The ACA in Maryland: A Case Study in Successful Bipartisan Innovation

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Introduction

The Affordable Care Act (ACA) sets up a structure with key roles for both federal and state policymakers. Federal regulations and subsidies are interwoven into a health insurance system that remains primarily a state responsibility, with additional options for state roles. It is not surprising, then, that different states have seen different market outcomes in terms of costs and enrollment.

Maryland fully embraced the ACA from the start. From establishing a state-based marketplace to a temporary Maryland supplemental reinsurance program, Maryland made every effort to ensure the ACA's success in the state.[1] These measures were generally successful—despite initial technical shortcomings with its Marketplace website, Maryland experienced several years of growing individual marketplace enrollment, diverse issuer and product offerings (HMOs, EPOs, PPOs, etc.), and premium increases that aligned with national trends.

Yet beneath these positive indicators was a looming concentration of high-risk enrollees whose growing claims, when coupled with federal action to undermine Marketplace stability, risked stymying Maryland's gains in health coverage—creating an affordability crunch for thousands of Marylanders.[2] Beginning in 2017, the increasing morbidity of the risk pool and adverse federal policy action (and uncertainty) resulted in two years of unsustainable premium increases, attrition of over 75,000 enrollees, and concentration in issuer market participation.[3]

Given the declining health of its individual market, Maryland's policy leaders worked collaboratively to respond to its health coverage affordability emergency in a bipartisan, multi-year approach that leveraged both regulatory and statutory levers to enact innovative policies that reduce premiums, lower out-of-pocket costs, and connect uninsured Marylanders to affordable coverage. Specifically, Maryland:

1. Established a state reinsurance program under a Section 1332 State Innovation Waiver, including novel measures to rationalize the interaction between the reinsurance program and federal risk adjustment.
2. Established a state-based health insurance assessment (HIA) to fund the reinsurance program, leveraging the opportunity created by the delayed, and then repealed, federal Health Insurance Providers Fee.
3. Established a tax-time facilitated enrollment pathway, the *Maryland Easy Enrollment Health Insurance Program*.
4. Implemented qualified health plan standard plans, referred to as *Value Plans.*
5. Implemented *Silver loading* with targeted steering and messaging to optimize enrollment outcomes.

These measures have interlocking and synergistic effects that amplify their impact and minimize unintended outcomes. As a result, Maryland has seen tremendous improvement in outcomes.

This story is especially significant given Maryland's political leadership. In some states, ACA implementation has been complicated by partisan politics. But Maryland's raft of innovation solutions has been forged under Republican Governor Larry Hogan and a Democratically controlled legislature.

This case study describes the measures taken by the state to improve affordability and coverage, identifies unique program design features, and discusses their bipartisan appeal as experienced in Maryland. Maryland's efforts can serve as a helpful framework for other similarly situated states seeking to address pressing health coverage affordability issues.

Early Individual Market Measures and Performance

With the ACA's main coverage provisions coming online in 2014, Maryland took several actions to support its individual health insurance market. Maryland established a state-based marketplace, established a temporary state reinsurance program to supplement the federal Transitional Reinsurance Program, and implemented a robust Navigator/Connector Entity program to support in-person enrollment assistance. These actions were successful in attracting substantial enrollment, with 162,000 enrolled through the Marketplace in 2016 (300,000 total when including off-Marketplace enrollment). For additional insight, Table 1. Maryland Individual Market Indicators provides details on Maryland's individual market performance across key indicators from 2014 to the present.

After the cessation of the reinsurance programs in 2016, the costs of high-claims enrollees drove adverse market outcomes. Between 2016 and 2017, premiums rose by more than 25 percent, and consumer choice decreased from five to three issuers.[4] By 2018, total enrollment decreased by about 10 percent. Much of the contraction was in off-Marketplace enrollment, (i.e., those who do not receive financial assistance to mitigate premium increases). Fears of a "death spiral" began to consume the media landscape as consumers voiced their concern over the growing unaffordability of the premiums and out-of-pocket costs for the plans available to them.[5,6]

This troubling trend was exacerbated in 2017 by the new federal Administration's efforts to repeal and undermine the ACA, creating issuer and public uncertainty over the ACA's future. This manifested in requests for 2018 premium increase of 38.5 percent (ranging from 9 percent to 150 percent). Federal disruption came to a head with the federal Administration's decision to cease payments to issuers under the Cost Sharing Reductions program and the repeal of the individual mandate in the Tax Cuts and Jobs Act of 2017. Collectively, these actions moved lawmakers to commit to legislative action to protect the individual market in the 2018 session of Maryland's General Assembly.

Political Alignment for Action

In acknowledgement of the growing instability of the individual market, Maryland's governor and General Assembly came together to act. Given uncertain prospects for federal stabilization legislation, Maryland officials knew a state-based solution would be necessary to help Marylanders who could no longer afford their premiums. They focused on a solution to stabilize the individual market in the short term to buy time for the crafting of a long-term solution.

As part of this collaboration, staff from the Maryland Insurance Administration and the Maryland Health Benefit Exchange, or MHBE (the state-based marketplace, which is an independent state agency), provided technical expertise to help draft legislation, build lawmaker understanding of the implications of policy proposals, and communicate with an uneasy public on the work being done to stabilize premiums.

Table 1. Maryland Individual Market Indicators (2014-2020)

Major indicators of Maryland's individual market performance, with early years of rapid expansion and ample choice (2014-2016), drastic market contraction amid rising unaffordability and issuer withdrawals (2017-2018), and eventual stability following policy responses (2019-2021).

Year	Issuers (#)	Offered Qualified Health Plans (#)	Exchange Enrollment	Exchange Subsidized/ Unsubsidized (%)	Market Enrollment	Premium Change from Prior Year (%)	Advanced Premium Tax Credits
2014	4	45	81,553	80/20	212,613	-	$98,908,974
2015	5	53	131,974	70/30	288,411	10.24%	$208,112,890
2016	5	53	162,652	70/30	291,567	18.0%	$279,711,868
2017	3	23	157,637	75/25	256,399	25.2%	$372,751,574
2018	2	21	153,584	79/21	214,833	33.0%	$720,991,962
2019	2	20	156,963	77/23	210,125	-13.2%	$670,416,358
2020	2	23	158,934	76/24	215,510	-10.3%	$700,000,000
2021	3	31	N/A	N/A	N/A	-11.9%	N/A

SOURCES: Varied, list below:
Maryland Health Benefit Exchange Annual Reports (2014-2019) & Press Releases (12/19)
Maryland Insurance Administration (MIA) 2018 & 2019 Covered Lives Report
MIA Press Releases
MHBE Data Report (June 2020)
MIA Press Release (September 15, 2020)
Author's estimate

Market Stability Initiatives & Outcomes (2018-Present)

Beginning in 2018, Maryland engaged in a multi-year, iterative market stability initiative to address the growing affordability and coverage loss crisis in the individual market. Table 2 identifies the key risks to market stability, details Maryland's policy responses for each risk, and summarizes the market outcomes. Several of these measures included unique features that magnified their impact.

Policy Response: State Reinsurance Program—coordination with risk adjustment and issuer cost-containment program transparency

As the 2018 legislative session began, bipartisan support coalesced around establishing a claims-based state reinsurance program via a Section 1332 State Innovation Waiver.[7] This support was bolstered by a growing consensus among lawmakers and stakeholders that the primary focus of relief should be for those who purchase health coverage without financial assistance (i.e., those who have borne the brunt of premium increases). Three states—Alaska, Minnesota, and Oregon—had reinsurance waivers approved effective for 2018, and several others were considering it. A reinsurance program enacted in 2018 could reduce premiums in 2019 and be an effective stopgap measure as the General Assembly considered long-term solutions to stabilize the individual market.

Maryland's state reinsurance program, the largest in the United States, was a resounding success. It reduced premiums for three consecutive years (2019-2021) for a cumulative reduction of 31.4 percent from 2018 levels.[8] Combined with MHBE greatly increasing its marketing and advertising budget[9], this led to the highest 2020 on-Marketplace enrollment in four years at 158,934 enrollees. The state reinsurance program also had the effect of stabilizing total individual market enrollment at 210,000 covered lives in 2019 and 2020, providing much-needed financial relief to thousands of Marylanders and ending the multi-year market contraction.

Perhaps the biggest threat to the reinsurance waiver's enactment was an issuer-expressed concern over the potential

for a "double payment" for high-risk individuals by the state reinsurance program and the federal risk adjustment program.[10] Modeling performed by an actuarial firm contracted by MHBE indicated that the combined payment from these programs could in some cases exceed the claims incurred by an enrollee. Without intervention, the potential for market distortions could be high as the highest-risk enrollees could become the most profitable—creating a disincentive to manage claims costs that could increase payouts under the state reinsurance program.

To address this issue, MHBE, in collaboration with the Maryland Insurance Agency (MIA), developed a methodology to mitigate the risk of double payment. The methodology modifies payouts under the state reinsurance program to account for any overpayment— decreasing payments to issuers whose enrollees have both high claims costs and receive risk adjustment payments and increasing payments to issuers that are risk adjustment payers. This approach effectively addressed issuer concerns about fairness. It also more efficiently allocates state reinsurance program funding across issuers to limit market distortions. Without the intervention, state reinsurance program and risk adjustment payments would have disproportionately gone to a single issuer with the highest claims and risk burden—yielding inefficient price signals to consumers. While Maryland continues to be the only state to have implemented such a mechanism, other markets that experience substantial risk adjustment transfers and seek to establish reinsurance programs with large rate offsets may benefits from such analysis.

Funding Source: State-based Health Insurance Assessment

The other key challenge in passing the reinsurance program was paying for the state share of the program. Under Section 1332, states can receive federal "pass-through funding" based on savings due to lower premiums. But states generally owe a share as well. The Hogan Administration expressed aversion toward legislation that increased taxes. Given Maryland's split-party governance and the need for immediate action, legislators were mindful that only a bipartisan solution would succeed.

To address this dilemma, lawmakers settled on a creative funding solution that raised funds for the state without any net tax increase. The state established a health insurance assessment that would recoup amounts that would have been paid to the federal government under the then-suspended Health Insurance Providers Fee.[11] The state assessment applies to all health insurance premiums that would have been subject to the federal fee and where the state has the authority to do so. This allowed the assessment to include individual, small group, and fully-funded large group insurance lines. The uniform and broad-based structure of the assessment also allows the state to incorporate Medicaid Managed Care Organization (MCO) premiums (i.e., the assessment meets federal Medicaid provider taxation rules). The inclusion of Medicaid MCO premiums in the assessment was critical in raising the revenue necessary to achieve the premium reduction goals of the state reinsurance program.[12] State officials estimated that Medicaid MCO premiums would account for 46 percent of total revenue collected under the assessment. The assessment was estimated to raise enough revenue to establish a reinsurance program that would achieve the goal of reducing premiums (estimated to collect $365 million in revenue in its first year at an assessment rate of 2.75%).

Critical to its legislative success was that the fee would not raise, in the aggregate, the overall tax rate that would be included in premiums. Essentially, as the federal fee was removed from premiums, the state assessment would take its place, maintaining the total tax burden level. This allowed Governor Hogan, who had campaigned against tax increases, to sign the legislation.

One challenge for the assessment was that it needed to have a uniform rate to satisfy federal uniformity rules, but the effective rate under the federal fee varied. The uniform structure was necessary for the inclusion of Medicaid MCOs. But under the federal fee, tax-exempt issuers paid at about half the rate of other issuers (which paid about 2.75% of premiums on average). In the 2019 legislative session lawmakers mitigated this concern by lowering the assessment rate from 2.75 percent to 1 percent for future years. Three other states—Delaware, Colorado, and New Jersey—have also recently enacted health insurer fees to collect amounts that would be have gone toward the federal fee, each with somewhat different terms. States seeking a revenue source for market stabilization/optimization initiatives should consider implementing an assessment structure that is bespoke to their unique needs and balances political/regulatory limitations.[13]

Policy Response: Facilitated tax time enrollment pathway—assisted enrollment into Medicaid & QHPs with special enrollment period

The Maryland Easy Enrollment Health Insurance Program (MEEHP) was borne from negotiations over a proposal for a state individual mandate coupled with an automatic enrollment mechanism. Under this earlier proposal, coverage and eligibility information from the tax return would be shared by the Comptroller's office (Maryland's tax authority) with the Marketplace. Uninsured household members would be automatically enrolled in Medicaid or a QHP. Given the difficult political ramifications of passing an individual mandate and operational challenges with auto-enrollment, this proposal was not enacted.

Fortunately, legislators were able to maintain key benefits of this proposal by scaling it back to a facilitated enrollment pathway. The final legislation, the MEEHP, uses tax return information to facilitate enrollment through a post-filing Special Enrollment Period and, once fully implemented, fully assisted enrollment into Medicaid. Given the long runway for integrating complex information systems, the program is being implemented in stages.

For the 2020 tax filing season, the tax return included two new questions: whether anyone in the household is uninsured, and whether the Comptroller may inform the Marketplace. If that answer to these questions is yes, the taxpayer's information is shared with the Marketplace, which can then contact the taxpayer. Using this approach, the Marketplace was able to deliver SEP eligibility notices to over 40,000 households. 4,000 Marylanders enrolled into insurance affordability programs through the MEEHP, with the majority enrolling (75%) into Medicaid. Nearly 66.1 percent of enrollees were younger than 34 years old and 50 percent were from households with incomes of less than 100 percent of the federal poverty level (FPL). Such outcomes indicate the program's potential to target disproportionately uninsured populations and also to improve the individual market risk pool. It is also important to note that the tax time intervention allowed for MHBE to reach more deeply into Maryland's uninsured population—increasing awareness of the Marketplace and improving visibility.

MHBE and the Comptroller's office are now evaluating outcomes of the first year of the program to determine next steps, with the goal of reaching full functionality by 2022. When fully functional, the system will assist with enrollment using eligibility information from the tax return. Other options are also being considered, such as modifying tax software to incorporate a link to MHBE to take advantage of having taxpayers' attention at that moment.

Key to the MEEHP's bipartisan appeal are the absence of an individual mandate and its low cost compared with some other programs to expand coverage. The final legislation passed unanimously in the Maryland Senate and overwhelmingly in the House of Delegates, and was signed by Governor Hogan to much media fanfare.

Policy Response: Offered "Value Plans"—reduced deductibles and out-of-pocket costs while providing issuers with the flexibility to innovate

Also beginning in plan year 2020, MHBE took action to address concerns over high and rising deductibles and out-of-pocket costs. To do this, MHBE leveraged its qualified health plan (QHP) certification standards to establish certain requirements on issuer plan offerings. Issuers are required to offer a single "Value" Plan at the bronze, silver, and gold metal levels. Value Plans at each metal level have specific requirements for deductible ceilings and certain services that must be covered with copays before deductible. Unlike traditional standard plan designs, MHBE is not prescriptive as to the specific copay dollar amounts for each pre-deductible service or the deductible. This approach promotes benefit designs that support medical adherence while giving issuers greater flexibility to compete on plan value. It also makes it easier for issuers to maintain actuarial value requirements while navigating yearly product design changes.

Additionally, this approach reduces administrative burden on both issuers and MHBE officials, as Value Plan requirements dovetail within existing QHP plan management pathways. States seeking to ensure that consumers have QHP options with lower deductibles and services before deductible may find the Value Plan approach advantageous. This approach has led to generous cost-sharing designs with pre-deductible services that were uncommon given past designs. For example, one issuer covered both mental health services and generic drugs pre-deductible for their bronze Value Plans. Value Plan requirements for 2020 can be found in Table A in the Appendix.

When coupled with the impact of the state reinsurance program, in 2020, premiums, deductibles, and other out-of-pocket costs decreased for the first time since the marketplace was established. While over 46,000 Marketplace enrollees have selected Value Plans for the 2020 plan year, most of the benefit will be experienced by 22,000 bronze and gold Value Plan enrollees, as nearly all on-Marketplace silver enrollees are eligible for robust Cost Sharing Reduction plans.[14] Value Plans are also available for off-Marketplace enrollees for whom enrollment data is unavailable. For the 2021 plan year, MHBE is maintaining Value Plan requirements.[15]

Table 2. Risks to Individual Market Stability, Policy Responses, and Outcomes

Risk	Policy Response	Mechanism	Outcomes
Increasing risk pool morbidity • Broad-based premium increases of 30 percent • Ongoing contraction of the individual market	Reinsurance Program through State Innovation Waiver: • Claims-based State Reinsurance Program • Pass-through funding *front loaded* into the first three years of the reinsurance program to magnify first-year impact • Coordination between the state reinsurance program and Federal risk adjustment (RA) Programs (dampening) to prevent double payment, interaction, and increase program efficiency • Transparency requirements for carriers to estimate their savings to the state reinsurance program attributable to care management programs (i.e., Carrier state reinsurance program Accountability Report) Implemented for the 2019 plan year	Statutory: • *Maryland Health Benefit Exchange—Establishment of a Reinsurance Program (2018)*	• Largest state reinsurance program in the nation by funding size ($373M, 2019) and percent of rate decrease (30 percent) • 2021 premiums are 31.4 percent lower than 2018 premiums • Individual market enrollment stabilized at 210,000 covered lives state reinsurance program/RA interaction dampening allowed for more egalitarian rate reductions across issuers
Need for revenue to support market stabilization measures	State-based health insurance assessment: • Recoups funds from repealed Section 9010 federal health insurance providers fee to help fund the state reinsurance program • Broad-based and uniform structure allow for Medicaid MCO premiums to assessed (2.75% of premiums in 2019, 1% 2020+) • Inclusive of all lines of health insurance that can be assessed by state governments • Added on to the existing premium assessment infrastructure set by Maryland Implemented for the 2019 plan year	Statutory: • *Maryland Health Care Access Act of 2018* • *Health Insurance—Individual Market Stabilization—Provider Fee (2019)*	• Estimated $326 million in revenue for 2019 (2.75%) • Estimated $119 million in revenue for 2020 (1%) • Inclusion of Medicaid MCOs increases federal share of total assessment revenues (approximately 30%).

Table 2. Risks to Individual Market Stability, Policy Responses, and Outcomes — continued

Risk	Policy Response	Mechanism	Outcomes

Contracting market enrollment
• Increasing uninsured rate
• Increased morbidity of the risk pool
	Facilitated tax time enrollment pathway:
	• Uninsured tax filers have the option to transmit tax/eligibility information to MHBE to receive a special enrollment period/facilitated enrollment into Medicaid or QHPs
	• Phased implementation approach:
	  • Phase 1: preliminary eligibility for Medicaid/QHP using income/household information with post-tax-filing Special Enrollment Period (2020)
	  • Phase 2: implementation of additional functionality to simplify enrollment (2022)
	
	Implemented for the 2020 plan year
		Statutory:
		• *Maryland Easy Enrollment Health Insurance Program Act of 2019*
			• In 2020, 40,000+ households with uninsured members received preliminary eligibility determination notices
			• 4,000 new enrollees into health coverage (75% Medicaid, 25% QHP)

Rising deductibles and out-of-pocket costs • Increased burden to consumers seeking care • Reduced treatment adherence	Value Plans: • Sets minimum cost-sharing design requirements for Value Plans at the bronze, silver, and gold metal levels • Value bronze plans require at least three primary care or urgent care visits before deductible • Deductible caps at $2,500 and $1,000 for silver and gold Value Plans • Increased access to health care services with copays before deductibles apply • Issuers have the flexibility to set copay amounts for required services before deductible • Issuers have the flexibility to enhance cost-sharing design requirements within their Value Plans Implemented for the 2020 plan year	Regulatory: 2020-21 QHP Certification Standards	• 46,000+ enrollees in Value Plans on-Exchange • Lower out-of-pocket costs for enrollees on- and off-Exchange • Value Plans allow issuers to compete on generosity; one 2020 Value bronze QHP offering includes generic drugs before deductible • Policy design promotes product innovation while setting minimum standards for affordability
Cessation of Cost Sharing Reduction Payments • Premium increases of 20+ percent for silver QHP enrollees without premium tax credits	Implementation of *silver loading with targeted steering*: • Allow silver QHP premiums to be priced higher than gold QHP premiums (i.e., actuarial value alignment of premiums) • "Mirror" silver QHPs offered off-Exchange • Used targeted outreach and website steering to help get consumers to switch plans based on novel price structure. Implemented for the 2018 plan year	Regulatory: Rate review process	• Average premium tax credits increased by 67 percent • 36 percent of Marketplace enrollment in gold QHPs in 2020 • Drastically increased access to zero cost bronze QHPs • Silver QHP enrollees without premium tax credits protected from additional premium increases

SOURCES: Varied, list below:

Presentation to the Maryland Easy Enrollment Health Insurance Program Workgroup—March 9, 2020, MHBE.
Maryland Health Connection Data Report—June 30, 2020, MHBE.
2019-2021 State Reinsurance Program, a Supplement to the 2020 Letter to Issuers, MHBE (2020).
COMAR 14.35.17 State Reinsurance Program, MHBE (2019).
Exhibit 1: 2021 Maryland, ACA, Individual Non-Medigap (INM), and Small Group Market Rate Filing Summary, MIA (2020).
2021 Plan Certification Standards, MHBE Board of Trustees Meeting—October 21, 2019, MHBE
Joint Chairmen's Report: Reinsurance Program Costs and the Provider Assessment–September 30, 2020

Policy Response: Implementation of "silver-loading" with targeted steering and messaging to optimize enrollment outcomes

Like nearly every state in the nation, Maryland implemented silver loading in response to the federal Administration's decision to cease Cost Sharing Reduction program payments in October 2017. Issuers loaded the cost of these payments only onto on-Marketplace silver QHP premiums and offered "mirror" off-Exchange silver QHPs aimed at consumers that still wanted to enroll in a silver health plan but did not receive premium tax credits.[16] Because of silver loading, average premium tax credits increased by 67 percent on a per-capita basis—shielding enrollees from a substantially greater portion of their premium costs.[17] Further, as in many parts of the country, silver loading resulted in Silver QHPs that were more expensive than at least one Gold QHP in every county. As a result, many consumers had access to zero-cost bronze QHPs and substantially reduced-cost gold QHPs. The MIA, MHBE, and partner issuers coordinated messaging to ensure that affected enrollees were notified of their off-Marketplace options. Approximately 8,000 enrollees migrated off-Marketplace as a result.

To maximize the benefit to consumers, MHBE engaged in a targeted messaging campaign that focused on consumers within the 200-400 percent FPL band—those eligible for little or no cost-sharing reductions and therefore most likely to benefit from lower-cost bronze and gold plans.[18] MHBE utilized enrollment and eligibility data from its Marketplace web platform to find the target population and then continued follow-up with enrollees based on their action/inaction within the platform. Further, MHBE modified automated filtering criteria on the Marketplace web platform to better steer enrollees to the ideal health plan, gold or silver. These efforts yielded outsized results as 20 percent of on-Marketplace enrollees (30,238) selected a gold health plan for 2018, four times the amount in 2017.[19] In 2020, 36 percent of on-Marketplace consumers are enrolled in gold QHPs, the second highest in the nation.

Conclusion

Maryland's policy responses to stabilize its individual market have established a robust foundation for future growth. Policy leaders took an iterative stepwise approach to gradually improve its individual marketplace outcomes in a bipartisan manner that was responsive to consumer and stakeholder concerns. Both the state reinsurance program and Maryland's unique approach to silver loading together reduced net premiums for Marylanders both ineligible and eligible for premium tax credits, respectively. Maryland also took advantage of the lapsing Health Insurance Providers Fee to create a funding mechanism for its state reinsurance program via the state-based health insurance assessment. The establishment of the Value Plans created additional plan options for Marylanders seeking lower deductibles and out-of-pocket costs, while increasing choice and promoting issuer competition for value. Finally, the MEEHP provides the MHBE with an avenue to reach more deeply into Maryland's uninsured population while providing opportunities for this population to enroll in health coverage. Policymakers looking to improve their individual health insurance markets might look to Maryland's example as a roadmap for bipartisan success.

Table A. 2020 Value Plan Requirements

Requirements	Bronze	Silver	Gold
Minimum offering	Issuers must offer at least one "Value" plan	Issuers must offer at least one "Value" plan	Issuers must offer at least one "Value" plan
Branding	Value Plans have the "Value" designation in their plan marketing name	Value Plans have the "Value" designation in their plan marketing name	Value Plans have the "Value" designation in their plan marketing name

Requirements	Bronze	Silver	Gold
Deductible ceiling	Set by issuer	Up to $2,500.	Up to $1,000.
Services offered before deductible*	At least three visits for: • Primary Care Visit and/or • Urgent Care Visit Added by one issuer: • Generic Drugs	Offered with copays before deductible: • Primary Care Visit • Outpatient Mental Health • Substance Use Disorder • Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging Recommended: • Generic Drugs	Offered with copays before deductible: • Primary Care Visit • Outpatient Mental Health • Substance Use Disorder • Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging • Generic Drugs

SOURCE:
Maryland Health Benefit Exchange (2020)

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ABOUT JP CONSULTING LLC

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ENDNOTES

1. See, e.g. Maryland Senate Bill 182. Retrieved from Maryland State Legislature website: http://mgaleg.maryland.gov/2011rs/bills/sb/sb0182t.pdf
2. Maryland Department of Legislative Services. (2017). "Report of the Maryland Health Insurance Coverage Protection Commission." Retrieved from https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/022400/022486/20180039e.pdf
3. Maryland Insurance Administration (2019, December 1). "2019 Report on The Number of Insured and Self-Insured Lives." Retrieved from: https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2019-Report-on-the-number-of-insured-and-self-insured-lives-MSAR7797.pdf
4. A study commissioned by the MHBE estimated that together the federal transitional and Maryland supplemental reinsurance programs reduced premiums by 14.2 percent in 2015 and 7 percent in 2016 (years for which both reinsurance programs issued payments).
5. Cohn, Meredith. (2017, August 29). "Obamacare premium costs in Maryland set to jump as state approves rates." The Baltimore Sun. Retrieved from www.Baltimoresun.com/business/bs-hs-obamacare-rates-20170829-story.html
6. Eichensehr, Morgan. (2017, June 21). "Md. regulators hear pleas from consumers over proposed health insurance hikes." Baltimore Business Journal. Retrieved from https://www.bizjournals.com/baltimore/news/2017/06/21/mdregulators-hear-pleas-from-consumers-over.html
7. Lawmakers briefly considered a condition-based approach to the reinsurance program, but stakeholders presented a consensus view on the advantages of a claims-based approach.
8. Ey, Craig. (2020, September 15). " Governor Hogan Announces Third Consecutive Year of Lower Individual Health Insurance Premiums," Retrieved from the Office of Maryland Governor Larry Hogan website: https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2020287
9. Plunkett, Betsy and Glasgow, Raelene. (2018, September 17) "MHBE Board Meeting: Marketing Procurements." Retrieved from the Maryland Health Benefit Exchange website https://www.marylandhbe.com/wp-content/uploads/2018/09/BoardMarketingNTE091718.pdf
10. Risk adjustment is a federally run premium stabilization program that transfers payments from issuers with relatively lower-risk enrollees to issuers with relatively higher-risk enrollees. This works to prevent cherry-picking for health enrollment and discrimination against enrollees with preexisting conditions by removing health status as a factor for enrollee profitability.
11. Established under Section 9010 of the Affordable Care Act.
12. The inclusion of Medicaid MCOs also maximized the federal contribution to the state reinsurance program with federal funds accounting for 62 percent of revenue collected from the MCO assessment.
13. Levitis, Jason. (2020 January 30). "Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee," Retrieved from the State Health and Value Strategies website: https://www.shvs.org/considerations-for-a-state-health-insurer-fee-following-repeal-of-the-federal-9010-fee/
14. (2020, April 30). "Data Report." Retrieved from the Maryland Health Benefit Exchange website: https://www.marylandhbe.com/wp-content/uploads/2020/05/Executive-Report_04_30_2020.pdf
15. For 2022 silver and gold Value Plans, MHBE added a requirement to cover insulin and glucometers without cost sharing (test strips already covered w/o cost sharing per MD law). For more information, see https://www.marylandhbe.com/wp-content/uploads/2020/11/2022-Plan-Certification-Standards-11-16-20.pdf.
16. A vision benefit was added to on-Marketplace silver QHPs to meet on- and off-Exchange premium parity rules.
17. Plunkett, Betsy. "Nearly 154,000 Marylanders Enrolled in Marketplace Health Coverage for 2018." Retrieved from the Maryland Health Benefit Exchange website: https://www.marylandhbe.com/wp-content/uploads/2018/01/010418_OE5Enrollments.pdf
18. For consumers with income of less than 200 percent FPL, Cost Sharing Reductions increase Silver QHP generosity to more than that of Gold QHPs making it more advantageous to remain enrolled in Silver QHPs.
19. Plunkett, Betsy. "Nearly 154,000 Marylanders Enrolled in Marketplace Health Coverage for 2018." Retrieved from the Maryland Health Benefit Exchange website: https://www.marylandhbe.com/wp-content/uploads/2018/01/010418_OE5Enrollments.pdf