

Individual Market Options

1. Merging the Individual and Small Group Markets

(2018 *Report of the Maryland Health Insurance Coverage Protection Commission* (MHICPC Report); pages 17-19, 26-28, 31, and 33-35)

- The Affordable Care Act (ACA) provides states the option to merge their individual and small group markets. Based on the work of advisory committees, the Maryland Health Benefit Exchange (MHBE) Board of Trustees recommended against merging the markets in 2011. In 2012, the General Assembly directed MHBE to formally study a potential merger and submit a report by 2016. Based on review of the 2016 report, the MHBE Standing Advisory Committee recommended deferring a policy decision at that time and revisiting the issue when more data was available. Wakely Consulting Group (Wakely) prepared a report on merging the markets for the commission in 2018. The report noted that, to date, only one state (Vermont) has fully merged its market under the federal definition, while Massachusetts and the District of Columbia have quasi-merged markets. The Wakely report laid out four policy options for merging the markets:
 - (1) merging experience to build premiums (which would reduce individual premiums but increase small group premiums);
 - (2) risk adjustment across both markets to transfer funds to the sickest enrollees (which would also reduce individual market premiums but increase small group premiums to a greater extent than option one);
 - (3) guaranteed issue for all products/offer the same plans in both markets like Massachusetts (which equalizes plans across both markets and would likely provide more protection to the individual market but create more disruption to the small group market and hinder the ability to create niche products in either market); and
 - (4) full merger like Vermont (much more disruptive to the small group market in terms of benefit calendar and elimination of quarterly rates) as described in Chapter 2 of the 2018 MHICPC Report.
- Both the MHBE and Wakely reports concluded that merging the individual and small group markets would increase the stability of the risk pool, with rates in the individual market declining and rates in the small group market increasing. Both reports also identified additional potential impacts on the small group market depending on the level to which the markets are merged, including the potential to move all policies to a calendar year basis, elimination of quarterly rate adjustments, and the availability of fewer niche products from carriers. Additionally, Wakely advises that a merger would reduce the impact of reinsurance and the amount of federal pass-through funding available under the Section 1332 waiver, noting that

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implementation of a merged market should likely be delayed until the reinsurance program ends. Wakely indicated that it would need additional information on how Maryland was considering merging the markets before it could provide a more in-depth analysis, including the estimated impact on rates.

2. Standardized Plan Design

(2018 MHICPC Report; pages 19-21, 23, and 33)

- MHBE established a workgroup to study standardized benefit design and issued a report in 2017. The workgroup found a range of standardization and varying approaches to standardized benefit design in other states. The report concluded that standardization of plans could help consumers compare plans and better understand the benefits and costs associated with different plans. The workgroup and report did not result in the implementation of a standardized benefit design in Maryland.
- Commissioners raised questions about the extent to which a standardized benefit design would benefit Maryland consumers, particularly given that there are only two carriers that participate in the individual market that have significantly different models of coverage. It is unclear how a standardized benefit design would assist consumers in choosing between such fundamentally different plans. It is also unclear how standardized benefit design would affect deductibles and premiums.

3. Basic Health Plan (BHP)

(2017 MHICPC Report; pages 23-25, 30)

- Michael Miller, Policy Director for Community Catalyst, proposed that a BHP may be a possible option but that the State would need to do some modeling to understand the impact on the risk pool overall for the individual market.
- Stan Dorn, Senior Fellow at Families USA, suggested that Maryland could consider implementing a BHP if federal funding is sufficient. Through a BHP, individuals with incomes up to 200% of federal poverty guidelines (FPG) would be covered through a public program, the State could use leverage and lower provider rates to improve affordability, and federal funding for the program would equal 95% of the subsidies consumers receive through MHBE. Mr. Dorn noted, however, that the financial feasibility of implementing a BHP is unclear due to the potential changes to the funding formulas for the program. He suggested Maryland track progress at the federal level and move forward if possible. He also highlighted success in New York with implementing a BHP.

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- In response to a question on whether implementing a BHP would be a “heavy lift” for MDH, Mr. Dorn stated that (1) the states that have implemented the plan have been able to use existing departments and resources and found it less administratively burdensome than originally anticipated; and (2) MDH’s response to the *Joint Chairman’s Report* that indicated implementing the plan would pose an administrative burden was drafted before the BHP payment methodology was issued, and the Centers for Medicare and Medicaid Services made it clear that states would be able to recoup administrative costs.
- Mr. Dorn also responded to a question regarding if Maryland would be playing with fire to implement both BHP and a reinsurance plan. He suggested that Maryland wait to see what happens with the federal Alexander-Murray legislation, which would address some of the issues Minnesota had when applying for a federal waiver to establish a reinsurance plan after establishing BHP.
- Under the BHP option in Section 1331 of the ACA, Maryland could elect to cover adults with incomes between 138% and 200% FPG through State-administered coverage instead of through qualified health plans offered by health insurance carriers participating in MHBE. States that implement a BHP receive 95% of what the federal government would have spent on advanced premium tax credits if the BHP enrollees had enrolled in marketplace coverage instead. BHP coverage could be provided through managed care organizations under contract to Medicaid. Minnesota and New York have implemented BHPs.