receive more data, which is important in a time of uncertainty.

Mr. Taneja asked about the impact of the expected annual $1,000 increase of the attachment point on the state funding and the reserve funds. Ms. Fabian-Marks responded that she can provide the difference in the projections between the $1,000 increase and no increase but the attachment point increase reduces the cost of the SRP because the SRP would be covering a slightly smaller portion of claims. She noted that by increasing the attachment point the MHBE extends the solvency of the SRP and reduces the reinsurance cost. The MHBE has previously examined the impact on rates and found that a $1,000 increase of the attachment point results in a .5% increase in premium rates. The MHBE wants to balance the preservation of state funds without increasing rates in a way that would

have significant impacts on the market. The MHBE will continue to receive more information and data on future funding and the fate of the enhanced federal subsidies in the coming months and will have more information on their recommendation to the Board in July.

Mr. Taneja asked if there were any comparisons to other states. Ms. Fabian-Marks responded that the MHBE worked with the MIA on a report last winter that examined the SRP and made recommendations to the state on whether changes should be made to the SRP. The report included looking at other state reinsurance programs. Ms. Fabian-Marks agreed to send the report to the Board and pull out the comparative analyses of reinsurance programs in other states. She noted that Maryland has one of the most generous reinsurance programs in the country with one of the lowest attachment points, so Maryland is covering a larger share of claims and has higher costs compared to other states. She explained that there is a positive relationship between the size of the SRP and federal funding in that Maryland has a higher percentage of costs covered by federal funding. Also, Maryland has the lowest cost bronze and gold plan nationally, largely due to the impact of the SRP.

Mr. Taneja asked whether, if the Board approves the SRP payment parameters today, there will be an opportunity to adjust the parameters if there is a change in circumstances. Ms. Fabian-Marks responded that she is presenting the estimated parameters to the Board today for the purpose of informing carriers' initial rate filings. The Board will lock in the final SRP parameters for 2026 in July when the MHBE comes back with their final recommendations.

Sec. Herrera Scott asked about the estimated end-of-year fund balance and whether it will be adjusted. Ms. Fabian-Marks responded that the MHBE will be focused on this issue between now and July as they receive final information on 2024 reinsurance payments to carriers and federal funding for 2025. After the MHBE receives that information then the SRP funding projections chart will be updated and the MHBE will adjust SRP parameters as needed.

Mr. Steffen asked whether the federal revenue estimates for 2026 and 2027 assume that the enhanced federal subsidies will be gone. Ms. Fabian-Marks responded in the affirmative. Mr. Steffen asked if the current projections take a more pragmatic approach. Ms. Fabian-Marks responded in the affirmative and noted that, if the enhanced federal subsidies are continued beyond 2025, then the funding outlook would be more positive with less need to draw down on reserves.

Ms. Eberle noted that the current waiver for the SRP ends in 2028 so the MHBE will need to make a decision about the future of the SRP in 2026 because they would need legislature approval to apply for another waiver. There will be serious discussions at the state level regarding funding for the SRP and whether it is still needed.

Sec. Herrera Scott moved to approve the estimated parameters for the 2026 State Reinsurance Program as presented with an attachment point of $22,000, a coinsurance rate of 80%, a cap of $250,000, and a dampening factor to be provided by the Insurance Commissioner. Mr. Taneja and Ms. Rodgers seconded. The Board voted unanimously to approve the 2026 estimated parameters for the state reinsurance program.

2025 Private Pay Enrollment Analysis

Andrew Ratner, Chief of Staff, MHBE

Mr. Ratner provided an overview of a private pay enrollment analysis that was done in the last month since open enrollment ended on January 15. He reported that, during the recent open enrollment, 247,243 individuals enrolled, which is a new record and a 16% increase from the previous year. New enrollments decreased by 4% while renewals increased by 22%. He noted that private-plan enrollments on MHC have grown by 60,000 people in the last two years which should have resulted in a decrease of the uninsured rate in Maryland, however the uninsured rate is also impacted by other factors such as Medicaid, Medicare, employer-sponsored insurance, and other programs. Mr. Ratner reported that, when open enrollment ended for plan year 2019, roughly 53,000 enrollees had Medicaid coverage at any point in the previous four years while for plan year 2025 almost 97,000 enrollees previously had Medicaid.

Mr. Ratner showed a chart displaying the MHC growth for 2025 by county and the uninsured rate by county. He noted that there is a lag in the uninsured data used for the chart. Prince George's County had the highest percentage of uninsured residents in the state and was second in enrollment growth. Wicomico County had the fifth highest percentage of uninsured residents and the third highest enrollment growth. Mr. Ratner noted that these two counties are a bright spot in terms of enrollment growth. Caroline County had the second highest uninsured rate and was fourth to last in enrollment growth, and Garrett County had the fourth highest uninsured rate and was the last in enrollment growth.

Mr. Ratner then showed three tables showing the top seven counties with the highest percentage of uninsured residents, the highest number of uninsured residents, and the highest enrollment growth on MHC. He explained that Baltimore City, Prince George's, and Wicomico counties had the highest enrollment growth in 2025 which are important counties for the MHBE because they lacked health insurance in the past. He showed a Venn diagram displaying the counties with the highest percentage of uninsured population, the counties with the most uninsured residents, and the counties with the greatest enrollment growth, included in full in the presentation for this meeting.

Mr. Ratner explained that the MHBE has focused outreach on meta areas which are zip codes with the highest levels of uninsured people in the state. He showed a map and chart displaying enrollment growth by these meta areas. There was significant enrollment growth in the Dundalk, Essex, and Edgemere area in eastern Baltimore County and less growth in the Eden, Pocomoke City, and Crisfield area in the Lower Shore.

Mr. Ratner displayed a pie chart showing the enrollment distribution across metal tiers. He explained that 75% of enrollees in MHC are in gold or silver plans with cost sharing reductions for lower deductibles. This is likely the result of the reinsurance program and young adult subsidy making these plans more affordable and accessible. He noted that, in 2024, enrollment stayed steady without a drop-off like in previous years indicating that consumers did not end coverage due to affordability problems.

Mr. Ratner showed a chart displaying enrollment growth by household income. He reported that there was significant enrollment growth for households with incomes below 150% of the federal poverty level (FPL); this population has a year-round special enrollment period. There was also substantial growth for Hispanic households with incomes below 138% of the FPL, which has grown nearly 50% in two years most likely due to targeted outreach. On the negative side, there was a large increase in the percentage of enrollees with an "unknown" income in the past couple of years meaning they did

not report their household income. These individuals may not be submitting their income information because they have an income above 400% of FPL and know they are not eligible for tax credits.

Mr. Ratner reported that the young adult subsidy program is working, with young adult enrollment growing by 21% this year to 89,642 people. More than two-thirds of these young adults were eligible for a state subsidy. The General Assembly is considering extending the program through 2028 or beyond. Mr. Ratner also displayed a chart showing enrollment growth for young adults by race and subsidy status. Black young adults made up 21% of young adult enrollment but 26% of young adult subsidy recipients. Similarly, Hispanic young adults made up 14% of young adult enrollment but 17% of young adult subsidy recipients. This indicates the importance of the young adult subsidy in driving enrollment for these groups. On the downside, there was little to no growth in new young adult enrollment either with or without subsidies.

Mr. Ratner provided an overview of minority enrollments, which have been a focus of marketing efforts. Enrollment by Black consumers grew by 21% to 51,086 and enrollment by Hispanic consumers grew by 25% to 35,883. Also, for the first time, DACA recipients were eligible to enroll in health insurance with subsidies through state exchanges through action by President Biden. A total of 249 DACA recipients enrolled for 2025 coverage through MHC.

Mr. Ratner showed a map displaying the percentage of uninsured people by county in 2010 before the Affordable Care Act. Some counties had an uninsured rate of more than 20%, and most counties had a 10% uninsured rate. He then showed a map of the uninsured rate in Maryland in 2022, which showed a significant decrease in the uninsured rate since 2010. In the outer suburbs the uninsured rate was below 6% and in the inner suburbs and rural areas the uninsured rate was between 6% and 12%.

Lastly, Mr. Ratner showed a map and table created by the Kaiser Family Foundation that displays the impact of the end of the enhanced federal tax credits by congressional district. In most of the districts, 25,000 to 30,000 people are enrolled in MHC which makes up 3% to 5% of the total district population. Without the enhanced subsidies, premium payments will be increased by $971 or 167%, which could have a substantial impact on enrollment. The MHBE will continue to advocate for the continuation of the enhanced subsidies and will closely monitor what happens.

Ms. Grant asked if the MHBE looked at the counties and zip codes with the highest Medicaid disenrollments during the PHE unwinding and their transition into QHP coverage. She commented that, based on the presented data, it looks like the MHBE did well with enrolling consumers who lost Medicaid in coverage through MHC. Mr. Ratner responded that the state had amazing success with transitioning individuals who lost Medicaid during the unwinding to the exchange. He noted that, since the pandemic, people may be more health-conscious and, after getting coverage through Medicaid, they may realize the importance and value of having health insurance and are more likely to enroll in coverage through the exchange after losing Medicaid.

Ms. Grant expressed concern about the end of enhanced subsidies and the impact on Maryland in terms of enrollment levels and morbidity.

Mr. Taneja commented that the enrollment growth for minority groups was impressive and asked how it related to the general population growth in the state and whether it was comparable. Mr. Ratner

responded that overall enrollment growth was 20% so it was comparable to growth in the minority populations. He noted that, for populations that historically were unable to access coverage due to affordability, the MHBE was very happy to have successful outreach to these communities. The state exchange has grown seven years in a row, and overall enrollment has increased 56% since the COVID pandemic.

Ms. Crandon asked if there is a further breakdown of the young adult subsidy by county or district. Mr. Ratner responded that he can get that data and asked whether Ms. Crandon wants the data broken down by county. Ms. Crandon responded that she would like county level data to identify the counties with the highest concentration of young adult subsidies and which would be the most impacted if the young adult subsidies are not continued.

Ms. Crandon asked about the rationale for the enrollment consistency over the past year and whether it is even across counties or congressional districts. Mr. Ratner responded that the MHBE's theory for the consistent enrollment is increased affordability of plans and individuals transitioning from Medicaid to the exchange during the PHE unwinding. He explained that enrollment did not decline towards the end of 2024 as expected and, as a result, the open enrollment started with the highest number of renewals ever. While new enrollment only increased by 4%, renewals were very strong.

Ms. Crandon asked whether the consistent enrollment would contribute to rate stability from carriers. Mr. Ratner responded that it does help with rates, and reinsurance has helped keep insurance premiums among the lowest in the country. The young adult subsidy further lowers premiums by an average of $40 a month. Mr. Ratner noted that enrollment growth among young adults without a subsidy was almost as high as those who received a subsidy. Ms. Crandon suggested that, for more rate stabilization, there should be growth in young adult enrollment, enrollment consistency, and lower utilization. Mr. Ratner responded that the young adult impact on the risk pool and morbidity is important.

Ms. Eberle expressed concern about the ending of the enhanced federal subsidies at the end of 2025 and the potential impact. She noted that a bill was introduced to the General Assembly that would give the MHBE authority to use reinsurance funds for one year to backfill the funding lost from the expanded tax credits to give the state time to figure out a long-term plan. The bill is currently going through the Health Care and Government Operations Committee. Ms. Eberle noted that the MHBE expects that reinsurance reserve funds will still be available by the end of 2028 so there is sufficient funding to cover the enhanced tax credits for one year. The MHBE will report back on the progress of the bill.

Mr. Steffen asked whether the individuals moving from Medicaid to the exchange are classified as new enrollments or renewals. Mr. Ratner responded that these individuals would be considered new enrollees for QHPs, but he would double-check. Mr. Steffen commented that the 4% increase in new enrollees seems low given the PHE unwinding. Ms. Eberle responded that, if the individuals moving from Medicaid to the exchange enrolled in a QHP during 2024, which many did, then they would be classified as a renewal for 2025 open enrollment period. Ms. Fabian-Marks added that, when looking at the year-over-year change for new enrollees, it is being compared to the 2024 open enrollment when there was strong enrollment due to enhanced subsidies and the unwinding so the year-over-year change may be small in part because the baseline from last year was strong.

Adjournment

Sec. Herrera Scott closed the meeting. The next Board meeting is on April 21, 2025. There will be no March meeting. Sec. Herrera Scott wished the Board the best of luck and thanked them for their service and support. The meeting was adjourned at 3:27 PM.