

# REPORT OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION



DEPARTMENT OF LEGISLATIVE SERVICES 2017

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**Report of the  
Maryland Health Insurance Coverage  
Protection Commission**

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**Annapolis, Maryland**

**December 2017**

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THE MARYLAND GENERAL ASSEMBLY  
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2017

The Honorable Thomas V. Mike Miller, Jr.  
President of the Senate  
State House  
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch  
Speaker of the House of Delegates  
State House  
Annapolis, Maryland 21401-1991

Dear President Miller and Speaker Busch:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its initial report containing a summary of the commission's activities and its recommendations regarding measures that should be taken to protect access to affordable health coverage in the State.

The commission held three informative meetings during the interim to monitor potential and actual federal changes to the federal Patient Protection and Affordable Care Act, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model, and to assess the impact of such changes. The briefings received by the commission included presentations on options to stabilize the individual insurance market in the State. The commission did not endorse any specific proposal, but there was consensus among commission members that the State should not delay in acting to stabilize the individual market. The State should obtain an independent actuarial analysis of stabilization options, specifically those relating to reinsurance, and a workgroup should be convened during the 2018 legislative session to work on stabilization legislation.

We wish to thank the commission members, the commission staff, and the many individuals who briefed the commission for their support of the commission's work.

Sincerely,

Handwritten signature of Brian J. Feldman in black ink.

Senator Brian J. Feldman  
Senate Chair

Handwritten signature of Joseline A. Peña-Melnyk in black ink.

Delegate Joseline A. Peña-Melnyk  
House Chair

BJF:JAP/PDC/kmc



**Maryland Health Insurance Coverage  
Protection Commission  
2017 Membership**

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**Senator Brian J. Feldman, Senate Chair  
Delegate Joseline A. Peña-Melnyk, House Chair**

**Senators**

Delores G. Kelley  
Thomas M. Middleton

**Delegates**

Kirill Reznik  
Chris West

**Non-legislative**

Donna M. Carris  
Vincent DeMarco  
Lori Doyle  
Joseph Fitzpatrick  
Jamal Lee  
Marco Priolo  
Carolyn A. Quattrochi  
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# Chapter 1. Introduction

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## Health Reform Efforts at the Federal Level

The election of President Donald J. Trump generated momentum in 2017 for an effort in the U.S. Congress to repeal and replace the federal Patient Protection and Affordable Care Act (ACA). The U.S. House of Representatives initiated the repeal effort with passage of the American Health Care Act (AHCA) on May 4, 2017. The U.S. Senate then worked to pass the Better Care Reconciliation Act, an alternative to the AHCA, during summer 2017. The repeal effort in the U.S. Senate culminated with the consideration, but ultimate failure, of the Graham-Cassidy-Heller-Johnson Amendment to the AHCA (commonly referred to as Graham-Cassidy legislation) in September 2017. Among other changes to the ACA, all of the legislative proposals generally would have repealed or phased down enhanced federal funding for the Medicaid expansion, converted Medicaid financing to a per capita cap or block grant funding model, repealed the individual and employer mandates, altered or converted to block grant funding the tax credits allocated for the purchase of health insurance, and modified rating rules and essential health benefits requirements for health insurance plans.

In addition to the repeal efforts in the U.S. Congress, the Trump Administration has taken executive actions to implement changes to the health insurance marketplace. Among other actions, President Trump issued an executive order on October 12, 2017, to (1) expand access to association health plans by allowing more employers to form such plans; (2) expand the availability of short-term, limited-duration insurance by allowing such insurance to cover longer periods of time and be renewed (currently, such coverage cannot exceed three months or be renewed); and (3) expand employers' ability to offer health reimbursement arrangements (HRA) to their employees and allow HRAs to be used in conjunction with nongroup coverage. On October 13, 2017, the Trump Administration also announced its decision to end cost-sharing reduction payments to insurers.

On December 22, 2017, President Trump signed Public Law Number 115-97; tax reconciliation legislation that repeals the penalty on individuals for not having minimum essential coverage under the ACA. The individual mandate penalty repeal is effective beginning in 2019.

The status of federal funding for the Maryland Children's Health Program (MCHP) is uncertain. Federal authorization for MCHP expired September 30, 2017. Both the U.S. House of Representatives and the U.S. Senate have passed re-authorization bills but they have not been reconciled. Each bill re-authorizes the program for five years, maintains current eligibility, and retains the enhanced 23% federal match through federal fiscal 2019 before phasing it out by federal fiscal 2021, returning to the normal 65% matching rate for Maryland.

## **The Maryland Health Insurance Coverage Protection Commission**

Both in response to and in anticipation of efforts at the federal level to repeal and replace the ACA, Chapter 17 of 2017 (**Appendix 1**) established the Maryland Health Insurance Coverage Protection Commission. The 19-member commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, MCHP, Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization; (8) one consumer of health care services; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of MedChi; (13) one representative of behavioral health care providers; and (14) two members of the public.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-Payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage. The commission may hold public meetings across the State to carry out its duties and convene workgroups to solicit input from stakeholders.

The commission is established for three years and will terminate on June 30, 2020. By December 31 each year, the commission must submit a report on its findings and recommendations. This report is the first annual report of the commission.

## **Chapter 2. Work of the Commission**

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### **Agenda and Presentations**

During the course of the 2017 interim, the commission held three meetings. At the first meeting, the commission received an overview of the impact of the Affordable Care Act (ACA) in Maryland, an update on the status of federal legislation to repeal and replace the ACA, and an assessment of the potential impact of changes to the ACA as well as the impact of administrative efforts to weaken the ACA. At the second meeting, the commission received an update on the health insurance rates approved by the Maryland Insurance Administration (MIA) for 2018, commentary on the rates approved, and an update on federal legislation and options for stabilizing the individual health insurance market. The third meeting included an update on the status of the Maryland All-Payer Model Contract and the negotiations and plans for Phase II of the contract. The commission also received additional presentations on options for improving the individual health insurance market in the State and discussed recommendations for State and local action to protect access to affordable health coverage.

Below is a summary of information as it was presented to the commission at the commission meetings. Accordingly, there may be some variation in figures referenced by presenters due to their drawing upon differing sources of information for their presentations. The views expressed by the presenters do not necessarily reflect the views of the commission or its members.

### **August Meeting**

On August 1, 2017, the commission received a presentation on the impact of the ACA in the State, as well as presentations on the status of federal legislation to repeal and replace the ACA and the potential impact of changes to and efforts to weaken the ACA. The commission also received comments from the public.

### **Overview of the Impact of the ACA in Maryland**

Carolyn A. Quattrochi, the Deputy Attorney General in the Office of the Attorney General, reviewed the impact of the ACA, noting the increase in enrollment in coverage, the financial assistance available for qualified health plan (QHP) enrollees, highlights of the Maryland Health Benefit Exchange (MHBE) operations, and matters for consideration in the future.

As of July 2017, 421,116 individuals were enrolled in ACA coverage in the State, including 133,092 individuals enrolled in QHPs and 288,024 individuals enrolled in Medicaid through the ACA expansion. (The Maryland Department of Health (MDH) subsequently indicated in

comments submitted to the commission that 309,540 individuals were enrolled in Medicaid through the ACA expansion as of July 2017, which raises the total ACA enrollment figure for the State to 442,632.) About 70,000 Maryland households are projected to receive approximately \$500 million in financial assistance to purchase QHP coverage in 2017, including \$400 million in advanced premium tax credits and \$100 million in cost-sharing reduction (CSR) payments to insurers that reduce out-of-pocket costs for eligible consumers who purchase CSR plans.

These coverage gains have resulted in a drop in the uninsured rate for Marylanders between the ages of 18 and 64, from 11.3% in 2013 to 4.0% in 2016. The largest reductions in the uninsured rate have been observed among the Hispanic and African American populations, declining from 18.0% to 7.0% and 16.0% to 6.0%, respectively. In addition, individuals between the ages of 18 and 34 have experienced a decrease in the uninsured rate from 15.0% to 4.0%, the largest drop among age groups. Counties on the Eastern Shore and in the western regions of the State have some of the highest rates of ACA enrollment in the State, benefitting, in particular, from the Medicaid expansion. An analysis by the State Health Access Data Assistance Center indicates that the areas of the State with the highest percentage of individuals (more than 68.0%) who are eligible for marketplace coverage but have not enrolled in coverage are located in Calvert, Caroline, Carroll, Dorchester, Kent, Queen Anne's, St. Mary's, and Talbot counties.

In an effort to make it easier for consumers to enroll in coverage, MHBE has developed a mobile application that may be used to process enrollments for both QHPs and Medicaid. The mobile application, which has been downloaded by more than 130,000 users, enables document verification through the use of mobile application cameras. More than one million pieces of information have flowed between MHBE and consumers. MHBE is working to add Medicaid managed care organization shopping and selection to the mobile application.

Ms. Quattrocki identified areas of challenge for the ACA implementation in the State. At the direction of the Trump Administration, the Internal Revenue Service is accepting tax returns without an attestation of insurance coverage. One carrier in the State has attributed 40% of its rate increase request for 2018 to the uncertainty associated with nonenforcement of the ACA's individual mandate and its impact on the insurance risk pool. In addition, the Trump Administration has proposed applying tax credits available under the ACA to less generous health benefit plans, which would reduce assistance for individuals who seek to maintain their existing coverage. Ms. Quattrocki noted the possibility that the Trump Administration may discontinue funding CSR payments to insurers, which could result in Maryland consumers losing up to \$500 million in financial assistance and prompt an increase in premium rates and a decline in QHP enrollment and health insurance carrier participation in the individual insurance market. (President Donald J. Trump subsequently signed an executive order in October 2017 stopping CSR payments.)

Ms. Quattrocki also noted that three health insurance carriers; UnitedHealthcare, Cigna, and Evergreen; are no longer offering plans in the individual market, leaving only CareFirst and Kaiser Permanente. This means less competition in the marketplace and fewer choices for consumers. In 13 counties in the State, CareFirst is the only carrier offering QHPs to consumers.

Ms. Quattrocki added that the open enrollment period in 2017 will last from November 1 to December 15, instead of to January 31 as in previous years. (MHBE subsequently extended open enrollment for one week, with open enrollment ending on December 22, 2017.) Although the open enrollment period is shorter this year, the impact on enrollment may not be significant with effective marketing. In 2016, 94% of enrollments occurred by December 15.

Ms. Quattrocki responded to questions from commission members. Regarding employer coverage under the ACA, Ms. Quattrocki indicated that there has been low enrollment in QHPs offered through the Small Business Health Options Program (SHOP) and that this has been a nationwide phenomenon. In response to a question about the impact of changes to the ACA on the small group insurance market, Ms. Quattrocki indicated that the main concern is the impact that the changes will have on the individual market and that there will be an increase in the uninsured rate in the State. Ms. Quattrocki responded to a question about the requirement in Massachusetts that an individual have insurance coverage and indicated that there is nothing in federal law that would prohibit Maryland from adopting a mandate that individuals have insurance coverage to supplement the federal mandate under the ACA. In response to a question regarding the discontinuation of CSR payments by the federal government, Ms. Quattrocki opined that the impact would be considerable, presenting a risk that the individual market could experience a spiraling effect of increasing rates, individuals dropping coverage, a deteriorating risk pool, and a disincentive for entry of carriers into the market. In response to a question about the potential absence of federal advertising for open enrollment for the 2018 plan year, Ms. Quattrocki indicated that this would have a limited impact on Maryland due to the State having established its own marketplace and MHBE having the ability to carry out its own marketing efforts.

### **Status and Impact of Federal Legislation to Repeal and Replace the ACA**

Karen C. McManus, the Deputy State Director for U.S. Senator Chris Van Hollen, remarked on the status of federal legislation in the U.S. Senate to repeal and replace the ACA, specifically the Better Care Reconciliation Act (BCRA) and the version of the legislation that did not pass when voted on by the U.S. Senate in July 2017. Ms. McManus indicated that the legislation would have caused harm to the individual insurance markets in the United States and cited findings by the Congressional Budget Office (CBO) that the legislation would result in 16 million Americans losing access to health care in 2018, a 20% increase in premiums in 2018, and another 20% increase in premiums each year thereafter over 10 years.

Bradley J. Herring, an Associate Professor and Deputy Chair for Academic Affairs for the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health, discussed the impact of the proposed federal legislation to repeal and replace the ACA on Medicaid, the individual market, and the Maryland All-Payer Model Contract. According to Dr. Herring, the main impact the American Health Care Act (AHCA), which passed the U.S. House of Representatives in May 2017, and the BCRA would have on Medicaid is to slow the growth of federal spending through the use of block grants or a per capita cap on funding. The legislation would also reduce the federal share of funding for the Medicaid expansion population from 90% to a lower percentage of funding. Dr. Herring noted that states could maintain existing

coverage levels by contributing more state financing, but acknowledged that this would present a fiscal challenge for states.

Regarding the impacts on the individual market, Dr. Herring indicated that the federal legislation would change and shrink the tax credits available for purchasing health insurance and modify rating rules so that insurers would be able to charge older insureds up to five times what they charge younger insureds for the same health plan. These actions would increase the number of uninsured individuals. He then noted that the legislation would give states the option to deregulate their health insurance markets, such as by bringing back high-risk pools, reinstating experience rating, and allowing unregulated health plans to exist in parallel to regulated health plans. Both the AHCA and BCRA included funding for reinsurance. Dr. Herring viewed this feature as positive, since the temporary reinsurance program under the ACA in 2014 through 2016 proved to be an effective way of subsidizing health benefit plans.

Dr. Herring did not view the federal legislation as jeopardizing the Maryland All-Payer Model Contract. The model contract was approved by the Center for Medicare and Medicaid Innovation (CMMI), an entity established under the ACA. The federal legislation does not repeal CMMI or its authority to authorize the model contract.

Benjamin Orr, Executive Director of the Maryland Center on Economic Policy, presented on the positive economic impacts of the ACA in Maryland. Mr. Orr testified that hundreds of thousands of individuals in the State have gained health coverage; hospitals are seeing fewer emergency room patients without coverage; and businesses are spending less money on employee insurance than they would have without the ACA. As the number of uninsured Marylanders has declined, the State has realized savings in the amount of uncompensated care. From fiscal 2013 to 2015, hospital uncompensated care costs declined by approximately \$311.0 million. Average costs for group health insurance have increased at a slower rate, increasing by 20% over the last five years (2011 to 2016), compared to a 31% increase over the prior five-year period. Mr. Orr also noted that hundreds of thousands of residents of the State have received refunds from their insurers putting \$99.1 million back into the State's economy since the ACA took effect. In addition, Medicare recipients in Maryland are saving millions in prescription drug costs due to the ACA's closing of the "doughnut hole." In 2015, approximately 86,000 seniors and individuals with disabilities in the State saved on average \$1,158 on drug costs.

Mr. Orr then reviewed federal legislative proposals that he perceived presented a threat to Maryland. The Graham-Cassidy amendment to the AHCA in the U.S. Senate, which was still under consideration, would eliminate premium tax credits and CSR payments and replace them with a block grant set at levels that are well below what states are receiving under current law. The amendment would also convert Medicaid to a per capita cap, which would lead to deep cuts in federal dollars flowing to states. In addition, budget outlines from the Trump Administration and the House Budget Committee would double down on the Medicaid cuts proposed in the ACA repeal bills. Both budget outlines assumed \$834 billion in cuts to Medicaid from the AHCA. The AHCA would have cut \$14 billion in funding for Maryland over 10 years, causing 265,000 individuals in Maryland to lose Medicaid coverage. The Trump Administration budget would then cut another 12% from state Medicaid grants over 10 years.

Mr. Orr indicated that the Trump Administration's threat to withhold CSR payments and nonenforcement of the individual mandate could further destabilize the individual insurance markets. Actuaries at Oliver Wyman concluded that this uncertainty will add 20% to 29% to rate increases for 2018.

Leighton Ku, a Professor and Director of the Center for Health Policy Research at the George Washington University Milken Institute School of Public Health, reviewed the economic and employment consequences for Maryland if the U.S. Senate's BCRA were to pass. According to Dr. Ku, the BCRA would result in an initial but short-lived increase in total employment of 753,000 jobs in the United States due to the repeal of a number of taxes. However, by 2026, the reduced federal spending for Medicaid and other ACA subsidies would result in a loss of 1.5 million jobs, including 919,000 health care jobs. States overall would lose about \$162.0 billion in gross state product and business output would decrease by \$265.0 billion. For Maryland, Dr. Ku estimated that the BCRA would have resulted in an initial increase in employment of 14,300 jobs; but that by 2026, Maryland would have ultimately lost 34,000 jobs, including 19,600 health care jobs. By 2026, the gross State product would have decreased by about \$4.0 billion and business output would have dropped by more than \$6.3 billion. The final version of the BCRA that was voted down by the U.S. Senate, commonly referred to as the "skinny repeal" bill, would have caused a smaller drop in employment than the BCRA, as introduced. Nonetheless, the skinny repeal bill would have resulted in a loss of 2,600 jobs by 2026.

The panelists fielded questions from commission members relating to the strength of the SHOP exchange and whether there has been a migration from fully insured products to self-insurance with stop-loss protection in the District of Columbia, whether there has been a reduction in emergency department (ED) utilization under the ACA, and whether the proposed cuts to Medicaid would create a risk of the State losing the model contract. Dr. Ku indicated that the SHOP exchange in the District of Columbia has benefitted from a requirement that all small groups purchase insurance through SHOP, as well as from a highly functioning website. On the question of whether there been a migration of small groups from fully insured products to self-insurance with stop-loss protection, Dr. Ku indicated that he has not observed this phenomenon in the District of Columbia. Regarding the impact of the ACA on ED utilization, Dr. Ku indicated that ED utilization has not gone down under the ACA. It was noted, however, that uncompensated care has dropped under the ACA. The panelists were unable to predict how Medicaid cuts might impact the model contract.

## **Public Comments**

The commission received comments from members of the public, including Rebecca Rehr from the Maryland Environmental Health Network, Jen Brock-Cancellieri from the Service Employees International Union (SEIU), and Jennie Foont on behalf of Congressman Jamie Raskin.



## **September Meeting**

On September 27, 2017, the commission received an update from MIA on the health insurance rates approved for 2018. The commission also received presentations on the Graham-Cassidy legislation considered by the U.S. Senate this summer and options for stabilizing the individual health insurance market in the State. In addition, the commission received a presentation from MHBE that included a review of the Maryland State Transitional Reinsurance Program and information on State Innovation Waivers under Section 1332 of the ACA.

### **Health Insurance Rates Approved for 2018**

Robert D. Morrow, Jr., Associate Commissioner for Life and Health Insurance at MIA, reviewed the process that MIA used when reviewing the rate filings submitted by health insurance carriers for 2018. Carriers in the individual market included in their rate filings factors to account for the uncertainty of the implementation and future of the ACA. MIA did not, however, approve rates on these factors but on the law as it stands currently, viewing it inappropriate to shift the cost of speculation on to consumers. Mr. Morrow noted that there are only two carriers left in the individual market and that CareFirst BlueCross BlueShield (CareFirst), the only carrier offering plans statewide, requested a substantial rate increase. Because of this, MIA hired an independent third-party consultant to review the CareFirst rate request. Mr. Morrow also noted that the small group health insurance market is more competitive and stable than the individual market and that the rate increases for plans offered in the small group market were more modest.

Todd Switzer, Chief Actuary at MIA, provided context for MIA rate approvals, noting that approximately 500,000 residents of the State (9% of the State's population) are covered by QHPs offered to individuals or small groups under the ACA. Of this population, 243,420 have coverage in the individual market and 256,967 have coverage in the small group market. The remaining 91% of Marylanders are covered by health insurance plans offered by large employers or employers that self-insure, grandfathered plans, or federal plans (*e.g.*, Medicaid, Medicare, and Tricare). Mr. Switzer then summarized the actuarial review process, noting that under § 11-603 of the Insurance Article, rates must be reasonable in relation to benefits, not inadequate or excessive, and not unfairly discriminatory. Moreover, actuarial standards of practice require that assumptions be supported and reasonable, both individually and in the aggregate.

Mr. Switzer identified the top assumptions that the actuaries at MIA consider when reviewing premium rates, including morbidity (the relative health of the insurance pool), trend (the pace in insurance costs and utilization), the contribution to reserve or profit, administrative costs, the health insurer fee, and drug manufacturer rebates. Mr. Switzer then reviewed the rates approved for the individual market for 2018. The average rate request for a silver plan was for a 43.1% increase, and MIA approved a 33.0% increase, which means for an average person an annual increase of \$1,396 and for an average family of four an annual increase of \$4,181. For comparison, Virginia approved a 52.5% increase, resulting in an average annual increase of \$1,972 for an individual and \$5,903 for a family of four. Unlike Maryland, Virginia did not assume that the CSR payments to insurers would be funded next year.

Reviewing the increase in premiums over time, Mr. Switzer noted that individual premiums have gone up from \$184 per member per month in 2012 to \$469 per member per month in 2018, representing an increase from 4% to 9% of per capita income. In addition, premium rates for individuals have increased when compared with premiums rates for small groups. In 2012, individual rates were 33% below the rates for small groups. In 2018, individual rates are 43% higher than the rates for small groups. Furthermore, 2018 is the fourth consecutive year in which rates for individuals have increased by over 20%. The individual market rate increases accelerated beginning in 2014, when underwriting was no longer allowed and guaranteed issue was required under the ACA. The small group market has been guaranteed issue since 1994 in Maryland. Mr. Switzer noted that when underwriting was allowed in the individual market, carriers were commonly denying coverage to as many as 40% of applicants due to preexisting conditions.

Mr. Switzer highlighted some of the impacts of the ACA in Maryland to date. At 6.1% in 2017, the uninsured rate in the State is the eleventh lowest in the nation. Uncompensated care as a percentage of gross patient revenue has dropped from 7.25% in 2013 to 4.51% in 2016, a reduction of \$362 million. Of the 243,000 members in the individual market, 41.0% (100,184 members) received advance premium tax credits (APTC) for their health coverage and 29.0% (71,537 members) purchased CSR plans. According to a report by the U.S. Department of Health and Human Services (HHS), Maryland had the fifth lowest average premiums in the nation for health benefit plans offered in the individual market for 2016 (13.0% lower than the national average). Enrollment in the individual market has nearly doubled in the last five years because of the ACA, whereas enrollment in the small group market has decreased by nearly 20.0%.

Mr. Switzer then reviewed the factors behind the 33% average increase in premium rates approved for 2018 for health benefit plans offered in the individual market. One factor contributing to the increase is the reinstatement of a 3% health insurer fee, which was waived in 2017. Other factors contributing to the increase include healthy members leaving the market; actual claims experience being higher than expected; and claims costs increasing by approximately 8% annually. Mr. Switzer noted that Kaiser Permanente's (Kaiser) rates, on average, were approximately 20% lower than CareFirst's rates. About 25% of members in the individual market are enrolled in Kaiser's health maintenance organization (HMO) plan; however, this plan is not an option in 13 rural counties in the State. CareFirst has the remaining individual market share, with 65% of the market enrolled in CareFirst's HMO plan and 10% enrolled in CareFirst's preferred provider organization (PPO) plan. Under the ACA, plans offered in the individual market must meet certain benefit and actuarial value requirements. Although plan benefits are federally prescribed, carriers are offering plans with varying designs and, in particular, varying deductible amounts. For silver plans, deductibles range from \$2,000 to \$6,000. The average deductible for plans offered in the individual market increased by \$380, from \$3,756 in 2017 to \$4,136 in 2018. In the small group market, the average deductible is closer to \$2,000.

MIA examined the 2016 experience of a cohort of enrollees in the individual market who were still enrolled in plans on June 30, 2017, and observed that the claims for this cohort were 6% higher than for the approximately 40% of individuals who allowed their coverage to lapse. This

suggests that the individuals who are leaving the market tend to be healthier. In addition, the claims experience of individuals who transferred from other markets was 6% higher than the claims experience of individuals in 2016 (approximately 13% of the individual market) and approximately 20% of the market who were new entrants had 11% higher claims. Overall, this change in morbidity in the insurance pool added 5% to the premium rates. MIA then observed further worsening of morbidity for the cohort in 2017 that added an additional 3% to the rates. This increase in claims costs has happened each year since 2014 and is consistent with a nationwide trend. In essence, the healthy are leaving the market, the unhealthy are coming into the market, and costs are rising.

Mr. Switzer reported that the approved rate increases for plans offered in the small group market are more modest. MIA approved an average rate increase of 1.7% for the first quarter of 2018. CareFirst has 66.0% of the market, followed by United HealthCare with 19.0%. Kaiser and Aetna also offer plans in the small group market. Plans in the small group market have a more favorable claims experience and a competitive marketplace.

Mr. Switzer then addressed the impact of the ACA on insurers. Since the start of the ACA in 2014 through 2016, Maryland insurers have sustained an underwriting loss of \$493 million (19% of revenue) in the individual market. In contrast, insurers in Maryland have realized an underwriting gain of \$179 million (5% of revenue) in the small group market. Although the individual market is only 4% of the total insurance market, it is about 25% of the fully insured market and growing faster than the small group market. The underwriting losses in the individual market are having an impact on insurer surplus. Even after investment income is factored in after underwriting gains and losses, 2016 was the first year that insurer surplus is estimated to have declined in dollar value. Insurers had about 3 to 5 months of fully insured claims and expenses in savings in 2016. This is down from the estimated 4 to 6 months in savings insurers had in 2012. Some actuarial consultants recommend that insurers have between 8 and 10 months in savings.

### **Commission Member Questions about Health Insurance Rates Approved for 2018**

MIA panelists received comments and fielded questions from commission members. Vincent DeMarco requested that MIA look into the impact of the reduction in uncompensated care under the ACA on premium rates, including rates of plans outside of the ACA markets. In response to a question by Dr. Stephen Rockower about MIA's statement that new entrants to the individual market in 2017 had 11% higher claims, Mr. Switzer indicated that level of claims for this population is an estimate based on the metal level mix of products purchased and what is known about the existing insurance pool. Lori Doyle inquired about whether there is a standard for determining whether premiums are becoming unaffordable to an average person, including taking into consideration deductibles and other cost-sharing requirements in plans. Mr. Switzer responded that MIA's review focuses on premiums only but that he would work to identify a benchmark for determining affordability.

Ms. Quattrocki inquired about the consequences, should the federal government decide to stop CSR payments. Mr. Switzer indicated that in 2016, insurers in the State received approximately \$50 million in CSR payments. The impact on premium rates on the whole individual market insurance pool is estimated to be about 4%. However, if the increase in rates is concentrated in silver plans only, the estimate is an increase in premium rates of more than 10%. In response to a question about whether MIA has one or two top recommendations for what the State could do to bring down premium rates, Mr. Morrow indicated that it did not but noted that other states are pursuing waivers under Section 1332 of the ACA that, by some estimates, could result in a 20% reduction in rates. MIA could not recommend whether it would be better to use funds for a reinsurance program versus using funds for increased marketing to get more younger and healthier individuals into the insurance pool. Mr. Morrow indicated, however, that the best way to get more individuals into the insurance pool is to reduce premium rates.

Senator Thomas M. Middleton inquired about the Trump Administration's nonenforcement of the individual mandate under the ACA and whether MIA took that into account in reviewing premium rates. Mr. Morrow indicated that because the mandate is still a requirement of the ACA, nonenforcement of the mandate is not a factor MIA considered in its rate review process. Sanford Walters inquired about whether a State law mandating that an individual have insurance and giving authority to the State to fine or penalize individuals who did not would have an impact on rates. Mr. Morrow assumed there would be some effect but could not speculate as to what the full effect would be.

### **CareFirst Commentary on Health Insurance Rates and Options for Stabilizing the Individual Market**

Chet Burrell, President and Chief Executive Officer of CareFirst BlueCross BlueShield, remarked that from CareFirst's perspective, premiums have reached an unaffordable level and are heading higher, the individual market is not stable, and without intervention there will be no viable individual market within 24 months. Mr. Burrell reviewed statistics showing that the ACA has reached its target population. Under the ACA, 27,796,000 individuals in the United States and 538,000 individuals in Maryland have gained coverage. Most of the coverage gains have been due to the Medicaid expansion with more than 16 million members in the United States and 396,000 members in Maryland enrolling in coverage between 2013 and 2016. In the individual market, more than 9.3 million individuals nationally and 101,000 individuals in Maryland received APTCs in the first quarter of 2016, with 68.0% nationally and 72.0% in Maryland purchasing CSR plans. The average APTC amount was \$291 nationally and \$243 in Maryland. Mr. Burrell also noted that a number of younger individuals have gained coverage under the ACA by staying on their parents' plan until the age of 26, noting that 2.3 million individuals nationally and 41,000 Marylanders obtained coverage through this means. The total coverage gains under the ACA has had a beneficial impact in reducing the uninsured rate, dropping from 14.5% in 2013 to 8.6% in 2016 nationally and from 10.2% in 2013 to 6.1% in 2016 in Maryland. The uninsured rate has dropped the most for individuals with incomes under 138.0% of federal poverty guidelines (FPG), reflecting the benefit of the Medicaid expansion.

CareFirst has approximately 3.1 million members in Maryland, including 169,857 members enrolled in individual ACA coverage (5%) and 168,264 members enrolled in small group ACA coverage (5%). Before the ACA, when underwriting was permitted, there were seven carriers participating in individual ACA market. That number has dropped to two under the guaranteed issue requirements of the ACA. In the individual market, CareFirst is the sole carrier in 13 counties and is a co-carrier with Kaiser in the rest of the counties of the State. Of the 242,800 individuals who have ACA coverage in the State, 146,400 obtained coverage through MHBE and 96,400 obtained coverage outside of MHBE. CareFirst has 75% and Kaiser has 25% of the individual ACA market share.

Mr. Burrell compared CareFirst's individual ACA market premium rates for 2014 and 2018. CareFirst's HMO premium rates are approximately 100% higher than 2014 premiums. The rate increases are driven by worsening morbidity of members. As premiums become unaffordable, the healthiest members either move to less expensive Kaiser products or drop coverage altogether. In 2018, a 40-year-old individual in the Baltimore metropolitan area will pay \$465 a month for a silver plan. For CareFirst's PPO plans, premium rates are approximately 150% higher than 2014 premiums. In 2018, a 40-year-old individual in the Baltimore metropolitan area will pay \$686 per month for a silver plan. The out-of-pocket maximum for silver plans in 2018 will be \$7,350. With large rate increases in individual rates and only modest increases in small group rates for 2018, the individual average premium will substantially exceed the average small group premium for the first time in 2018. The average individual premium rate increased by 153% from 2013 to 2018, whereas the average small group premium rate increased by 18% during that same time period.

Mr. Burrell attributes the considerably lower individual premium rates in 2013 to the use of medical underwriting and the enrollment of unhealthy individuals into the Maryland Health Insurance Plan (MHIP). MHIP enrollees were five times more expensive to insure than other individuals insured in the individual market. The single risk pool and guaranteed issue requirements of the ACA have resulted in the individual market having a higher level of morbidity, and this morbidity is driving up premium rates. Mr. Burrell indicated that because of these market conditions, CareFirst has experienced an underwriting loss of \$426 million from 2014 through 2017 on its individual ACA market enrollment in Maryland. CareFirst's preliminary estimate for 2018 is that it will lose an additional \$75 million on its individual ACA market enrollment.

Mr. Burrell reviewed an analysis of CareFirst's individual ACA population health and noted that for CareFirst's HMO enrollment, the 3.4% of the population who have an advanced or critical illness account for 37.3% of health care costs. Enrollees with multiple chronic illnesses comprise 8.8% of the population but account for 26.1% of the costs. Enrollees who are healthy or have a stable health profile represent approximately 75.0% of the population but account for about 20.0% of the costs. If healthier individuals were to drop coverage and the percentage of healthy or stable individuals in the insurance pool were to drop to 65.0%, this would require a 30.0% increase in premium rates to account for the higher percentage of unhealthy risk. Mr. Burrell anticipates that healthier individuals will drop out of coverage during open enrollment and premium rates will increase again in 2019. Two-thirds of CareFirst individual ACA market enrollees do not receive an ACA subsidy. These individuals are the most impacted by premium increases and high out-of-pocket costs and the most likely cohort of enrollees to drop coverage.

Mr. Burrell proposes that the State obtain a State Innovation Waiver under Section 1332 of the ACA to stabilize the individual market. CareFirst's proposal includes five points to (1) move from multiple insurance options to one standard product in the individual ACA insurance market with a \$1,000 deductible and a \$3,500 out-of-pocket maximum; (2) establish a stop-loss reinsurance limit of \$50,000 per person per year above which costs would be split 80% federal government and 20% carriers; (3) reallocate federal funding for APTCs and CSR payments to fund reinsurance and premium subsidies for individuals with incomes up to 400% FPG; (4) place a rate stabilization surcharge on the premiums of carriers that do not participate in the individual ACA market; and (5) include other funding mechanisms to promote market stabilization, such as an assessment on hospital rates. Under the third element of the proposal, Mr. Burrell recommends a reallocation of federal funding so that half of the funding would be used to reduce premiums by approximately 20% for everyone and the remaining half would be used for age-adjusted, low-income subsidies. According to Mr. Burrell, the plan would have no financial impact to the federal government, reduce premiums by 20% across the board, continue subsidies to low-income enrollees, and maintain key elements of the ACA, such as keeping essential health benefits and the 3:1 age band rating restriction. The plan would also ease the administrative burden through the simplification of offered products and may incentivize more carriers to rejoin the ACA market.

### **Kaiser Commentary on Health Insurance Rates**

Sheila Schroer, Executive Director of Actuarial Services for the Kaiser Foundation Health Plan of the Mid-Atlantic States, reviewed the premium rates approved for Kaiser individual market plans for 2018. Ms. Schroer noted first that Kaiser's share of the individual market in 2017 is 38% and that its market share has increased every year through 2017 and is expected to grow further in 2018. Ms. Schroer then indicated that Kaiser's individual market business segment has generated a loss every year since the inception of the ACA. From 2014 through 2017, Kaiser expects that it will have lost \$92 million, an operating loss of 22%. Ms. Schroer presented information on Kaiser's average monthly rate for the lowest priced plans offered to a 40-year-old in each metal level in 2018. Kaiser's average rates for these plans are lower than the rates for comparable plans offered by CareFirst. Kaiser's rates increased by 24% in 2017 and by 23% in 2018. Ms. Schroer indicated, however, that these levels of rate increases are not expected to continue if there is no market destabilization or major changes to the ACA. Kaiser's expense trend for 2016 through 2018 has risen at a lower rate than its revenues. Medical claims expenses, in particular, have been stable. Risk adjustment expenses have, however, grown over time, most notably in 2017, due to Kaiser having relatively lower medical claims expenses. While Kaiser has experienced single-digit increases in its expense trend and double-digit increases in revenue, it has lost money due to initial pricing through 2016 that underestimated costs under the ACA. Once costs for its ACA plans became better known to Kaiser, it requested and received rate increases for 2017 and 2018 that reflected pricing corrections. If nothing major changes in the future, Kaiser expects that its pricing corrections are largely complete.

According to Ms. Schroer, Kaiser's medical trend experience is different than CareFirst's medical trend experience, due to Kaiser's integrated HMO structure and the different way it pays medical claims and reimburses providers. Unlike traditional insurers, Kaiser pays its physicians a

budgeted amount set in advance that does not vary depending on the health of its members. Traditional insurers pay providers based on the number and types of services provided, resulting in more volatility and unpredictability. Kaiser also has significant fixed costs and tends to have healthier members.

### **Commission Member Questions about Options for Stabilizing the Individual Market**

The carrier panelists fielded questions from commission members. In response to a question about the anticipated impact of the CareFirst reinsurance proposal, Mr. Burrell indicated that even with the reinsurance program, premiums would continue to increase, but at levels that are more in line with increases attributable to overall medical trends and less from increases associated with higher morbidity from a sicker pool of insureds. The reinsurance proposal would reduce the growth in premiums by removing the volatility of claims above the \$50,000 attachment point. To have market stability, more younger and healthier individuals will need to be in the risk pool. If monthly premium rates could be at a level of \$400 to \$500 a month and remain stable year-over-year, the rates may be affordable enough to younger and healthier individuals. Mr. Burrell acknowledged that there is a need for expert actuarial analysis of the CareFirst proposed reinsurance model and that the model may need to be refined. The goal would be to get individual market rates at levels that are more in line with the group insurance market.

Mr. Burrell was asked about whether one should expect CareFirst enrollees to migrate to Kaiser plans in years ahead if CareFirst rates continue to increase while Kaiser rates remain relatively static. Mr. Burrell responded that, given a large difference in price, some portion of the market will choose Kaiser plans, and Kaiser's share of the market will increase. More individuals will be enrolled in a closed staff HMO model in which a member is not free to see any physician of their choosing. In response to a question about risk adjustment, both carrier representatives recommended changes to the federal program to make it more equitable. Both panelists called for the inclusion of pharmaceutical drug claims in the model. Mr. Burrell also recommended that the model have a longer look-back period for determined illness levels of individuals.

Commission members and Mr. Burrell discussed the limitations of reinsurance as a mechanism to control costs and attract younger individuals into the insurance risk pool. Even if the model proposed by CareFirst were able to achieve premium rates at \$500 a month or \$6,000 a year, the cost of insurance may still be too high for younger individuals. Mr. Burrell agreed that other mechanisms are needed to contain costs, such as complex case management and care coordination programs for the sickest 2% of the health insurance pool. There was also discussion about the need to analyze the CareFirst proposal in depth to determine who would pay more and who would pay less under the model. Mr. Burrell was asked about the Alaska model, which reinsures individuals with certain high-cost conditions; he responded that he favors a model that has a dollar-based attachment point over a condition-based model.

## **Impact of Federal Legislation and Actions Being Taken by Other States to Stabilize Individual Insurance Markets**

Dennis R. Schrader, Secretary of Health, delivered a message from Governor Lawrence J. Hogan, Jr. expressing the Governor's view that the Graham-Cassidy legislation considered by the U.S. Senate would not work for Maryland. The Governor supports bipartisan solutions to address the problems in the individual market, such as the legislation under consideration in the U.S. Senate sponsored by Senator Andrew Lamar Alexander, Jr. and Senator Patricia Lynn Murray.

Haley Nicholson, a Senior Policy Specialist with the National Conference of State Legislatures (NCSL), updated the commission on actions being taken by other states to stabilize their insurance markets. Some states are submitting State Innovation Waiver applications under Section 1332 of the ACA. Ms. Nicholson stated that the Centers for Medicare and Medicaid Services (CMS) is encouraging states to apply for Section 1332 waivers but that the review process takes approximately 18 months on average. Some states, such as Iowa, have decided to pursue smaller and more temporary market stabilization measures than an Section 1332 waiver. Ms. Nicholson also addressed the Graham-Cassidy legislation and noted that, for NCSL members, the main feature of concern is that the legislation would convert funding for the ACA Medicaid expansion and QHP coverage, as well as funding for traditional Medicaid coverage, to block grant funding. The legislation would give more flexibility to states in using the federal funding but concerns have been expressed about the sufficiency of funding to states to respond to public health crises or to pay for new expensive treatments. CBO has estimated that, all together, states would lose approximately \$1 trillion in funding over time under the legislation.

Simon G. Powell, a Senior Operating Budget Manager for the Department of Legislative Services (DLS), presented on the impact of the Graham-Cassidy legislation on Maryland. Mr. Powell began by highlighting the impact on Medicaid and the Maryland Children's Health Program, noting that enrollment in these programs has doubled in the last decade. About 380,000 individuals have enrolled in the Medicaid program since January 2014. Eighty percent of these individuals became eligible through the ACA expansion. In addressing what is at stake under the Graham-Cassidy legislation, Mr. Powell noted that Maryland currently receives over \$2.5 billion in federal Medicaid funding to support the ACA expansion population and that this support is expected to grow to \$4.8 billion by fiscal 2026. In addition, federal funding for populations covered under the Graham-Cassidy block grant proposal for the traditional Medicaid program totaled almost \$3.0 billion in fiscal 2017 and is anticipated to grow to \$4.3 billion by fiscal 2026. According to estimates from MHBE, Maryland residents will receive \$417 million in APTCs in calendar 2017, and insurers will receive \$97 million in CSR payments.

Mr. Powell reviewed estimates of the loss of federal funds due to the Graham-Cassidy legislation, both nationally and in Maryland. For Maryland, estimates vary from \$2.6 billion to \$13.0 billion for federal fiscal 2020 through 2026. Estimates for federal fiscal 2027 show a significant drop in funding, ranging from \$3.8 billion to \$6.0 billion. DLS calculated its own



estimate for Maryland using a current Medicaid baseline forecast from actual fiscal 2017 spending, projected APTCs, and CSR payments for calendar 2017 for QHPs with a trend forward at 6%, and a general consensus estimate of funding for Maryland under the proposed ACA expansion and marketplace block grant of 1.5% to 1.6% of total available funding. Based on these assumptions, DLS estimates that the State could lose up to \$13.5 billion in federal funding between fiscal 2020 and 2026 under the Graham-Cassidy ACA expansion/marketplace block grant proposal. Assuming that the grant is no longer available in fiscal 2027, Maryland would lose as much as \$6.0 billion in federal funding in that year. Regarding the impact of block granting most of the traditional Medicaid program (*e.g.*, elderly, disabled adults, children, and other adults), Maryland is most at risk toward the end of the fiscal 2020 through 2026 forecast period. However, a provision that would allow the U.S. Secretary of Health and Human Services to reduce inflationary growth for high-cost states could have a significant impact on the State, as Maryland is a relatively high-cost state.

Mr. Powell concluded that the Graham-Cassidy legislation's proposed changes to the Medicaid program and the availability of subsidies for QHPs would significantly impact coverage in Maryland and that the changes proposed to the funding of the ACA expansion population would have the most far-reaching consequences. Any loss of federal funding would require difficult decisions at the State level at a time when the overall State budget continues to see projected spending outpacing projected revenues.

### **Update from MHBE**

Michele Eberle, the Chief Operating Officer at MHBE, provided an update from MHBE. Ms. Eberle began by addressing comments and questions that had been raised during the meeting. Ms. Eberle noted that the threshold for being eligible to receive a subsidy to purchase a QHP under the ACA is a household income of up to 400% FPG. In 2018, this equates to up to \$48,240 for an individual and \$98,400 for a family of four. Ms. Eberle then indicated that MHBE has convened a workgroup that will be bringing forward recommendations in November 2017 for having a plan with a standard benefit design in 2019. Ms. Eberle also noted that on the Eastern Shore and in far western regions of the State where CareFirst is the only carrier offering plans in the individual market, many consumers who will receive a subsidy will pay less for a QHP in 2018 than they did in 2017, due to the way subsidies are calculated under the ACA. MHBE is marketing heavily in these areas to individuals who are between the ages of 18 and 34.

Ms. Eberle reviewed the efforts MHBE is making to enroll "young invincibles" – individuals who are between the ages of 18 and 34. In 2017, nearly 50,000 enrollees in QHPs, or 30.2% of the total QHP enrollment, are young adults, which rank Maryland fifth in the nation in the number of young adults enrolled and ahead of the national average of 26.9%. MHBE attributes its success in enrolling young adults to the development of a mobile application, with 62.0% of mobile application enrollments completed by an individual between the ages of 18 and 34; targeted outreach events; and a large social media presence.

## **State Transitional Reinsurance Program and MHIP**

Ms. Eberle reviewed the State's transitional reinsurance program. The program received funding from surplus funds in the MHIP fund. In 2014, a federal transitional reinsurance program was established with an attachment point of \$45,000, a cap of \$250,000, and a coinsurance amount initially set at 80.0% that was later raised to 100.0% by HHS. Ms. Eberle indicated that the total reinsurance payout that year was \$57,352,134. (MIA indicates, however, that the total reinsurance payout for 2014 was \$67,322,426, a figure that accounts for a payment to CareFirst's subsidiary Group Hospitalization and Medical Services, Inc.) In 2015, the federal government initially increased the attachment point to \$70,000 but later reduced it to \$45,000, maintained the cap at \$250,000, and set a coinsurance amount at 50.0%. The State established a supplemental reinsurance program in 2015 that provided an additional coinsurance amount of 30.0% that was later reduced to 24.9%. In 2015, \$39.5 million from the MHIP surplus was approved to fund the supplemental reinsurance program. The total reinsurance payout in 2015 was \$143,424,330, including \$103,924,330 in federal program funds and \$39,500,000 in State program funds. In 2016, the federal government increased the attachment point to \$90,000 and maintained the \$250,000 cap and 50.0% coinsurance amount. The Maryland reinsurance program provided an additional coinsurance amount of 30.0% that was later reduced to 22.3%. The total reinsurance payout for 2016 was \$77,186,659, including \$55,886,659 in federal program funds and \$21,300,000 in State program funds. The federal and State supplemental reinsurance programs together are estimated to have lowered premiums somewhere in the range of 8.0% to 18.0% in 2015 and 3.0% to 13.0% in 2016.

Ms. Eberle also commented on MHIP, the high-risk pool that operated in the State before the ACA. Ms. Eberle noted that MHIP was very successful but also very expensive. MHIP had a rich benefit structure and received over \$100 million a year in funding from a 3% assessment on hospitals.

## **State Innovation Waivers under Section 1332 of the ACA**

Ms. Eberle submitted a presentation to the commission providing an overview of state innovation waivers under Section 1332 of the ACA. Section 1332 permits states to apply for waivers to pursue innovative strategies for providing their residents with access to high quality, affordable health coverage. States may request waivers from provisions of the ACA but must retain the law's basic protections. Waivers may be approved for periods of up to five years and may be renewed. To receive approval, a state must demonstrate that the waiver (1) provides access to quality health care that is at least as comprehensive as would be provided without the waiver; (2) provides access to quality health care that is at least as affordable as would be provided without the waiver; (3) provides coverage to at least a comparable number of residents as would be provided without the waiver; and (4) does not increase the federal deficit.

Before submitting an application for a waiver, states must give public notice of the application and have a minimum 30-day public comment period, hold a minimum of two public

hearings on separate dates and locations, and enact a law providing for implementation of the waiver. Among other application requirements, states must provide reports on the issues raised during the public comment process and public hearings, as well as actuarial and economic analyses and actuarial certifications.

Eight states have begun or completed a Section 1332 waiver process. Alaska, Minnesota, and Oregon have each received approval of reinsurance programs under Section 1332 waivers. The Alaska Reinsurance Program will reinsure individuals with 1 or more of 33 identified high-cost conditions to help stabilize premiums using pass-through funding based on the amount of APTCs that would have been paid absent the waiver. The Minnesota Premium Security Plan, like Alaska's program, uses pass-through funding based on the amount of APTCs that would have been paid absent the waiver but is also funded by state appropriations. The program is modeled after the federal reinsurance program and reimburses 80% of individual market claims between \$50,000 and \$250,000. Oregon's program also uses pass-through funding and will reinsure 50% of claims, in excess of an attachment point to be determined, up to \$1 million.

## **Public Comments**

The commission received comments from members of the public, including Chris Sabas, Ramar Robinson, and Kevin Estis, who each testified about the benefit they have received from the ACA.

## **December Meeting**

On December 5, 2017, the commission received an update on the status of the Maryland All-Payer Model Contract and presentations on options for stabilizing the individual health insurance market. The commission also received comments from the public and discussed policy options for potential recommendations.

## **Maryland's All-Payer Model Contract**

Secretary Schrader and Katie Wunderlich, Principal Deputy Director of the Health Services Cost Review Commission (HSCRC), updated the commission on behalf of the Executive Branch. Maryland has had an all-payer hospital rate-setting system since 1977. Maryland has a unique model and despite a changing national landscape, Maryland has remained a leader in health care delivery. In 2014, Maryland entered a five-year contract with CMS, which moved Maryland from a volume cost per case model to a per capital hospital growth limit. This move led to a value-based total cost of care system in which each hospital receives a fixed Global Budget Revenue payment system that focuses on reducing hospital costs and improving health outcomes by working with providers across the health care continuum. As part of Maryland's contract with the federal government, the State's performance on a number of metrics is monitored closely. Based on Maryland's data reported to the federal government, the State has met or exceeded most of the

targets to date. Secretary Schrader indicated that because of Maryland's success under the model contract, CMS wants to work with Maryland in the future and use Maryland as a national model.

The current model contract expires on December 31, 2018. In December 2016, the Hogan Administration filed a progression plan with the federal government to negotiate the next phase of the contract. Contract negotiations began in January and continued through May 2017, including engagement with key stakeholders to develop a contract framework, including the development of a terms sheet. From May to September 2017, MDH and HSCRC reached out to the Maryland congressional delegation, Maryland legislative leaders, and health care community stakeholders, including the private sector, for feedback and incorporated the responses into the model. MDH and HSCRC indicated that the contract is in the final clearance process with the federal government and anticipates that a new contract will be signed in early 2018 and will go into effect on January 1, 2019.

Maryland is requesting that the length of the new contract be extended to 10 years. Based on experience with the current contract, the first three years of the contract were spent establishing the all-payer model; and as soon as the model was fully functional, negotiations began on the next phase, putting a strain on the stakeholders and resources. The new model is referred to as the Enhanced Total Cost of Care Model (Enhanced Model) and will coordinate inpatient and outpatient services in hospital and nonhospital settings to generate positive health outcomes and lower costs. The Enhanced Model will build on the model contract by encouraging health care innovation and flexibility, containing costs through use of a global budget based on health care outcomes, and promoting and sustaining rural health care initiatives. Additionally, the Enhanced Model aims to align hospitals, physicians, and long-term care and other health care providers by providing incentives for the coordination and streamlining of care. The first five years of the contract will include a testing period in which the State must show total cost-of-care savings of \$300,000,000 in the fifth year of agreement. The last five years of the contract will require maintenance of Medicare cost savings and quality improvement, including the management and prevention of chronic and complex conditions, improved population health, and access to quality primary care.

MDH and HSCRC are working with stakeholders across Maryland to prepare them for the upcoming changes. An innovations workgroup comprised of the private sector will meet and discuss the foundation for making coordinated health care improvements to deliver the first set of milestones in 2019 to 2023. Through the workgroup, providers and clinicians from different communities and disciplines will discuss innovative strategies and how to implement them in the new model. Further, the Department of Aging, MDH, HSCRC, the Maryland Health Care Commission, and other State agencies will act as facilitators for the industry's transformation to ensure an efficient use of resources. In particular, MDH will focus on delivering improvements to targeted health populations to promote health and wellness, including behavioral health, opioid use and abuse reduction and prevention, Hepatitis C reduction, smoking, diabetes and obesity prevention, and targeting falls in seniors.

During the 2017 legislative session, the General Assembly passed legislation that enables hospitals to partner with physicians and other providers to improve health care. In July 2017,

two programs became effective that aim to align hospitals and other providers: (1) the Hospital Care Improvement Program (HCIP) and (2) the Complex and Chronic Care Improvement Program (CCIP). Sixteen hospitals will participate in the two programs in 2017, and more are expected to participate when the next performance period begins in January 2018. HCIP aims to improve the coordination between hospital-based physicians. CCIP aims to connect hospitals with community-based providers to manage chronic conditions. Both programs will continue under the Enhanced Model, and additional hospital- or nonhospital-based programs may also be implemented.

In addition, Maryland is also in the process of establishing a Primary Care Program. The program will increase focus on prevention and primary care activities, and the success of the program will be impacted by the providers giving care in community-based settings. The Primary Care Program requires federal approval on a separate but parallel track to the federal approval required for the Enhanced Model. The Primary Care Program is based on a national program, and MDH and HSCRC indicated that they expect approval for the program by the end of the year. Through the Primary Care Program, the State will receive additional federal money for Medicare. If approved by the federal government, the Primary Care Program will launch in summer 2018.

The Medicare Performance Adjustment (MPA) and a program for the dual-eligible population are scheduled to become effective in 2018 and 2020, respectively. MPA will link global budgets to the Enhanced Model. The program for the dual-eligible population will increase coordination for individuals who are eligible for both Medicaid and Medicare.

Mike Robbins, Senior Vice President of the Maryland Hospital Association (MHA), echoed the view of MDH that CMS wants to work with Maryland because of the success Maryland has had with the model contract. Since January 2014, the number of hospital-acquired infections has dropped by nearly half, Maryland has outpaced the nation in reducing readmissions, and Maryland has saved Medicare more than \$650,000,000. In large part, MHA credits the expansion of insurance coverage under the ACA for the savings to Medicare. As the Enhanced Model replaces the model contract, the focus will shift from hospitals to all providers in all settings, from hospital savings to total cost-of-care savings, and from hospital quality metrics to quality and population health metrics. The Maryland Primary Care Program and the federal money attached to it, as well as physician alignment measures available under the federal Medicare Access and Children's Health Insurance Protection Reauthorization Act of 2015 (MACRA) and post-acute alignment will facilitate the change in models. MHA testified that to be successful, the Enhanced Model must: (1) facilitate close partnerships among hospitals, physicians, skilled nursing facilities, home health professionals, pharmacists, and other health care providers; (2) provide greater flexibility for providers to transform care; and (3) remove legal and regulatory barriers so that hospitals can work with other health care providers to ensure access to the right care, at the right time, in the right setting. Additionally, MHA commented that success for the Enhanced Model will depend on:

- engaging the community and stakeholders in cultural awareness and education about the shift from volume to value-based health care models;

- working between State agencies, hospitals, and the provider community to develop policies to support new models of care; and
- working with policymakers to remove barriers to health care innovation, reduce costs, and create opportunities for success.

Mr. Robbins also testified that the General Assembly may support the success of the Enhanced Model by taking actions that would contribute to reducing the total cost of care or by avoiding actions that would increase the cost of care, including:

- securing the Budget Reconciliation and Financing Act's recommended \$35,000,000 spend-down for fiscal 2019 of Maryland's hidden sick tax through budget negotiations;
- committing resources to strengthen the behavioral health care workforce and expand crisis services, including reducing emergency room visits;
- rejecting attempts to raise the State's cap on noneconomic damages; and
- supporting legislation to create a no-fault birth injury fund.

Gene M. Ransom, III, Chief Executive Officer of MedChi, stressed that many groups representing a variety of providers were involved in the negotiations on the Enhanced Model and that although the groups may have had differing opinions on aspects of the model, all of the groups agreed that the contract with CMS must be extended because it would be cataclysmic if Maryland loses its unique all-payer hospital model. Moving forward, MedChi suggested that:

- HSCRC be given the resources necessary to implement the Enhanced Model, including staff, contractors, and subcontractors;
- funding for the Chesapeake Regional Information System for Our Patients remain at appropriate levels to retain Maryland's exemplary health information exchange;
- checks and balances be implemented to protect workers in hospitals; and
- all parties have a seat at the table as the Enhanced Model is implemented.

### **Commission Member Questions about the Maryland All-Payer Model Contract**

The panel answered questions from commission members. In response to questions about the lack of stability regarding health insurance at the federal level, MHA reiterated its support for

maintaining coverage and access that facilitates providing the right care, in the right setting, at the lowest cost. MDH pointed out that the ACA has stabilized the uninsured population and that enrollment through MHBE is up for the 2018 open enrollment period but that the individual market needs to be stabilized. HSCRC informed commission members that the Enhanced Model includes an exogenous factor clause that will allow Maryland to seek exceptions to certain terms of the contract if action is taken by the federal government that greatly impacts the Maryland markets. MedChi stressed that, for the clause to take effect, action must be taken on the part of the federal government not because of changes at the State level. When asked how the proposed model compares to the old model, HSCRC responded that it would provide the commissioners with an updated draft of the terms. When asked about the peer review and evidence used to develop the new model, HSCRC explained that the State has continuously met the metrics for the old model on which the new model is based. In developing the new model, HSCRC looked at new systems that are value based and incorporated them into the model.

The panel also addressed questions concerning the Enhanced Model's impact on the health care workforce. MedChi opined that workers need to know their rights and MHA provided the viewpoint that the incentives to reduce the use of inpatient hospital services has resulted in repurposing of current positions focused on supporting care provided in the community outside of the hospitals. Further, when asked about how the model applies to nonhospital settings, MDH explained that the model will not regulate nonhospital providers but that MDH is partnering with hospitals to develop a system that gets patients to appropriate settings for care. MDH and MedChi explained that the model is aligned to the federal MACRA program, which creates economic incentives for physicians to participate.

Other questions arose regarding long-term care and preventative care. MDH explained that it is in the process of moving about 300,000 Medicare recipients to the new Primary Care Program, which will receive financial incentives from CMMI. MDH is hopeful that the move will delay entry to nursing homes. As for the developmentally disabled population, the Money Follows the Person initiative has assisted in moving many individuals from nursing homes into community-based settings. Regarding preventative care, MDH indicated that it is focusing on population health and health disparities.

Additional questions addressed the Primary Care Program, consumer protections, and total cost-of-care calculations. In response to a question regarding how physicians will know at which hospitals their patients will be attributed, commissioners learned that the program would be based on attribution data from CMS and that the program would attribute patients by physician. When asked what consumer protections exist in the Enhanced Model to protect consumers from hospitals denying services in order to meet the budget, HSCRC responded that it will be tracking complaints and quality measures. The total cost of care is calculated using data on Medicare Part A and Part B that is collected by CMS and provided to the State. For the first five years of the Enhanced Model, this data will not include the additional payments that Medicare will be making under the Maryland Primary Care Program.

## Options for Stabilizing the Individual Market

Michael Miller, Policy Director for Community Catalyst, framed the issue of market stabilization with three factors, whether: (1) there is adequate access; (2) there is adequate and robust participation; and (3) premiums are stable. He opined that Maryland is ahead of the curve in keeping health care costs down, which ultimately assists market stabilization. Mr. Miller suggested that the three-legged stool upon which the current system is based – access to care, responsibility to have insurance, and subsidies – can work but that there is a need to pair more subsidies with the responsibility requirement, so that the public perception is that individuals are being asked to do something that is reasonable and has value to them. Mr. Miller also suggested that Maryland be proactive in light of the potential repeal of the federal individual mandate and provided several ideas that Maryland could implement to stabilize markets:

- substituting or enforcing the federal mandate;
- enhancing premium support to individuals up to 200% FPG by implementing the Basic Health Program (BHP) option under Section 1331 of the ACA, which may not require State money or to individuals above that income threshold, which would require State money;
- incentivizing carriers to participate in the individual market, such as through the adoption of reinsurance, conferring on carriers preferred status in other markets, imposing penalties on carriers that choose not to participate in the individual market, or establishing a requirement that carriers participate in the individual market in order to participate in other insurance markets;
- regulating the sale of short-term plans to ensure that the plans do not cannibalize the guaranteed issue individual market; and
- providing robust outreach for enrollment.

Mr. Miller acknowledged that both premium support and reinsurance will require State money, and that the State should do some modeling and implement whichever option would drive up enrollment the most. Mr. Miller proposed that 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. Finally, Mr. Miller cautioned that the federal policy landscape for health care is unstable, including the status of federal waivers; if the State is planning to rely on a federal waiver to save the individual market, the State should have a “plan B” that does not require federal permission.

Stan Dorn, Senior Fellow at Families USA, suggested goals, provided facts, and presented options Maryland should consider to stabilize the individual market. During this time of uncertain and changing federal policy, Mr. Dorn suggested that Maryland’s goals should include preventing damage and achieving progress. Facts concerning the individual market in Maryland include that



1 in 10 Marylanders rely on the individual market and that the average premium for a 40-year-old in Maryland has increased from \$220 in 2014 to \$487 in 2018, in part because of the end of CSR payments.

Mr. Dorn presented three potential options for Maryland to consider. First, he suggested supplementing or replacing the federal individual mandate. His proposal included a pilot program for part of the State through which the penalty payment for uninsured taxpayers coupled with the premium tax credit could be used to obtain insurance. An individual could be enrolled, by default, into the most generous plan with no cost to the consumer. The goals of the pilot program would be to determine the impact of the program on coverage and risk level of marketplace enrollees. Potentially, this approach might improve the risk pool while covering numerous uninsured individuals. Mr. Dorn pointed out that the individual mandate matters in Maryland because it changes the incentives for consumers balancing premiums and penalties, and because CBO projected that a federal repeal of the individual mandate will (1) lower Medicaid enrollment because fewer consumers will explore coverage options and discover that they qualify for Medicaid; and (2) result in less employer coverage because of the decline of labor-market advantages of offering health insurance.

Second, Mr. Dorn suggested that Maryland could consider implementing BHP if federal funding is sufficient. Through BHP, individuals with incomes up to 200% 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 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 BHP.

Finally, Mr. Dorn proposed that Maryland consider a surcharge on silver QHPs to increase coverage and improve risk, a plan that would not require additional State money. This option would not affect APTC beneficiaries and, in some cases, may increase APTCs. Non-APTC silver plan purchasers could buy other metal level plans or off-marketplace policies. Revenue from the surcharge could be used to enroll uninsured individuals and improve the risk pool by supplementing federal assistance for lower income consumers to attract younger and healthier uninsured individuals, by funding reinsurance to lower premiums in all markets, or through a combination of supplementing federal assistance and funding reinsurance.

### **Commission Member Questions about Stabilization Options**

Mr. Dorn and Mr. Miller responded to questions from the members of the commission. In response to a question on whether implementing 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

CMS made it clear that states would be able to recoup administrative costs. Additionally, when asked what options Maryland should be wary of, Mr. Miller responded that inaction would be detrimental for Maryland and Mr. Dorn warned against offering low-cost coverage options that do not cover catastrophic events. 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. Finally, Mr. Miller stressed that the most important factor in stabilizing the markets is the underlying cost of health care, which Maryland has been fairly aggressive in addressing.

### **Public Comment**

The commission received public comment from SEIU and Kaiser. Ms. Brock-Cancellieri from SEIU asked the commission to consider the workforce issue when considering reforms. Ms. Schroer from Kaiser recommended that Maryland supplement the federal mandate or establish a State mandate and establish a reinsurance program to stabilize the individual market.



## **Chapter 3. Recommendations**

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During the December 5, 2017 meeting, the commission considered options presented for stabilizing the individual market in the State, including proposals by CareFirst BlueCross BlueShield (CareFirst) and Kaiser Permanente (Kaiser), reinsurance programs adopted in other states, adopting a State-based individual mandate, the Basic Health Program (BHP) option under the Affordable Care Act (ACA), establishing a pilot program that would combine individual mandate penalty payments and premium tax credits to enroll certain uninsured individuals in insurance coverage, and establishing a surcharge on silver-level qualified health plans (QHP) and using the revenue to enroll uninsured individuals into coverage and improve the risk pool.

While the commission did not endorse any specific proposal, there was consensus among commission members that (1) the State should not delay in acting to stabilize the individual market; (2) the State should obtain an independent actuarial analysis of the options to stabilize the individual insurance market; and (3) a workgroup that includes members of the commission should assist the General Assembly during the 2018 legislative session in working on individual market stabilization legislation.

### **Summary of Options Considered by the Commission**

The commission considered the following options for stabilizing the individual market raised at commission meetings during the interim.

#### **State-based Individual Mandate**

In light of the repeal of the ACA penalty on individuals for not having qualifying coverage and concerns that this could aggravate adverse selection in the individual market, it has been suggested that Maryland could adopt its own individual mandate or enforce the federal mandate. For example, through legislation, Maryland could adopt a mandate that mirrors the federal individual mandate but that would only take effect if the federal government stops enforcing the federal individual mandate. Under the ACA, an individual who does not have minimum essential coverage can face either a fixed dollar penalty (\$695 per adult plus \$347.50 for every child up to a maximum of \$2,085 for a family) or a percentage-based penalty (2.5% of adjusted gross income), whichever is higher. The penalty amount is capped at the average cost of a bronze plan in the Individual Marketplace. For 2016, the cap is \$2,676 per year for an individual and \$13,380 per year for a family with five or more members. Legislation adopting a State-based individual mandate could be structured to provide a 100.0% credit for any penalties paid to the Internal Revenue Service.

Massachusetts adopted an individual mandate in 2006. In 2017, the Massachusetts penalty for not having coverage is \$96 per month (\$1,152 per year) for an individual with an income above

300% of the federal poverty guidelines (FPG). Individuals in lower income categories pay lower penalty amounts or are exempt from the penalty. To prevent assessing a taxpayer both a Massachusetts penalty and a federal penalty, the amount of the Massachusetts penalty is reduced by the amount of the federal penalty paid by the individual for not having coverage.

In a memorandum shared with the commission (**Appendix 2**), Michael Miller urged consideration of four key policy questions when designing a State individual mandate: (1) what qualifies as minimum essential coverage; (2) what is the penalty for not having minimum essential coverage; (3) who is exempt from the penalty and what are the affordability standards; and (4) which State agency will develop and handle appeals processes, oversight, and enforcement of the mandate.

As discussed in Chapter 2, Stan Dorn of Families USA suggests that Maryland could implement a pilot program that would use individual mandate penalty payments to jumpstart enrollment in QHPs. Under the pilot program, uninsured taxpayers could direct that their penalty payment be used to obtain insurance. When coupled with the advanced premium tax credits (APTC) available to eligible individuals, penalty payments could be used to purchase a QHP at little to no cost for consumers. The pilot program would be tested in part of the State with the goal of determining the impact of the program on coverage and the risk level of marketplace enrollees.

### **CareFirst Proposal**

As discussed in Chapter 2, CareFirst proposes that the State obtain a State Innovation Waiver under Section 1332 of the ACA. CareFirst's proposal includes five points to (1) move from multiple insurance options to one standard product in the individual ACA insurance market with a \$1,000 deductible and a \$3,500 out-of-pocket maximum; (2) establish a stop-loss reinsurance limit of \$50,000 per person per year above which costs would be split 80% federal government and 20% carriers; (3) reallocate federal funding for APTC and cost-sharing reduction payments to fund reinsurance and premium subsidies for individuals with incomes up to 400% of FPG; (4) place a rate stabilization surcharge on the premiums of carriers that do not participate in the individual ACA market; and (5) include other funding mechanisms to promote market stabilization, such as an assessment on hospital rates.

Under the third element of the proposal, CareFirst recommends a reallocation of federal funding so that half of the funding would be used to reduce premiums by approximately 20% for everyone and the other half would be used for age-adjusted, low-income subsidies. According to CareFirst, the plan would have no financial impact to the federal government, reduce premiums by 20% across the board, continue subsidies to low-income enrollees, and maintain key elements of the ACA, such as keeping essential health benefits and the 3:1 age band rating restriction.

### **Reinsurance Programs Adopted in Other States**

Alaska, Minnesota, and Oregon are implementing reinsurance programs under Section 1332 waivers. Maryland could model a program on what is being done in other states.

- **Alaska:** The Alaska Reinsurance Program will reinsure individuals with 1 or more of 33 identified high-cost conditions to help stabilize premiums using pass-through funding based on the amount of APTCs that would have been paid absent the waiver.
- **Minnesota:** Like Alaska's program, the Minnesota Premium Security Plan uses pass-through funding based on the amount of APTCs that would have been paid absent the waiver but is also funded by state appropriations. The program is modeled after the federal reinsurance program and reimburses 80.0% of individual market claims between \$50,000 and \$250,000. Participation in the program is invisible to individuals. In addition to the pass-through funding, \$540 million in funding for the program over two years comes from Minnesota's general fund and a Health Care Access Fund, which is financed by a 2.0% provider tax. Minnesota estimates that the program will reduce premiums by an average of 20.0% or more.
- **Oregon:** Oregon's program also uses pass-through funding based on the amount of APTCs that would have been paid absent the waiver. Oregon's program will reinsure 50.0% of claims, in excess of an attachment point to be determined, up to \$1 million. Oregon is funding its program in part through a 0.3% premium tax. The total funding for the program for 2018 is expected to be approximately \$90 million. Rates have been reduced by 6.0% for 2018 plans due to the adoption of the program.

### **Kaiser Proposal**

As noted in Chapter 2, Kaiser supports the adoption of a State-based individual mandate and the implementation of a State-based reinsurance program under Section 1332 of the ACA. Regarding the individual mandate, Kaiser believes that the penalties associated with the mandate should be sufficient in amount to incentivize consumers to maintain coverage and that the federal penalty is too low. Kaiser supports a penalty based on a percentage of individual income (*e.g.*, 5%) or higher amounts (*e.g.*, \$1,000) and fewer exemptions. If Maryland seeks to establish its own mandate, Kaiser recommends a penalty that is no less significant than the penalty under current federal law.

On the establishment of a State-based reinsurance program, Kaiser favors a claims-based program that includes a cap where the federal risk adjustment program begins (*i.e.*, \$1 million in 2019) with a sufficiently high attachment point to encourage efficient claims management. Revenue generated through the enforcement of a State-based individual mandate should be dedicated to fund the reinsurance program. Kaiser believes that alternative funding mechanisms would likely be needed to cover the full cost of the reinsurance program but views with skepticism a premium tax on insurers as a funding source unless such an assessment could encompass self-insured plans or third-party administrators of such plans.

## **Basic Health Program**

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 QHPs offered by health insurance carriers participating in MHBE. States that implement BHP receive 95% of what the federal government would have spent on APTCs 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.

## **Surcharge Silver-level Qualified Health Plans**

Stan Dorn of Families USA proposes that Maryland impose a surcharge on silver-level QHPs to increase coverage and improve the insurance risk pool. Under the ACA, the benchmark for determining the amount of the APTC available to an insured individual is the second lowest cost silver plan. APTC beneficiaries may be unharmed and, in some cases, benefit from the imposition of a surcharge due to the receipt of a larger premium tax credit. Surcharge revenue could be used to supplement federal assistance for lower income consumers to attract relatively young and healthy uninsured individuals and to fund reinsurance to lower premiums.

## **Recommendations for State Action in 2018**

### **Recommendation 1: The State should not delay in acting to stabilize the individual insurance market.**

The commission believes that the State should act in 2018 to adopt measures to stabilize the individual insurance market. There is concern that the repeal of the federal penalty for not having qualifying coverage under the ACA could cause premium rates to increase to unaffordable levels, result in adverse selection as healthier individuals drop coverage, and jeopardize the viability of the individual market in 2019 if stabilization measures are not adopted in 2018. There are stabilization options that would require approval of a Section 1332 waiver by the Centers for Medicare and Medicaid Services (CMS), such as the adoption of a reinsurance program. Approval of a Section 1332 waiver may need to be obtained from CMS by October 2018 for carriers to have time to upload insurance rates for 2019. Because the process for approval of a Section 1332 waiver requires an opportunity for public comment and public hearings, the State needs to take prompt action to analyze and approve measures to stabilize the individual market, including enactment of legislation providing for implementation of the measures that would be included under a Section 1332 waiver.

**Recommendation 2: The State should obtain an independent actuarial analysis of the options to stabilize the individual insurance market.**

As noted previously, the commission did not endorse any specific proposal to stabilize the State's individual insurance market. However, there was consensus among commission members that the State should obtain an independent actuarial analysis of the stabilization options, specifically the reinsurance proposals offered to the commission for its consideration. Actuarial analysis is needed to identify the parameters for a reinsurance program, including the optimal attachment points and the amount of funding needed for the program. Commission members advised that an actuarial analysis should include an estimate of funding for a reinsurance program that could come from penalties collected from enforcement of a State-based individual mandate, an analysis of the number of individuals who would gain or lose coverage under the options considered, and an analysis of the impact of options on younger individuals and the group insurance market. Assistance of an independent actuary should be obtained as soon as possible so that the actuary is able to provide an analysis for consideration by the General Assembly during the 2018 legislative session.

**Recommendation 3: A workgroup could assist the General Assembly during the 2018 legislative session in working on individual market stabilization legislation.**

As discussed previously, some of the individual market stabilization options presented to the commission, such as those relating to reinsurance, require an actuarial analysis to determine optimal program parameters. Because the commission does not have the information it needs to endorse a specific proposal, the commission suggests that a workgroup be convened during the 2018 legislative session to work on individual market stabilization legislation. This workgroup should include members of the commission.

Under Chapter 17 of 2017, the commission may convene workgroups to solicit input from stakeholders. As an alternative, the Presiding Officers have convened workgroups in the past to develop legislation during the session, such as with the legislation to combat the opioid addiction epidemic in 2017. A workgroup convened by the commission or the Presiding Officers could continue the work that has been started by the commission and develop legislation from an actuarial analysis or other information that is not yet available to the commission.

**Additional Comments**

Commission members offered a variety of comments on the market stabilization options that may be considered during the 2018 legislative session. One commission member urged the legislature to consider the impact on health care provider networks and access to care when evaluating the market stabilization options. On the CareFirst proposal to place a rate stabilization surcharge on the premiums of carriers that do not participate in the individual ACA market as a source of funding for a reinsurance program, another commission member urged careful



consideration of the impact a surcharge might have on those carriers and their participation in the insurance markets in the State.

On the adoption of a State-based individual mandate, one commission member advocated for its adoption even if the individual mandate under the ACA is not repealed, due to the potential efforts at the federal level to weaken the individual mandate. The member urged the General Assembly to consider guidance in Mr. Miller's memorandum (Appendix 2) when developing a State-based individual mandate and recommended that the amount of the penalty should align with the federal penalty. The member also urged additional consideration of whether BHP coverage could be adopted along with a reinsurance program under a Section 1332 waiver. Regarding the proposal for a pilot program that would use individual mandate penalty payments to jumpstart enrollment in QHPs, another commission member expressed concern that such a proposal would result in adverse selection.

# Appendix 1

LAWRENCE J. HOGAN, JR., Governor

Ch. 17

## Chapter 17

### (Senate Bill 571)

AN ACT concerning

#### **Maryland Health Insurance Coverage Protection Act**

FOR the purpose of establishing the Maryland Health Insurance Coverage Protection Commission; providing for the composition, ~~chair~~ cochairs, and staffing of the Commission; prohibiting a member of the Commission from receiving certain compensation, but authorizing the reimbursement of certain expenses; requiring the Commission to ~~study~~ monitor and assess the impact of certain changes to certain laws and programs and make recommendations regarding certain matters; requiring the duties of the Commission to include a certain study; authorizing the Commission to hold public meetings across the State for a certain purpose; authorizing the Commission to convene certain workgroups; requiring the Commission to report its findings and recommendations to the Governor and the General Assembly on or before a certain date each year; providing for the termination of this Act; defining a certain term; and generally relating to the Maryland Health Insurance Coverage Protection Commission.

#### Preamble

WHEREAS, The Congressional Budget Office estimates that a repeal of the Patient Protection and Affordable Care Act (ACA) may result in 22 million individuals becoming uninsured in the United States; and

WHEREAS, With a health insurance market collapse potentially resulting from a repeal of the ACA, an additional 7.3 million individuals could lose insurance coverage, leading to a total of nearly 30 million individuals losing health care coverage nationwide; and

WHEREAS, In Maryland, more than 350,000 people may become uninsured in the aftermath of a repeal of the ACA; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare could more than double the number of individuals without health insurance by 2019; and

WHEREAS, One in five of the nonelderly population in the State could become uninsured, which would be more individuals uninsured than before the implementation of the ACA in 2009; and

WHEREAS, About 12.9 million individuals in the United States could lose Medicaid or Children's Health Insurance Program coverage as a result of a repeal or weakening of the ACA or Medicaid, including more than 200,000 individuals in our State; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare ~~would~~ could disproportionately affect working and retired individuals and families; and

WHEREAS, Millions of American seniors, including ~~hundreds of~~ thousands of Maryland seniors, could see their prescription drug costs rise substantially as a result of a repeal or weakening of the ACA or Medicare; and

WHEREAS, It is prudent for Maryland to study and develop a plan to mitigate these negative effects of a repeal or weakening of the ACA, Medicaid, or Medicare, address economic impacts, help save lives, and protect public health by recommending and implementing solutions to this broad-scale loss of health coverage; and

WHEREAS, The United States Congress should not diminish any of the benefits of the ACA, Medicaid, or Medicare; now, therefore,

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

(a) In this section, “ACA” means the federal Patient Protection and Affordable Care Act.

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

(c) The Commission consists of the following members:

(1) ~~two~~ three members of the Senate of Maryland, appointed by the President of the Senate;

(2) ~~two~~ three members of the House of Delegates, appointed by the Speaker of the House;

(3) the Secretary of Health and Mental Hygiene, or the Secretary’s designee;

(4) the Maryland Insurance Commissioner, or the Commissioner’s designee; and

(5) the Attorney General, or the Attorney General’s designee; and

~~(5) (6) five the following members of the public, appointed jointly by the President of the Senate and the Speaker of the House;~~

~~(i) one representative of a hospital, appointed jointly by the President of the Senate and the Speaker of the House;~~

(i) one representative of the Maryland Hospital Association;

(ii) one representative of a managed care organization, appointed jointly by the President of the Senate and the Speaker of the House;

(iii) one consumer of health care services, appointed jointly by the President of the Senate and the Speaker of the House;

~~(iv) one representative of a health insurance carrier, appointed by the Governor;~~

~~(iv) one representative of a nonprofit health service plan that has continuously offered plans in all jurisdictions and in all fully insured markets in the State both before and after the enactment of the ACA, appointed by the Governor~~ health insurance carrier, appointed jointly by the President of the Senate and the Speaker of the House;

(v) one representative who is an employer, appointed by the Governor;

(vi) one representative of the nursing home industry, appointed by the Governor; and

(vii) one representative of MedChi;

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

~~(vii)~~ (ix) two members of the public:

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

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

(d) ~~The chair of the Commission shall be designated jointly by the~~ The President of the Senate and the Speaker of the House of Delegates shall designate a member who is a Senator and a member who is a Delegate, respectively, to serve as cochairs of the Commission.

(e) The Department of Legislative Services, the Department of Health and Mental Hygiene, and the Maryland Insurance Administration jointly shall provide staff for the Commission.

(f) A member of the Commission:

(1) may not receive compensation as a member of the Commission; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) (1) The Commission shall:

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

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

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

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

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

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

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

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model; and

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

(h) The Commission may:

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

(2) convene workgroups to solicit input from stakeholders.

(i) On or before December 31, ~~2017~~ each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of ~~1 year~~ 3 years and 1 month and, at the end of June 30, ~~2018~~ 2020, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

**Enacted under Article II, § 17(b) of the Maryland Constitution, April 6, 2017.**



## Appendix 2

**To:** Vinny DeMarco  
**From:** Michael Miller, Ashley Blackburn and Quynh Chi Nguyen  
**RE:** State Individual Mandate: Policy Considerations for Maryland

**December 1, 2017**

As Maryland considers a state individual mandate bill to be introduced during the 2018 legislative session, below we've outlined a set of policy considerations advocates and state policymakers should consider when thinking about creating a state-level individual mandate with supporting citations from the Affordable Care Act (ACA) and Massachusetts. Before diving into the nuts and bolts of which provisions should be considered when drafting a bill, there are several big picture questions worth considering to help guide the formation of a state individual mandate.

**Is the state individual mandate intended to be a safeguard in the event that the federal individual is repealed; is it meant to compensate for potentially weak federal enforcement; to correct deficiencies in the federal law or is it meant to be a fully operational stand-alone policy?**

Different policy considerations flow from the answer to this question. For example, if mandate is merely a hedge against weak federal enforcement by the IRS, closely tracking the federal law may be the best option. However, if the state law is standing in place of a no longer existent federal law it may make the most sense to make some modifications to current ACA policy, as discussed further below.

**What happens if other provisions of the ACA are eventually repealed (i.e. tax credits)?**

The individual mandate works as a part of a three-legged stool alongside the insurance market reforms (i.e. ending the ability of insurance companies to discriminate against people with preexisting conditions) and financial assistance to consumers to help afford coverage in the form of cost-sharing reductions and advanced premium tax credits. It's worth thinking about if and how a state mandate would interact with federal changes to either or both of these other legs. If, for example, the tax credits are repealed, then would a state preserve their state mandate *and* step in to fill the tax credit void? Alternatively, assuming that this wouldn't be feasible for most state budgets, state mandate legislation could include a sunset provision. In the alternative, since the elimination or reduction of subsidies would make coverage less affordable, the state could decide that in some cases the interaction between subsidies and the mandate is self-adjusting. A state might also want to go a step further and consider codifying the insurance market reforms along with the individual mandate.

**Do you want to fully replicate the ACA's individual mandate at the state level?**

If yes, then given the volatility at the federal level it seems prudent to avoid simply codifying the ACA's mandate by reference to the ACA and instead fully codifying the provisions in state law. While replicating the ACA's mandate might expedite the drafting process and has the added value of familiarity to consumers, the state might want to consider improving on the federal mandate. In particular, and discussed in more detail below, a state could consider a sliding scale for the affordability exemption, like Massachusetts, and/or creating a stronger penalty to



encourage more people to enroll (We recommend consideration of this latter option only if the state is also able and willing to accompany the penalty increase with increased financial assistance to address affordability concerns).

### **Policy and Drafting Considerations**

There are four key policy questions advocates and state policymakers should consider when designing a state individual mandate:

1. What qualifies as minimum essential coverage?
2. What is the penalty for not having minimum essential coverage?
3. Who is exempt from the penalty and what are the affordability standards?
4. Which state agency will develop and handle appeals processes, oversight and enforcement the mandate?

As advocates and state policymakers work through these questions it's worth looking to the statutory and regulatory structure of both the ACA's individual responsibility provision and the Massachusetts state mandate, which predated the ACA's mandate. Below, in Appendix A, is a chart outlining the major provisions of the federal and Massachusetts policy with links to the relevant statutory and regulatory citations.

#### **Drafting considerations for minimum essential coverage**

The minimum coverage standards in both the ACA and Massachusetts can serve as a good starting place for drafting a similar requirement at the state level and the respective federal and state definitions are provided below. However, given the recent executive order regarding certain insurance products, a state should look at its current regulation, if any, over short-term, limited duration plans and other limited benefit insurance products.

Under current federal regulation, a short-term, limited duration plan cannot last more than three months and does not qualify as minimum essential coverage for the purposes of the federal penalty. We anticipate these rules being substantially relaxed. However, the federal mandate provides some disincentive for people to abandon the guaranteed issue market. In a scenario where a state is crafting its own mandate and its own minimum coverage standard, it would be prudent to explicitly exclude these plans and similar limited benefit products.

#### **Drafting considerations for the penalty scale**

When considering how high a monetary penalty should be and to whom it should apply, a state should consider the possibility of deviating from the penalty scale outlined in the ACA. While this would be possible even if the federal mandate remains on the books (Massachusetts continues to implement a state mandate that differs in some respect from the ACA), it is especially worthy of consideration if the federal mandate is repealed.

Under the ACA, any person not otherwise exempt who fails to comply with the individual mandate will be charged the greater of either 2.5% of their household income or a flat rate of \$695. In contrast, Massachusetts has a more progressive sliding scale structure, which, compared to the ACA, levies lower penalties for lower income residents and higher penalties higher up the

income scale. For example, individuals under 150% FPL are not subject to the penalty (and also have a zero-premium plan available to them which offsets the lack of penalty). Penalties for individuals at 300% of the FPL would be half of the lowest priced individual Catastrophic Plan offered through the Health Connector for individuals ages 18-30 or half of the lowest priced individual Marketplace Bronze premium for ages 31 and above. Structuring the penalty in this way would allow a state to better protect individuals at the lower end of the income scale while also creating a stronger incentive for middle-income households to enroll.

**2017 EXAMPLES:** If Mike makes 200% FPL (or \$23,760) is subject to the penalty he would pay \$695 (because the flat rate is greater than 2.5% of income) under the ACA, but only \$492 under MA's sliding scale. As you go up the income scale the MA penalty gets stronger. If Sally, at 40 years old, making 300% FPL (or \$35,640) was subject to the penalty she would pay \$891 under ACA (because 2.5% of income is greater than the flat rate) or \$1,152 under MA's sliding scale.

As noted above we believe it makes most sense to consider this type of modification if it is accompanied by enhanced premium support for example by implementing a Basic Health Program coupled with some additional assistance for moderate income enrollees.

### **Drafting considerations for exemptions and hardships**

A big consideration when thinking about hardships and exemptions is an affordability exemption. Under the ACA, individuals whose required contribution for insurance coverage for the month exceeds 8.16% of the household income for the taxable year are exempt from the mandate. Massachusetts, however determines a yearly affordability scale through their state-based marketplace that, like the penalty scale, is sliding and adjusts for income. For example, the monthly [affordability standard](#) for someone making 200% FPL in MA is 4.2% this year, but under the ACA a person making the same amount faces an affordability standard of 8.16%.

### **Drafting considerations for appeals processes, oversight and enforcement**

For a state-based marketplace, like Maryland, there are likely already appeals processes in place through the marketplace that could handle an appeal for individuals who believe they were eligible for an exemption from the mandate.

However, taking on the oversight and enforcement of a state individual mandate would require a state to determine for itself what, beyond the basic affordability standard, would constitute grounds for exemption from the penalty and how that process would be handled. This would likely require a combination of agencies including, but not limited to, the state's department of revenue. A state would need to consider what combination of existing agencies and authority would be needed to carry out these functions, or perhaps what new authority or even new entity would need to be created to do so. (Massachusetts created the [Commonwealth Health Insurance Connector](#) as independent quasi-governmental agency created to facilitate the individual market and new marketplace coverage as a part of their health reform effort in 2006)

## Appendix A

<b>Affordable Care Act Mandate</b>	<b>Massachusetts State Mandate</b>
<p><b>Statutory definition of minimum essential coverage (MEC):</b> <a href="#">26 U.S.C. 5000A(f)</a></p> <ul style="list-style-type: none"> <li>• Government sponsored programs</li> <li>• Employer-sponsored plans</li> <li>• Plans in the individual market</li> <li>• Grandfathered health plans</li> <li>• “other” coverage as defined by the secretary of HHS</li> </ul> <p><b>Regulatory requirements</b></p> <ul style="list-style-type: none"> <li>• “Other” coverage must “substantially” comply with all of title 1 of the ACA and meet certain procedural requirements to meet MEC. <a href="#">45 CFR 156.604</a></li> <li>• “Excepted benefit” coverage that is not MEC: <a href="#">45 CFR 148.220</a></li> <li>• “short-term, limited duration plans” defined; not MEC: <a href="#">45 CFR 144.103</a></li> </ul> <p><b>Related CMS guidance:</b> obtaining MEC <a href="#">recognition</a> and application <a href="#">review</a> process; <a href="#">IRS guidance</a> on MEC</p>	<p><b>Defining minimum creditable coverage (MCC):</b> <a href="#">Chapter 111M; Section 1</a></p> <ul style="list-style-type: none"> <li>• Government sponsored programs</li> <li>• Federally qualified high deductible health plans</li> <li>• Tribal or Indian Health Service plans</li> <li>• Qualified health plans certified by the Health Connector</li> <li>• Student health plans</li> </ul> <p><b>Related provisions</b></p> <ul style="list-style-type: none"> <li>• Further defining MCC for plans not identified as categorically MCC: <a href="#">956 CMR 5.00</a></li> </ul>
<p><b>Statutory penalty for not maintaining MEC:</b> <a href="#">26 U.S.C. 5000A (b) -(c)</a></p> <ul style="list-style-type: none"> <li>• Failure to maintain MEC for 1 or more months results in a penalty equal to the greater of a percentage of your household income or a flat dollar amount, but is capped at the national average premium for a bronze level health plan available through the Marketplace.</li> <li>• In 2017, this amounts to 2.5% of household income or \$695 per adult/ \$347.50 per child under 18 without coverage. The maximum penalty is \$2,085.</li> </ul>	<p><b>Penalty for not maintaining MCC:</b> <a href="#">Chapter 111M; Section 2</a></p> <ul style="list-style-type: none"> <li>• Failure to maintain MCC for each of the 12 months of the taxable year without a certificate of exemption issued under <a href="#">section 3 of chapter 176Q</a> or <a href="#">section 3 of chapter 111M</a> results in a penalty, which varies with age and increases with income.</li> <li>• In 2017, the penalty equals             <ul style="list-style-type: none"> <li>○ 0-150% FPL – no penalty</li> <li>○ 150.1-300% FPL half of the lowest price ConnectorCare premium at the corresponding income level;</li> </ul> </li> </ul>

<p><b>Corresponding regulations for computing the penalty:</b> <a href="#">26 CFR 1.5000A-4</a></p> <p><b>Related IRS guidance:</b> <a href="#">individual shared responsibility provision</a></p>	<ul style="list-style-type: none"> <li>○ Above 300% FPL for ages 18-30, half of the lowest priced individual Catastrophic Plan; for ages 31 and above, half of the lowest priced Bronze plan,</li> </ul> <p><b>Corresponding regulations for computing the penalty:</b> <a href="#">830 CMR 111M.2.1</a></p> <ul style="list-style-type: none"> <li>● The penalty schedule, published annually by the Commissioner of the Department of Revenue, and is calculated based on the lowest monthly cost premium available through the Connector in the taxable year to which the penalty applies.</li> </ul> <p><b>Related guidance issued by MA Department of Revenue for Tax Year 2017:</b> <a href="#">TIR 17-1</a></p>
<p><b>Statutory exemptions from mandate:</b> <a href="#">26 U.S.C. 5000A(e)</a></p> <p>Including, but not limited to,</p> <ul style="list-style-type: none"> <li>● Individuals whose required contribution for coverage for the month exceeds 8.16% of the individual’s household income for the taxable year.</li> <li>● Members of Indian tribes</li> <li>● Individuals experiences hardships as defined by HHS</li> </ul> <p><b>Regulatory hardship exemptions:</b> <a href="#">45 CFR 155.600 - 155.630</a></p> <ul style="list-style-type: none"> <li>● General hardship (including, but not limited to, homelessness, eviction, foreclosure, domestic violence, death of a close family member, and unpaid medical bills.)</li> <li>● Lack of affordable coverage</li> <li>● IRS exemption</li> </ul>	<p><b>Statutory exemptions from mandate:</b> <a href="#">Chapter 111M Section 3</a></p> <ul style="list-style-type: none"> <li>● Individuals who have religious objections but receive medical health care during the taxable year for which the return is filed.</li> </ul> <p><b>Regulatory exemptions:</b> <a href="#">956 CMR 6.00</a> and <a href="#">830 CMR 111M.2.1(6)</a></p> <ul style="list-style-type: none"> <li>● Populations exempted include children, those with religious objections, those demonstrating financial hardship who are granted a Certificate of Exemption by the Connector and those who are without coverage for less than 90 days during the year.</li> <li>● Each year the Health Connector Board is required to vote to adopt an affordability schedule that vary with</li> </ul>

<p><b>Related IRS guidance:</b> <a href="#">claiming or reporting exemptions</a></p>	<p>income and household configuration (such as single, couple, or family). Residents with lower incomes have lower shares of income to be spent for health insurance. However, for those with income below 400 % of the FPL, the state’s affordability schedules are more progressive than the ACA’s affordability standard.</p> <p><b>Related guidance:</b> <a href="#">2017 affordability schedule</a></p>
<p><b>Statutory appeals authority:</b> <a href="#">42 USC 18081</a></p> <p><b>Regulatory right to appeal:</b> <a href="#">45 CFR 155.635</a></p> <p><b>Related guidance:</b> How to <a href="#">appeal</a> a marketplace decision</p>	<p><b>Statutory appeal process:</b> <a href="#">Chapter 11M Section 4</a></p> <p><b>Regulatory right to appeal:</b> <a href="#">830 CMR 111M.2.1 (7)</a></p>