
Report of the Maryland Health Insurance Coverage Protection Commission

Annapolis, Maryland

December 2018

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THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2018

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, Maryland 21401-1991

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

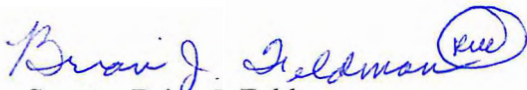
Dear President Miller and Speaker Busch:

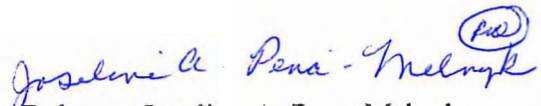
The Maryland Health Insurance Coverage Protection Commission respectfully submits its second report containing a summary of the commission's activities during the 2018 interim.

The commission held three informative meetings to monitor potential and actual federal changes relating to the federal Patient Protection and Affordable Care Act and to assess the impact of such changes. The briefings received by the commission included presentations on federal actions relating to health care, Maryland's Section 1332 waiver and State Reinsurance Program, calendar 2019 health insurance rates, merging the individual and small group markets, standardized benefit design, and individual mandates.

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,


Senator Brian J. Feldman
Senate Chair


Delegate Joseline A. Pena-Melnyk
House Chair

BJF:JAP/LJS:JBC/bao

Enclosure

Maryland Health Insurance Coverage Protection Commission 2018 Membership

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

Bob Atlas
Donna M. Carris
Vincent DeMarco
Lori Doyle
Joseph Fitzpatrick
Laurie Kuiper
Jamal Lee
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Chapter 1. Introduction

Health Reform Efforts at the Federal Level

Legislative Efforts

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. 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 for tax credits for the purchase of health insurance, and modified rating rules and essential health benefits requirements for health insurance plans.

Executive Efforts

In addition to 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 (AHP) 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 (previously, 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 (CSR) payments to insurers.

On December 22, 2017, President Trump signed Public Law Number 115-97, the Tax Cuts and Jobs Act (TCJA) of 2017, that zeroed out the penalty on individuals for not having minimum essential coverage under the ACA. Thus, the federal individual mandate will no longer be enforced effective calendar 2019.

On June 21, 2018, the U.S. Department of Labor (DOL) published the Association Health Plan Final Rule, expanding on the October 12, 2017 executive order. The rule establishes additional criteria under the Employee Retirement Income Security Act (ERISA) for determining when employers may join together in a group or association of employers that will be treated as

the “employer” sponsor of a single multiple-employer “employee welfare benefit plan” and “group health plan” as those terms are defined by the ERISA. The rule revises the “commonality of interest standard” so that associations can be composed of members who are in the same trade, industry, line of business, or who have a principal place of business within the same state or metropolitan area and allows self-employed individuals or individuals who have ownership rights in a trade or business that earn income and work at least 80 hours a month to participate in a group AHP. The rule became effective on August 20, 2018, with a staggered implementation date. All associations became authorized to establish a fully insured AHP on September 1, 2018. On January 1, 2019, associations that sponsored an AHP on or before August 20, 2018, will become authorized to establish a self-funded AHP. On April 1, 2019, all other associations will become authorized to establish a self-funded AHP.

On August 3, 2018, the U.S. Department of the Treasury, DOL, and the U.S. Department of Health and Human Services published the Short-Term, Limited-Duration Insurance Final Rule, expanding on the October 12, 2017 executive order. The rule amends the definition of short-term, limited-duration insurance for purposes of its exclusion from the definition of individual health insurance coverage. The rule lengthens the maximum duration of short-term, limited-duration insurance by allowing consumers to purchase policies that (1) are less than 12 months in duration; (2) contain a consumer notice explaining the policy; and (3) may be renewed for up to 36 months. The rule became effective on October 2, 2018.

In fall 2018, the Trump Administration released new guidance related to Section 1332 waivers that supersedes and replaces guidance given by the President Barack H. Obama Administration in 2015. The Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of the Treasury advise that the guidance is intended to loosen excessive restrictions that limit state flexibility and consumer choice while maintaining the requirements of the statute by shifting focus from the number of individuals actually estimated to receive comprehensive and affordable coverage to the availability of comprehensive and affordable coverage. The guidance is also intended to provide flexibility for states to meet the state legislative authority requirement by providing that, in some circumstances, existing state statutes will suffice as authority if combined with a duly enacted state regulation or executive order. The guidance renames the waivers State Relief and Empowerment Waivers and outlines five principles for states to follow: (1) provide increased access to affordable private market coverage; (2) encourage sustainable spending growth; (3) foster state innovation; (4) support and empower those in need; and (5) promote consumer-driven health care. The guidance specifies requirements that must be met for the approval of the waivers including review procedures, calculation of pass-through funding, analytical requirements, and operational considerations.

CMS followed up the guidance with the release of four concepts for states’ use in applying for waivers. The concepts include (1) account-based subsidies; (2) state-specified premium assistance; (3) adjusted plan options; and (4) risk stabilization strategies. States are not required to use these concepts but are encouraged to couple waiver concepts with other innovative ideas. Waiver applications are required to meet federal statutory requirements. The new guidance and concepts do not impact previously approved waivers, such as the one approved for Maryland as discussed later in this report, but will affect any future applications.

Legal Challenges Regarding the Affordable Care Act

Texas v. United States

In *Texas v. United States*, 20 states filed suit in the U.S. District Court, Northern District of Texas in February 2018 arguing that the ACA (as amended by the federal TCJA that eliminated the tax penalty of the individual mandate) is no longer constitutional because it is not supported by a tax penalty. The lawsuit asserts that the entire ACA is unlawful and requests that the District Court enjoin its operation. The U.S. Department of Justice declined to defend the statute, leaving defense of the ACA to a group of 17 attorneys general, led by California Attorney General Xavier Becerra, who asserts that the mandate remains constitutional even in the absence of an individual mandate penalty and that, even without the individual mandate, the remainder of the ACA would stand.

According to a June 2018 Urban Institute report, should the ACA be invalidated, the number of uninsured would increase nationally by 50%, Medicaid enrollment would fall by 15.1 million individuals through elimination of the ACA's Medicaid expansion (the assumption being that states will not be able to bear the full cost of coverage for the existing ACA Medicaid population, which, for example, would be an estimated \$2.7 billion in Maryland in fiscal 2019), and the number of individuals with private nongroup insurance would decline by 25%. Those retaining private nongroup coverage would likely have policies that cover fewer benefits and require more out-of-pocket spending due to elimination of minimum benefit and actuarial value standards. These policies would be substantially less accessible to people with current or past health problems because of the elimination of guaranteed issue and modified community rating rules.

State of Maryland v. United States of America

In response to *Texas v. United States*, on September 13, 2018, Maryland Attorney General Brian E. Frosh filed a lawsuit in the U.S. District Court for the District of Maryland seeking a declaratory judgment that the ACA is constitutional and that Congress' decision to eliminate the individual mandate penalty does not invalidate any of the ACA's remaining provisions. The suit asserts that eliminating the ACA would cause immediate and long-term harm to Maryland, citing that Maryland received \$2.77 billion in federal funds in fiscal 2017 under the ACA, as well as \$65 million in public health funding between fiscal 2012 and 2016.

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. Section 2 of Chapters 37 and 38 of 2018 altered the membership and charge of the commission (**Appendix 2**).

The commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, Maryland Children's Health Program (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; (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 the Maryland State Medical Society, also known as MedChi; (13) one representative of behavioral health care providers; (14) two members of the public; and (15) one representative of a group model health maintenance organization that participates in the individual market.

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.

Chapters 37 and 38 also require the commission to study and make recommendations for individual and group health insurance market stability, including:

- the components of one or more Section 1332 waivers;
- whether to pursue a standard plan design that limits cost sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or CSRs; and

- whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance.

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. The commission must report its findings and recommendations from the required study in the annual report submitted by December 31, 2019. This report is the second annual report of the commission.

State Actions to Stabilize the Individual Health Insurance Market

In response to recommendations by the commission, emergency legislation was enacted to adopt measures to stabilize Maryland's individual market. Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to submit an application for a State Innovation Waiver under Section 1332 of the ACA to establish a State reinsurance program and seek federal pass-through funding. MHBE submitted the waiver application on May 31, 2018, and the federal government approved the waiver on August 22, 2018. The waiver runs for up to five years.

The State Reinsurance Program, which begins January 1, 2019, will provide reinsurance to carriers that offer individual health benefit plans in the State. Carriers that incur total annual claims costs on a per individual basis between a bottom attachment point (to be determined) and a cap of \$250,000 will be reimbursed for 80% of those claims costs. Payments to insurance carriers will be made after the plan year ends, and all costs have been recorded and reconciled.

Chapters 37 and 38 established, for calendar 2019 only, a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under the ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. The assessment must be used for the State reinsurance program. MHBE advises that total funding for the program is estimated at \$1.1 billion between calendar 2019 and 2021, including \$365 million in State funds from the one-time assessment on health insurance carriers and, under the State's approved Section 1332 waiver, an estimated \$730 million in federal pass-through funds (federal funding that would have been provided to Maryland residents in the form of advanced premium tax credits in the absence of the reinsurance program). By calendar 2021, additional funding will be required to fully fund and continue the program.

Prior to approval of the Section 1332 waiver, Maryland carriers requested rate increases for calendar 2019 averaging 30.2%. Following waiver approval, the average requested rate increase fell to 23.4%. Ultimately, the rates approved by the Maryland Insurance Administration, reflecting the anticipated impact of the State's reinsurance program, declined by an average of 13.2%. The rate reductions vary by metal levels. In 2019, young adult catastrophic plans sold in Maryland will likely be the most affordable in the nation.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2018 interim, the Maryland Health Insurance Coverage Protection Commission held three meetings. At the first meeting, the commission received a briefing on federal actions relating to health care, updates on the Section 1332 waiver and proposed regulations for the State Reinsurance Program, and the approval process for individual market health insurance rates for calendar 2019, as well as discussed the commission's 2018 interim activities. At the second meeting, the commission received a presentation on the health insurance rates approved by the Maryland Insurance Administration (MIA) for 2019, commentary on the rates approved, a review of past reports regarding the potential to merge the individual and small group markets and standardized benefit design, and an overview of individual mandates at both the federal and state level. The third meeting included a presentation on consumer protections for individuals with preexisting conditions, the Wakely Consulting Group (Wakely) report on issues relating to merging the individual and small group markets, and a presentation on the potential for a State-based individual mandate in Maryland.

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.

September Meeting

On September 18, 2018, the commission received a briefing on recent federal action related to the Patient Protection and Affordable Care Act (ACA) and access to health insurance and updates on the State Reinsurance Program, Section 1332 waiver, and the approval process for 2019 health insurance rates. The commission also received comments from the public.

Federal Action Related to the ACA and Access to Health Insurance

Ms. Alyssa Penna, Health Policy Advisor for the Office of Senator Chris Van Hollen, briefed the commission on federal action related to the ACA, including the zeroing out of the federal individual mandate penalty and two executive rules on short-term health insurance plans and association health plans. In late 2017, the U.S. Congress passed tax reconciliation legislation that repealed the federal penalty for individuals not having minimum essential health insurance. Ms. Penna cited national projections from the Congressional Budget Office (CBO) that found that the zeroed out tax penalty will result in (1) fewer healthy people signing up for health insurance

coverage; (2) an increase in average health care costs and a 10% rise in premiums in the individual market; and (3) an estimated 13 million individuals becoming uninsured and a 50% increase in nonelderly individuals who are uninsured.

In August 2018, the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), and the U.S. Department of the Treasury issued a rule that expands access to short-term, limited-duration health insurance coverage. The rule extends the duration of plans from 3 months to up to 12 months and authorizes carriers to renew or extend the plans for up to 36 months. Ms. Penna explained to the commission that short-term plans do not need to comply with ACA market reforms and can therefore (1) charge higher premiums based on health status; (2) exclude coverage for preexisting conditions; (3) impose annual or lifetime limits on coverage; (4) opt not to cover entire categories of benefits; (5) rescind coverage; and (6) require higher out-of-pocket cost sharing than ACA-compliant plans. Ms. Penna further explained that these limitations will cause short-term coverage to only be available to individuals who can pass medical underwriting and that because short-term plans are less expensive than ACA compliant plans, the sale of short-term plans will likely result in adverse selection against the individual market as healthier individuals exit ACA-compliant plans for short-term plans. Additionally, Ms. Penna warned that short-term plans can be confusing for consumers because they mimic fully insured plans, and consumers will not realize the extent of the coverage until they are sick and try to utilize their benefits.

Ms. Penna described to the commission the process for a Resolution of Disapproval under the Congressional Review Act that allows Congress to overturn executive regulations by a simple majority approval of a joint resolution in both chambers. Senator Tammy Baldwin of Wisconsin introduced the joint resolution in the Senate. Ms. Penna told the commission that the timing for a vote on the resolution was uncertain but expected by the end of the year. (Update: The joint resolution failed by one vote in October 2018.)

Ms. Penna discussed DOL's June 2018 finalized rule on association health plans (AHP) that, similar to the rule on short-term plans, is expected to expand enrollment in AHPs. Ms. Penna explained that AHPs are health plans that employer groups and associations offer to provide coverage to employees that allows small employers to band together to purchase types of insurance available to large employers. Problems with AHPs have included defrauding and scamming members into insolvency.

Ms. Penna told commission members that the ACA did not outlaw AHPs but did limit abuses and expanded market protections. The exception to these protections, Ms. Penna explained, is that coverage sponsored by an association constitutes a single Employee Retirement Income Security Act (ERISA)-covered plan so that a multiemployer plan would be treated as an employer sponsoring a single plan for employee members under the ERISA and be subject to reporting and fiduciary requirements but would not be subject to ACA requirements for essential health benefits or community rating rules. The DOL rule targeted this exception by allowing more associations to be regulated as a large group. Although the rule does not exempt certain categories of self-funded AHPs from state regulation, DOL has indicated that it might do so in the future if states go too far in regulating non-fully insured AHPs in ways that interfere with the rule.

Ms. Penna acknowledged that Maryland took legislative action in 2018 to protect consumers against the federal regulations for short-term plans and AHPs.

Legislation to stabilize health care on the federal level stalled in 2017. Ms. Penna described the Bipartisan Health Care Stabilization Act of 2017, commonly referred to as the Alexander-Murray proposal, as legislation that would have funded cost-sharing reductions (CSR) for two years, partially restored outreach and enrollment funding for two years, authorized catastrophic plans for individuals of all ages, and loosened requirements for Section 1332 waivers. Since no agreement was reached on the proposal, Ms. Penna opined that no ACA stabilization legislation would be considered by Congress in 2018.

Ms. Penna also briefed the commission on *Texas v. United States*, a court case brought by attorneys general from several states alleging that since Congress zeroed out the individual mandate penalty, the entire ACA was unconstitutional. Ms. Penna told commission members that the U.S. Department of Justice appeared to agree with the plaintiff and, although it did not assert blocking the law, urged the court to strike down provisions related to preexisting conditions and community rating provisions.

In response to the court case, several Republican senators introduced the Ensuring Coverage for Patients with Preexisting Conditions Act. Ms. Penna explained that the Act would prohibit group health plans or insurers offering group or individual plans from establishing rules for eligibility based on preexisting conditions but included a loophole providing that plans were not required to cover treatment of preexisting conditions. Thus, under the legislation, insurers could not deny coverage for preexisting conditions but could offer plans that do not include treatment for preexisting conditions. Ms. Penna stated that no timeline has been established for consideration of the legislation.

Commission Member Questions about Federal Action Related to the ACA and Access to Health Insurance

At the conclusion of the presentation, Senator Thomas M. Middleton asked what the impact in Maryland has been relative to CBO's estimated 10% increase in premiums as a result of the zeroing out of the individual mandate penalty and if younger individuals were leaving the individual market as a result. CareFirst BlueCross BlueShield (CareFirst) responded that it was too soon to determine the increase on premiums but that it would look into it. Additionally, CareFirst told commission members that it appeared that the individual market demographic was becoming more elderly. Kaiser Permanente (Kaiser) estimated that premiums would increase by 6.5% to 7.0% and told commissioners that it would look into whether the individual market was trending younger or older.

State Reinsurance Program and Section 1332 Waiver

Ms. Michele S. Eberle, Executive Director of the Maryland Health Benefit Exchange

(MHBE), and Mr. John-Pierre Cardenas, Director of Policy and Plan Management of MHBE, provided the commission with an update on the State Reinsurance Program and the Section 1332 waiver. Ms. Eberle began the presentation by explaining to commission members that enrollment in the individual exchange had gone down by 2.5% during the previous year due to high premiums and that the situation would have only gotten worse had the State not sought and received a Section 1332 waiver. Ms. Eberle thanked members of the General Assembly and Executive Branch officials for working together to get the Section 1332 waiver approved and the State Reinsurance Program regulations drafted. She concluded that the success of everyone's hard work should be evident when the open enrollment period begins in November.

Mr. Cardenas continued the presentation by describing the timeline and process for obtaining the Section 1332 waiver. In April 2018, MHBE released a draft application for a State Innovation Waiver (Section 1332 waiver), and started the 30-day public comment period. Statute required MHBE to hold at least two public hearings on the application; however, Mr. Cardenas explained that MHBE decided to hold four meetings in four different regions throughout the State. Mr. Cardenas told commission members that an estimated 70 members of the public attended the public meetings and that participants at the meetings and through written comments included insurance carriers, professional organizations, legislators, advocacy organizations, and consumers.

The public comment period revealed areas of consensus and concern. Mr. Cardenas stated that all written comments and spoken testimony unanimously expressed support for the establishment of the State Reinsurance Program. However, Mr. Cardenas told commission members that many stakeholders expressed concern that the potential issuer payments under the State Reinsurance Program and the federal Risk Adjustment Program would be duplicative and that an insurer could potentially receive payments from both programs for the same enrollee. Both CareFirst and Kaiser requested that Wakely look into the interaction. Mr. Cardenas also said that through the open comment period many stakeholders expressed support for establishing the State Reinsurance Program to attract new insurers to the individual market and to provide incentives for care management and quality improvement that would support other State initiatives, including the Medicare Waiver.

MHBE submitted a final application to HHS and the U.S. Department of the Treasury in May 2018. In June 2018, MHBE received an analysis from Wakely that found that there would be a material interaction between the State Reinsurance Program and the federal Risk Adjustment Program that could result in insurers receiving payments greater than the claims incurred if no action was taken to address duplicative payments. In July 2018, MHBE received notice from the federal government that the waiver application was complete, launching the 30-day federal public comment period, and MHBE voted to account for interaction between the State Reinsurance Program and federal Risk Adjustment Program through the regulatory process.

In July and August 2018, MHBE began public meetings on the State Reinsurance Program regulations. During the meetings, MHBE heard again from stakeholders concerned over duplicative payments for both the State Reinsurance Program and the federal Risk Adjustment Program. In August 2018, the federal government asked the State to respond to stakeholders'

concerns, and the State submitted an amendment to the waiver application. MHBE received notice that the Section 1332 waiver was approved on August 22, 2018. Also in August 2018, MHBE resolved to account for program interaction between the State Reinsurance Program and federal Risk Adjustment Program through equalizing profitability between sick and healthy members. This process will essentially equalize the healthiest and sickest members by removing any incentive for carriers to pick healthier members over sicker members.

Mr. Cardenas also explained that the public hearings process that MHBE used in drafting regulations for the State Reinsurance Program. MHBE voted to release the proposed regulations in September 2018 and held four public hearings. Mr. Cardenas said MHBE received written testimony from eight respondents and estimated that 30 members of the public attended the meetings, including insurance carriers, professional organizations, advocacy organizations, and consumers.

There were three areas addressed in the regulations in response to comments made during the open comment period. First, at the request of insurance carriers, the regulations provide that MHBE will leverage the EDGE Server to implement the State Reinsurance Program. Mr. Cardenas explained that the EDGE Server is the technical infrastructure that the federal government utilizes to administer the federal Risk Adjustment Program. Second, the regulations address the interaction between the State Reinsurance Program and federal Risk Adjustment Program. Mr. Cardenas described for the commission the disagreement between the insurance carriers over the degree to which the programs' interaction should be accounted for. Some stakeholders supported an approach that fully removed program interaction, while others supported an approach that balanced profitability between sick and healthier members. Mr. Cardenas told commission members that MHBE decided on the latter approach in the State Reinsurance Program regulations. Third, the regulations include existing incentives and programs that encourage issuers to manage cost.

Several issues were not addressed in the regulations. Mr. Cardenas told commission members that the regulations do not include new incentives in the program or address chronic disease and population health but encouraged continued stakeholder engagement on the issues. Additionally, Mr. Cardenas said that the regulations did not address value-based benefit design or the use of State reinsurance dollars to fund incentive programs. A complete summary of public testimony is available online at <https://www.marylandhbe.com/policy-legislation/public-comment/state-reinsurance-program/marylandhbe.com>.

Mr. Cardenas described some of the details of the regulations for the State Reinsurance Program. The regulations establish eligibility standards for payment and indicate that specified health benefit plans are not eligible to receive payments. Additionally, the regulations establish a Carrier State Reinsurance Program Accountability Report that requires carriers to supply information on savings to the State Reinsurance Program, the impact of initiatives on rates, and population health initiatives and outcomes.

The regulations also specify the calculation of reinsurance payments. The regulations establish payment parameters for the program including an attachment point, coinsurance rate,

reinsurance cap, and a carrier-specific dampening factor that takes into account the overlap in the program and federal risk adjustment payments. The regulations also detail the methodology for determining reinsurance payments and provide information on payment adjustments in instances where reinsurance claims are greater than the program funding allocation. Finally, the regulations contemplate State Reinsurance Program surplus and provide that, for benefit year 2019, MHBE will reserve any surplus for claims in future years. The comment period on the regulations ended December 10, 2018, and final issue of the regulations is expected in early January 2019.

Commission Member Questions about the State Reinsurance Program and Section 1332 Waiver

Mr. Cardenas and Ms. Eberle responded to several questions. Senator Middleton asked questions related to how the reinsurance regulations make adjustments to duplicate transfer payments from reinsurance and risk adjustment and how much money would be involved. Mr. Cardenas responded that it would be about 20% of the total federal risk adjustment, which is estimated at \$26 million that would be more equitably distributed among the carriers.

Delegate Chris West asked several questions. His first question addressed advertising that would be done to notify consumers that premiums had decreased. Ms. Eberle responded that MHBE advertises open enrollment every year and is planning a larger media buy this year to inform consumers of the change in rates. Delegate West followed up with several questions on reinsurance funding. Mr. Cardenas responded that for the total five-year waiver period, the State would contribute \$365 million. In 2019 and 2020, with additional federal pass-through funding, total funding for the program will be approximately \$462 million and \$459 million, respectively. Finally, in 2021, the State will have approximately \$237 million in surplus pass-through funds. Mr. Cardenas further explained that, pending confirmation from the federal government, the attachment point for payments would be \$20,000 and that, although the waiver was approved for five years, additional legislation would be required to back up funding in 2021 and future years.

Delegate Kirill Reznik questioned the impact of the decrease in rates on consumers. Ms. Eberle and Mr. Cardenas responded that final rates had not been confirmed but that it appeared that rates for the small group market would increase and generally rates in the individual market would decrease even if some consumers saw an increase. Delegate Reznik pointed out that over the six years that the exchange has been implemented, premiums have raised 80% to 100% overall, while inflation has only raised by 5.2%. He also surmised that the State has taken \$500 million in taxpayer money to purchase high-risk health insurance plans.

Delegate Joseline A. Peña-Melnyk asked several questions to clarify the funding for and impact of the reinsurance program. Mr. Cardenas explained that although the federal government had not given a final number on the amount that the State would receive from pass-through funding, the current match that has been approved for other states is approximately one-third state funds to two-thirds federal funds. He further explained that the waiver is for five years but that MHBE plans to front load the money for the first three years. Ms. Eberle pointed out that the

impact of the reinsurance program could be seen in the reduction in rate requests from carriers. In May 2018, CareFirst requested a 94.1% increase for its preferred provider organization (PPO) product and an 18.5% increase for its health maintenance organization (HMO) product, while Kaiser requested a 37.5% increase. However, after federal approval of the Section 1332 waiver, CareFirst and Kaiser both asked for reductions in their rates for those products.

Ms. Deborah R. Rivkin asked for clarification on where the \$26 million that would not be going to the insurers under the changes intended to eliminate duplication between reinsurance and federal risk adjustment would go. Mr. Cardenas responded that the \$26 million is the specific amount accounted for under the interaction between the State Reinsurance Program and the federal Rate Adjustment Program and that the money would be reallocated across the carriers.

Ms. Lori Doyle asked whether MHBE looks at quality measures for what the insurers are doing and whether there are incentives to bring down health costs. Ms. Eberle responded that there are quality ratings for consumers to compare while shopping for products. Further, Ms. Eberle stated that MHBE looked into incentives when drafting the regulations and decided to monitor the insurers through the Carrier State Reinsurance Program Accountability Report.

Mr. Sanford Walters asked for clarification on the risk adjustment between the two carriers and the rate offsets because of funding from the federal government. Mr. Cardenas clarified that the risk adjustment will be between two carriers and four licenses because CareFirst has three licenses, two for PPOs and one for an HMO, and Kaiser has one license. Mr. Cardenas clarified that the federal government contribution should be approximately \$730 million over three years and the State's contribution should be approximately a onetime payment of \$365 million. Based on these numbers, Mr. Cardenas estimated that the offsets will be 30% for 2019, 30% for 2020, and 16% for 2021. Mr. Cardenas agreed with Mr. Walters that because of medical inflation the offset could be level in 2021. Mr. Walters also questioned whether MHBE, through the legislature, should revisit provisions that prohibit a carrier that left the individual market from reentering the market for a period of time.

Mr. Bob Atlas asked whether MHBE anticipated additional carriers to enter the market after 2019. Ms. Eberle replied that MHBE, along with MIA, has reached out to carriers, and some have expressed interest.

Mr. Marco Priolo asked what plans will be subject to the State assessment that funds the reinsurance program and whether premiums would have been lower without the assessment. Mr. Cardenas responded that the assessment takes advantage of a federal moratorium on an assessment that is part of the ACA and repurposed it for State reinsurance purposes. All plans subject to the federal assessment that the State has authority over will be subject to the State assessment. The ERISA plans are not assessed. The premium assessment is level from an aggregate perspective because the amount levied at the State level was the aggregate amount that would have been levied at the federal level. It also depends on how the plan is constituted under the ACA. Some entities such as Kaiser experienced an assessment increase from 1.00% under the federal assessment to 2.75% under the State assessment.

Mr. Jamal Lee asked what incentives and programs exist to encourage cost management and which are most effective. Mr. Cardenas replied that the carriers are more knowledgeable about the incentives but that MHBE intends to ask issuers what the incentives and programs are and estimate the impact on savings and premiums.

Rate Review Process for 2019 Rates

Maryland Insurance Commissioner Alfred W. Redmer, Jr. updated the commission on the rate review process. The process has not changed over the past four years. Carriers present proposed rates for individual and small group markets and supporting data by May 1 each year. The rates cannot be excessive, inadequate, or unfairly discriminatory. MIA has actuaries that work closely with the carriers' actuaries. Factors looked at include carriers' experience with morbidity, risk adjustment, inflation, contribution to reserves, profit, and administrative costs. Each year, MIA holds a public hearing on rate requests.

This year, CareFirst requested rate increases of 18.5% for its HMO product and 94.1% for its PPO product, and Kaiser requested a rate increase of 37.4%. After the initial public hearing and approval of the Section 1332 waiver, MIA requested CareFirst and Kaiser to resubmit rates. CareFirst resubmitted rate decreases of 15.8% for its HMO product and 11.1% for its PPO product, and Kaiser resubmitted a rate decrease of 6.9%. Another public hearing was held on the repropoed rates. MIA planned to announce approved rates within a few days.

Commission Members Questions about the Rate Review Process for 2019 Rates

Commissioner Redmer responded to questions from commission members. Delegate West asked if some rates will go up. Commissioner Redmer explained that all rates will decrease but that federal subsidies will decrease too resulting in some people paying a slightly higher share of the premium rate.

Mr. Atlas asked to what extent MIA looks at cost sharing. Commissioner Redmer replied that MIA does not mandate cost sharing but does look at the impact that cost sharing has on the rates to ensure that rate requests are actuarially justified.

Senator Delores G. Kelley asked about turnout for the public rate hearings and advertisement for meetings. Commissioner Redmer said turnout was typical and that MIA uses email distribution lists, Facebook, and the MIA website to advertise meetings. MIA also has a consumer outreach division.

Ms. Carolyn A. Quattrochi asked how the actuaries account for the zeroing out of the federal individual mandate penalty, and Commissioner Redmer responded that there is a factor of 5.0% assumed in the rates. Senator Middleton asked whether the increase in the tax assessment on Kaiser was taken into account when Kaiser proposed rates for 2019, and Commissioner Redmer

replied that he assumed that it did because the rate approval process looks at the amount of revenue based on past expenses and future projected expenses. Senator Middleton also asked whether the shared responsibility of \$26 million would be paid by CareFirst to Kaiser and whether that would be considered in rate setting. Commissioner Redmer said that he believed that it was considered by MHBE and also by the actuaries at the rate setting level. Ms. Laurie Kuiper from Kaiser clarified that Wakely had estimated the overlap in payment to be \$44 million but that MIA reduced the amount to \$26 million.

Public Comment

Ms. Tinna Quigley from the League of Life and Health Insurers of Maryland told commission members that the league was thrilled with the results that the State Reinsurance Program had on the individual market. Ms. Quigley expressed the position of the league to look for a permanent solution that does not jeopardize the small group market. Ms. Quigley also voiced the league's support for a statewide individual mandate requirement.

October Meeting

On October 2, 2018, the commission received an update from MIA on the health insurance rates approved for 2019. MHBE presented its 2016 Merging Markets Study regarding the potential merger of the individual and small group health insurance markets and the 2017 workgroup report on standardized benefit design. The Department of Legislative Services (DLS) presented an overview of individual mandates at the federal and state level.

Health Insurance Rates Approved for 2019

Commissioner Redmer and Ms. Todd Switzer, Chief Actuary for MIA, presented on the approved calendar 2019 individual and small group market rates. Commissioner Redmer noted that carriers provide MIA with proposed rates for the following year in the preceding May. Maryland law dictates the standards that MIA must use to approve rates, which must be actuarially justified. Rates must also be adequate, cannot be excessive based on the specifics of the carrier's business, and cannot be unfairly discriminatory.

Mr. Switzer expressed thanks for the various steps taken by the Governor Lawrence J. Hogan, Jr. Administration and the General Assembly to help stabilize rates in the individual market, noting that MIA received 66 pages of public comments on the proposed 2019 rates, many of which underscored the need for affordable health insurance.

Mr. Switzer noted that, as of June 2018, there were 192,279 individuals enrolled in the individual market and two participating carriers. On May 1, 2018, carriers submitted requests for rate increases for calendar 2019 averaging 30.2% (ranging from 18.5% for the CareFirst BlueChoice HMO product to 91.4% for CareFirst PPO products). Prior to approval of the

Section 1332 waiver, MIA anticipated granting rate increases averaging 23.0%. However, following approval of the Section 1332 waiver, and in anticipation of the State Reinsurance Program, final approved rates for calendar 2019 reflect an average rate decrease of 13.2% (ranging from a reduction of 7.4% for Kaiser to a reduction of 17.0% for the CareFirst BlueChoice HMO product). Per Mr. Switzer, this represents the first decrease in individual market rates in decades. Mr. Switzer noted that there is variation in the rate decreases based on the metal level of the plan selected, highlighting that rates for young adult catastrophic plans in Maryland may now be the lowest cost in the country.

Mr. Switzer discussed the differences in assumptions used by MIA in the approved 2019 rates for the individual market compared with those used by carriers in their submitted rates. Specifically, MIA assumed less morbidity, less risk adjustment, less medical trend, fewer contributions to reserve/profit, and slightly fewer broker costs on a per member per month basis than carriers assumed.

Mr. Switzer summarized rate actions for 2019 in other states, noting that 12 states will have individual market rate decreases in 2019 but that Maryland's rates will be among the lowest (even among other states with reinsurance programs). Mr. Switzer noted that Maryland's proposed reinsurance program is the richest reinsurance program among states, with a low attachment point of \$20,000 and a high coinsurance rate of 80%. Mr. Switzer also compared the premium cost for a 40-year-old in 2018 to what will be paid in 2019, noting that some consumers will continue to have access to free bronze plans (using their federal advanced premium tax credit (APTC)). Silver plan premiums on-exchange are 11% to 28% higher than silver plans sold off-exchange. Therefore, Mr. Switzer noted that consumers who do not receive an APTC should buy their plans off-exchange.

Mr. Switzer discussed how the average small group employer in Maryland has fewer than six employees and is subject to significant volatility in rates with changes in the age mix of employees. As of June 2018, there were 270,267 individuals enrolled in the small group market and four participating carriers. On May 1, 2018, carriers submitted requests for rate increases averaging 7.0% (ranging from 3.3% for Kaiser to 14.9% for UnitedHealthcare Optimum Choice). Final approved rates for calendar 2019 reflect an average rate increase of 5.0% (ranging from a decrease of 0.7% for CareFirst PPO products to an increase of 10.6% for UnitedHealthcare's PPO product). Mr. Switzer highlighted that the Centers for Medicare and Medicaid Services (CMS) ranks states based on affordability of rates. In 2016, Maryland ranked twenty-seventh, improving to eighteenth in 2017, reflecting improving affordability for small employers compared with other states.

Mr. Switzer discussed the differences in assumptions used by MIA in the approved 2019 rates for the small group market compared with those used by carriers in their submitted rates. Specifically, MIA assumed slightly less morbidity, less risk adjustment, less medical trend, and slightly fewer contributions to reserve/profit than carriers assumed in their submitted rates.

Mr. Switzer noted that the number of small businesses offering health insurance in the small group market has fallen from 56.4% in 2006 to 32.9% in 2016 (a decline of 23.5%), stating that stable premiums may maintain affordability and combat premium volatility.

Commission Member Questions about Health Insurance Rates Approved for 2019

MIA panelists received comments and fielded questions from commission members. Delegate Reznik inquired about where deductible levels were headed relative to premium increases. Commissioner Redmer responded that there has been, on average, a slight increase in deductibles but that MIA does not regulate deductible amounts. Delegate Reznik noted that although premiums may decrease for some consumers, deductibles may increase leading some consumers to ultimately pay more in 2019. Dr. Stephen Rockower reiterated Delegate Reznik's point, noting that lowering premiums and raising deductibles can be an unfair cost shift to patients and can become a problem for the patient when they receive unexpected bills. The MIA panel again noted the importance of consumers shopping for the best plan for their financial situation. Ms. Rivkin advised that carriers have some flexibility in designing rates but must meet certain federal parameters. Based on the metal level of the plan, there must be a balance between how much the carrier pays versus the amount a consumer pays out of pocket. As out-of-pocket costs go up, premiums come down.

Mr. Walters inquired as to whether there are enough advisors to help consumers choose the plan that is best for them financially, such as buying a plan on-exchange versus off-exchange or the opportunity to get a free plan using their APTC. Mr. Walters noted that the committee should better assist these consumers to make the best decision that they can make for themselves before they enroll in coverage. Mr. Vincent DeMarco concurred with this comment, asking if the State can write to those individuals who are paying more than they should and educate them on their options.

Delegate West asked whether the number of uninsured is actually decreasing if young healthy individuals and families are leaving the individual market. Mr. Switzer noted that although some consumers have left the market, the uninsured rate has continued to decline due to increasing Medicaid enrollment and the APTC drawing in new consumers, yielding a net decline. Delegate West also inquired about how many of the uninsured are subject to the federal individual mandate penalty in 2018.

Merging Individual and Small Group Markets

Ms. Eberle presented information on merging the individual and small group markets. Ms. Eberle described how the ACA provides states with the option to merge their individual and small group markets to create a single risk pool and a single index rate to combine claims costs and spread out risk.

Ms. Eberle described how, in 2011, MHBE was directed to form advisory committees and look into whether the two markets should be merged. Based on the work of advisory committees, the MHBE Board of Trustees recommended against merging the markets. At the time, the small group market was twice the size of the individual market, and not all carriers were participating in

both markets. There was concern that merger would drive the cost up for small employers and push more small employers to self-insure and thus leave the market. In 2012, the General Assembly required MHBE to complete a formal study on whether to continue to maintain separate small group and individual markets or to merge the two markets. The report was submitted on December 1, 2016, and updated on January 31, 2018.

Important considerations that MHBE looked at included marketwide impact, rate impact, the timing of rate adjustments (annual in the individual market vs. quarterly in the small group market), new market entrants, federal risk adjustment, variation in essential health benefits between the individual and small group markets, and the timing of MIA rate and form review and MHBE plan certification processes.

Ms. Eberle discussed the federal requirements on merged markets under the ACA. Carriers must consider all enrollees in the carrier's individual and small group plans to be members of a single risk pool and establish a single index rate. Carriers must consider marketwide payments and charges under risk adjustment and reinsurance programs. Carriers may only establish rates on an annual basis. Carriers must offer coverage on a calendar year basis with policies ending on December 31. Employees of small businesses may enroll in any health benefit plan and are not limited to plans in the small group market.

Ms. Eberle described the size of the individual and small group markets in 2018 and the shift in enrollment among the markets since 2015. While enrollment in the individual market has declined from 232,586 in 2015 to 211,773 in 2018, enrollment in the small group market has increased from 252,131 in 2015 to 264,835 in 2018.

The trajectory of rates in the two markets from 2014 to 2018 was also discussed. Whereas average premiums in the individual market rose from \$213 in 2014 to \$469 in 2018, average premiums in the small group market remained steadier, increasing from \$304 in 2014 to \$328 in 2018.

Ms. Eberle summarized the experiences of other states regarding market mergers. Massachusetts merged its individual and small group markets in 2006 (prior to passage of the ACA) but does not meet the federal definition of a merged market. Vermont merged its markets in 2014, but only has two carriers that participate in either market, as well as a small enrolled population (approximately 75,000). Vermont's merged market also does not meet the federal requirements because it allows direct enrollment in plans rather than going through an exchange. The District of Columbia merged its markets in 2014 using a hybrid approach. Carriers must use a single risk pool in the development of the index rate, but all other aspects of rate development are separate; carriers can make quarterly rate adjustments, and carriers may offer different plans in the two markets.

Ms. Eberle discussed how the same considerations used when the study was done in 2016 apply now but that new modeling would need to be done to consider reinsurance and risk adjustment to determine the impact to premium rates.

Commission Member Questions about Merged Market Study

Ms. Eberle received comments and fielded questions from commission members. Mr. Joseph Fitzpatrick raised several technical and timeline issues noting that MIA must inform CMS by February 1 if it wants a merged market for the following plan year, with plans due March 1 from carriers and rates due May 1. Mr. Fitzpatrick also noted that Section 31-111 of the Insurance Article, which establishes the Small Business Health Options Program (SHOP) exchange as a separate exchange, prohibits the SHOP exchange from being merged with the individual market. Mr. Fitzpatrick questioned what the impact of a merged market would be on the State Reinsurance Program and the associated federal pass-through funding and whether an amendment would need to be submitted for the Section 1332 waiver. Mr. Cardenas responded that there are certainly implications on the Section 1332 waiver. MHBE would have to go back to CMS and change its underlying assumptions for the waiver, such as to which market the reinsurance program would apply. Should the program be expanded to include the small group market, it would require a change in the funding that goes into the program. The current program is based on using \$462 million to reduce premiums by an estimated 30% for the individual market only. Mr. Cardenas noted that there would need to be significant lead time to allow MHBE to recalculate and resubmit waiver materials, which likely could not be done until calendar 2021.

Delegate Peña-Melnyk interjected that the draft Wakely report recommends that if a merged market policy is implemented, it should be done after the current Section 1332 waiver expires in order to ensure that the State does not lose any pass-through funding. Delegate Peña-Melnyk noted that the funding for the reinsurance program will run out in either 2020 or 2021, and therefore, a permanent solution is needed. The commission will continue to look at options.

Standardized Benefit Design

Senator Brian J. Feldman described how in 2017, MHBE convened a workgroup to review standardized benefit design and issued a report. Senator Feldman asked commission members that if there are ideas that they would like additional information on or that if there are concepts that do not make sense or should not be pursued further, to please weigh in with questions to narrow the focus of the commission on some other alternative policy possibilities.

Mr. Cardenas presented the findings of the stakeholder workgroup, beginning with background information. Mr. Cardenas defined standardized benefit designs as health benefit plans with benefits and cost sharing set by a noncarrier entity in the marketplace with the intent of assisting consumers in comparing plans “apples to apples” across the carriers that offer them. There is a range of standardization, and states vary in policy approach to standardized benefit designs. Mr. Cardenas described how nine marketplaces offer some level of standardized plan.

The 2017 Standardized Benefit Design Work Group met eight times and developed the following philosophy: (1) unless a high deductible health plan, standard plans should offer

first-dollar coverage of services before the deductible; (2) standard plans should incentivize consumers to seek care at lower cost facilities and providers; (3) standard plans should reduce the cost of care for children to the extent actuarially possible; (4) standard plans should be designed such that there is an easily understandable cost-sharing structure across all services; (5) standard plans should use co-payments instead of coinsurance as the cost-sharing structure to the extent possible; and (6) issues will also offer other nonstandard plans.

Mr. Cardenas presented the consensus recommendations of the workgroup: (1) plans should not be standardized on the SHOP marketplace; (2) plans should be standardized at bronze, silver, and gold metal levels; (3) existing plan rules should not be amended; (4) the coverage categories in the Summary of Benefits and Coverage should be the standardized categories; (5) nonstandard benefits may be offered if such benefits have a *de minimis* impact on essential health benefits as a percentage of premium; (6) only in-network cost sharing should be standardized; and (7) the MHBE Board of Trustees has existing waiver authority to support new market entrants. Mr. Cardenas noted that Kaiser opposes usage of this authority to waive standard plan requirements. The workgroup did not have consensus on whether plans should be standardized in the individual marketplace (five yeas, three nays).

Commission Member Questions about Standardized Benefit Design

Mr. Cardenas received comments and fielded questions from commission members. Mr. Walters asked if the workgroup thought nonstandardized plans should be offered, and Mr. Cardenas confirmed that yes, such plans were allowed but at least one plan must be standardized.

Ms. Rivkin stated that she recalled that there was not as much consensus on recommendations as is reflected in Mr. Cardenas' presentation and suggested that commission members review the appendix of the workgroup report to note the actual votes, which show some no and abstention votes on key recommendations rather than complete consensus.

Mr. Fitzpatrick reiterated that MIA does not have much authority regarding how carriers structure deductibles, out-of-pocket maximums, co-payments, and coinsurance but noted that through standard benefit plan design, MHBE could impact this design through the Qualified Health Plan certification process for plans sold through MHBE.

Dr. Rockower noted the difficulty for providers and billing offices to deal with so many nonstandardized plans and so much variability in cost sharing in order to determine how much a patient owes at the time of service. Mr. Cardenas replied that standardization helps people with less health literacy to understand and interpret their benefits.

Ms. Quatrocki asked whether standardized plans decrease consumers' out-of-pocket costs and whether there is any evidence that standardized plans can affect deductibles and premiums. Mr. Cardenas replied that, regarding premiums, the more generous the plan, the more induced demand to use the plan. Thus, depending on how generous the standardized plan is, this affects the

premiums. Regarding reducing out-of-pocket costs, Mr. Cardenas described that premiums must increase in order to decrease out-of-pocket costs. Ms. Quatrokcki inquired what the impact has been on premiums in other states that have implemented standardized benefit plans. Mr. Cardenas responded that reductions in out-of-pocket costs lead to reduction in uncompensated care among insured populations.

Ms. Laurie Kuiper noted that, regarding whether standardized plans should be required or optional, given that there are only two carriers in the individual market, it does not make sense to have standardized plans that are optional. Ms. Kuiper also asked if any other states that have standardized plans have measured or tried to capture consumer satisfaction with the ability to compare plans. Mr. Cardenas noted that while concrete data is not available, anecdotally, it appears to have improved consumer satisfaction and usability of coverage in California.

Mr. Atlas inquired if the workgroup looked at Medigap coverage, which has a long history of standard benefit design as a consumer protection measure, and its impact. Mr. Cardenas noted that the standardization of Medigap plans inspired the work of the workgroup, but in terms of its impact on enrollee experience, the workgroup did not look at that, though they did look at available evidence in other states. Mr. Atlas noted that if the State is to pursue standardized benefit plans, it should ensure that it has the science behind the standardized benefit plans correct in terms of which policy impacts which behavior. Mr. Atlas noted that the State still seems to be missing rules about what a reasonable amount of cost sharing is – an issue that the State should take up – as higher deductibles lead to consumers being unable to pay their share, which becomes uncompensated care to providers.

Mr. DeMarco asked if MHBE could provide the commission with a list of pros and cons for consumers of both merging the individual and small group market and standardized benefit plan design.

Individual Mandate Overview

Ms. Jennifer B. Chasse, Principal Policy Analyst at DLS, submitted an individual mandate overview presentation to the commission. Ms. Chasse described that individual mandates require individuals to purchase health insurance coverage or pay a penalty. Individual mandates are intended to guard against adverse selection, reduce “free riders,” and recognize the cost of the uninsured and uncompensated care but are viewed by some as government intrusion into private decision making.

Ms. Chasse described Massachusetts’ individual mandate, the first individual mandate adopted in 2006 (prior to the ACA). Massachusetts’ mandate applies only to adult residents, who must report their coverage information on the state income tax return. Massachusetts’ penalty is no more than one-half of the lowest cost Health Connector premium available but varies slightly based on age and income. In 2017, the penalty ranged from about \$252 to \$1,152 and is lower than the federal penalty. The penalty is paid by about 50,000 Massachusetts residents annually and is estimated to generate about \$18.0 million in revenues that are used to subsidize Massachusetts

Health Connector Programs. Massachusetts provides several exemptions from the requirement to purchase coverage, including individuals with income up to 150% of federal poverty guidelines (FPG) and a religious exemption that is broader than the current federal exemption.

Ms. Chasse summarized the federal individual mandate adopted under the ACA, effective tax year 2014, including the multiple available exemptions. The federal Tax Cuts and Jobs Act of 2017 eliminated the tax penalty for failure to comply with the mandate effective tax year 2019. Ms. Chasse reported that CBO projected that, nationally, elimination of the mandate penalty will decrease health insurance enrollment by three million to six million individuals between 2019 and 2021 and increase individual market premiums by 10%, while reducing federal spending by \$318 billion over 10 years due to fewer premium tax subsidies being paid.

Ms. Chasse reviewed state responses to elimination of the federal individual mandate penalty, noting that, in 2018, nine states (including Maryland) and the District of Columbia considered implementing state-based individual mandates to encourage younger, healthier consumers to maintain coverage and preserve a broader risk pool. Penalty revenues could be used for market stabilization or other efforts.

To date, only New Jersey, Vermont, and the District of Columbia have enacted individual mandates. New Jersey's mandate, which takes effect January 1, 2019, largely mirrors the federal mandate, with penalties being used for the state's reinsurance program. Vermont's mandate will not take effect until 2020, and a separate working group was established to develop recommendations on what the specific penalties and enforcement mechanisms will be. The District of Columbia adopted an individual mandate similar to the federal mandate but with significant additional exemptions based on income. The penalty will be developed annually by the DC Health Benefit Exchange Authority.

Several other states considered but did not pass individual mandates, including Connecticut, Hawaii, and Maryland. Maryland considered SB 1011 and HB 1167 of 2018, which mirrored the federal mandate regarding penalties and exemptions but allowed penalty payments to be used as a down payment for coverage.

Ms. Chasse reported that the Urban Institute estimates that a Maryland individual mandate could decrease the number of uninsured individuals by 15.8% and reduce the average individual market premium by as much as 13.5%. In calendar 2016, the most recent year for which data is available, 68,150 Maryland returns paid the penalty, for a total of \$51.0 million in penalties. Of the returns subject to penalty, 96% had an adjusted gross income (AGI) less than \$100,000, 76% had an AGI less than \$50,000, and 34% had an AGI less than \$25,000.

Ms. Chasse concluded her presentation by highlighting key policy issues for consideration should Maryland wish to pursue an individual mandate, including (1) what qualifies as minimum essential coverage; (2) what the level of the penalty should be; (3) how penalty revenues would be used (4) which exemptions would be provided; (5) what level of affordability standards would there be; and (6) which State entity would develop and handle appeals, oversight, and enforcement.

Commission Member Questions about Individual Mandate Overview

Ms. Chasse received comments and fielded questions from commission members. Mr. Vincent Demarco expressed the support of Health Care for All for the down payment proposal and noted that there has been a long history of Republican support for an individual mandate. Mr. DeMarco asked for clarification about when the federal enforcement ends. Ms. Chasse explained that taxpayers will be subject to the penalty for tax year 2018 under federal law but not subject to a federal penalty for tax year 2019.

Delegate West asked whether the number of uninsured individuals will skyrocket in 2019 because the federal mandate will no longer be enforced. Ms. Chasse replied that it remains uncertain exactly how many will drop coverage, though it has been estimated at between three million and six million nationally.

Mr. Priolo inquired if state mandates might provide an economic incentive for younger, healthier individuals to move away from states with mandates. Ms. Chasse noted that the impact of any mandate on economic behavior would depend on the amount of the penalty, but that given how few states have adopted state-based penalties, there is not any research on this impact yet. Senator Feldman noted that the down payment bill proposal from 2018 was mindful of this in that it allowed consumers to keep their penalty and use it to purchase insurance.

Mr. Atlas asked how much improvement in coverage Maryland is expecting as a result of lower premiums from the reinsurance program. Mr. Cardenas responded to this question, stating that, for purposes of the Section 1332 waiver application, MHBE had assumed a 10% attrition of the entire market due to the loss of the federal individual mandate (down to around 172,000 covered individuals in 2019). As a result of reinsurance and the associated reduction in premiums, MHBE estimated a 5.8% increase in enrollment.

Mr. Fitzpatrick raised the issue that anything with the potential to reduce premiums and go into the pot of money being used for reinsurance likely needs to be contingent on the Section 1332 waiver and approved by CMS.

Public Comments

The commission received comments from the public, including Mr. Bryson Popham and Mr. Mike O'Halloran. Mr. Popham, on behalf of the National Association of Insurance and Financial Advisors and the Maryland Association of Health Underwriters (collectively known as insurance brokers), indicated that consumer choice should be a major consideration of any policies pursued, including any potential merger of the individual and small group markets. Mr. O'Halloran, on behalf of the National Federation of Independent Businesses Maryland, reiterated the organization's ongoing opposition to the federal individual mandate as a tax, noting that rising health insurance costs remain a major concern for its members.

Mr. DeMarco shared with the commission a Democratic Staff Report prepared for Congressman Elijah E. Cummings regarding the potential impact of pending litigation on individuals with preexisting conditions. Mr. DeMarco asked that the commission seriously consider what Maryland should do in the event the courts rule against the ACA, asking that staff look at what Maryland law has and does not have to protect people with preexisting conditions and determine what is needed if these provisions were no longer part of the ACA. Mr. DeMarco suggested that the commission may wish to recommend legislation in the 2019 session to protect Marylanders if the courts rule that the ACA's preexisting condition provisions no longer apply.

November Meeting

On November 20, 2018, the commission received a presentation on consumer protections for individuals with preexisting conditions under current Maryland law, merging the individual and small group markets, and options for a State-based individual mandate. The commission also received comments from the public.

Consumer Protection for Individuals with Preexisting Conditions

Senator Feldman opened the meeting by noting that one subject that the commission has not spent time a lot of time on yet is ongoing litigation at the federal level involving preexisting conditions and consumer protections for individuals. Ms. Quattrocki, Deputy Attorney General, Office of the Attorney General, submitted a presentation on protections for Marylanders with preexisting conditions, including various options that the State could pursue to retain consumer protections should either the ACA be repealed, in whole or in part, or if a judge were to rule it unconstitutional, in whole or in part.

Ms. Quattrocki described the current preexisting condition protections in the ACA, including guaranteed issue and renewability requirements, a ban on preexisting condition exclusions, and community rating. Ms. Quattrocki then presented three options for continuing protections for Marylanders in the absence of the ACA: (1) take no action; (2) reinstate prior ACA protections; or (3) enact actual ACA protections as stand-alone provisions in Maryland law.

Under option one, Maryland would rely on State law that incorporates ACA preexisting condition protections by reference, some State stand-alone provisions that apply in certain markets, and federal law that provides guaranteed issue and prohibition on preexisting condition exclusion coverage for certain people. This option would not require legislation but comes with certain risks. For example, ACA protections incorporated by reference in Maryland law could be subject to legal challenge, and stand-alone protections in State law are limited and do not apply to all markets. Under option two, Maryland would supplement existing stand-alone State law protections by reinstating some preexisting condition protections in State law prior to the ACA. Under option three, Maryland would enact actual ACA provisions as stand-alone provisions in Maryland law. This option would reduce the risk of potential legal challenge by reinforcing legislative intent

to preserve ACA protections in State law. Alternatively, Ms. Quattrocki stated that Maryland could reinstate the Maryland Health Insurance Plan high-risk pool to protect access to health insurance for individuals with preexisting conditions.

Commission Member Questions about Consumer Protection for Individuals with Preexisting Conditions

Ms. Quattrocki answered questions from commission members. Ms. Rivkin inquired if the Attorney General's office had a preferred option. Ms. Quattrocki noted that option three (importing the actual protections from the ACA into Maryland statute) would be the cleanest and safest option.

Delegate West asked if any other states, particularly neighboring jurisdictions, have already adopted their own ACA provisions in state law. Ms. Quattrocki replied that four states have or are pursuing option three (Colorado, Massachusetts, New York, and Virginia) and the District of Columbia has adopted at least one preexisting condition provision. Delegate West raised a hypothetical question, asking if the ACA is deemed unconstitutional and Maryland had adopted its own ACA (via option three), could it lead to adverse selection from people moving to Maryland from other states. Ms. Quattrocki replied that adverse selection is possible, but the extent to which it would happen and any potential impact on premiums in Maryland would vary.

Ms. Doyle asked for clarification if substance use disorder is specifically protected as a preexisting condition. Ms. Quattrocki noted that ACA protects against all preexisting conditions, including mental health and substance use disorders.

Dr. Rockower asked if the ACA was declared unconstitutional but Maryland had the same language in its State law, would Maryland law be deemed unconstitutional. Ms. Quattrocki replied this is unlikely as the basis for the legal challenge to the ACA is whether Congress had the power to enact the law, whereas the State has the clear power to adopt such laws.

Senator Kelley noted that were people to move to Maryland if we were to adopt such protections, it may ultimately be a benefit to the State.

Mr. DeMarco remarked that, from a consumer/patient standpoint, option three sounds like the best option to protect Marylanders and noted that Maryland should not be concerned about people moving to the State but rather focus on protecting Maryland consumers.

Delegate Peña-Melnyk clarified that option three really reflects current federal law just being codified into Maryland law and noted that states can always offer additional protections beyond what federal law provides.

Mr. Walters commented that providing these consumer protections may in fact draw individuals to Maryland in a beneficial way, but noted that more study is needed on what the overall effects might be were Maryland to adopt these provisions if Maryland's neighboring states do not.

Senator Feldman noted that, if the ACA were to be overturned, other states would likely be moved to adopt these preexisting protections in their own states due to political pressure to protect consumers.

Merging Individual and Small Group Markets

Mr. Michael Cohen, Consultant, Policy Analytics, Wakely, presented the Wakely report on merging the individual and small group markets.

Mr. Cohen provided an overview of the policy options and trade-offs of merging the individual and small group markets, indicating that, for the past decade, merging markets has been considered a potential option to improve the risk pool by combining the healthier small group market with the individual market. Section 1312 of the ACA authorizes states to formally merge the two markets. To date, only one state (Vermont) has fully merged its market under the federal definition (carriers have to operate in both markets, the same products must be offered in both markets, and benefit years must be aligned). Massachusetts and the District of Columbia have quasi-merged markets but are not fully merged under the federal definition.

Mr. Cohen described the differences between Maryland's individual and small group markets, noting that the small group market contains about 210,000 members and 265 small groups (as of February 2018). Individuals in the individual market tend to be a little bit sicker than those in the small group market, while the small group market tends to be slightly younger and have a richer benefit in terms of cost sharing and actuarial value.

Mr. Cohen presented four policy options for merging the markets: (1) merging experience to build premiums (which would reduce individual premiums but increase small group premiums); (2) risk adjustment across both markets to transfer funds to the sickest enrollees (which would also reduce individual market premiums but increase small group premiums to a greater extent than option one); (3) guaranteed issue for all products/offer the same plans in both markets like Massachusetts (which equalizes plans across both markets and would likely provide more protection to the individual market but create more disruption to the small group market and hinder the ability to create niche products in either market); and (4) full merger like Vermont (much more disruptive to the small group market in terms of benefit calendar and elimination of quarterly rates).

Mr. Cohen emphasized that timing is an important consideration for pursuing any policy options. All parties involved would need sufficient time to adjust. Carriers not participating in the individual market would need time to create plans and set rates. Maryland has unique circumstances in terms of timing. Mr. Cohen noted that a merger during the Section 1332 waiver could reduce the impact of reinsurance and reduce the amount of federal pass-through funding available.

Mr. Cohen concluded that a merger could increase the size and stability of the risk pool over the long term; however, in the short term, reductions in individual market premiums likely result in increases in small group market premiums. Mr. Cohen stressed that details matter,

specifically the timing of a merger, the level of merger chosen, and the distributional implications and their impact. Mr. Cohen noted that Wakely would need to analyze the more specific impact of various levels of merger to provide additional guidance.

Commission Member Questions about Merging the Individual and Small Group Markets

Mr. Cohen responded to questions from the members of the commission. Ms. Kuiper inquired if Maryland would need to go to CMS to amend its Section 1332 waiver to merge the market. Mr. Cohen responded that, while this is ultimately a decision for CMS, it is a distinct possibility.

Mr. Walters asked about the implications on employer offers of coverage in the small group market, in particular whether employers would continue to help their employees by subsidizing their coverage. Mr. Cohen replied that employers could still subsidize employee coverage, noting that Massachusetts and Vermont have not seen changes in employer offers or levels of subsidization of employees.

Dr. Rockower asked how much rates would go up or down as a result of a merger. Mr. Cohen indicated that Wakely would need to do more analysis to provide such an estimate. Senator Feldman noted that it is up to the commission – if it thinks it needs additional analysis, Wakely can move forward with additional analysis.

Mr. Atlas inquired if Wakely had looked at who the players are in the markets, in terms of increasing participation or making sure that the State does not lose participation by active issuers of plans. Mr. Cohen replied that it is unknown what the effects would be on carriers, and this would be a key market scanning activity were Maryland to move forward.

Delegate West asked if, under a merger, would small group plans have to change their benefits to equate to ACA-mandated benefits. Mr. Cohen noted that the same 10 essential health benefits are required to be offered in both markets, though there is some flexibility in terms of the exact benefits and cost sharing offered. Mr. Cohen replied that the main differences between the markets are cost sharing. Premiums would be what would primarily change under a merged market.

Mr. Lee inquired about the impact on small businesses of a merged market, specifically how would this benefit small business owners. Mr. Cohen replied that a merger provides a larger pool of people that are easier to price to, but in the short term, a merger represents a trade-off to reduce rates in the individual market while increasing rates in the small group market. Mr. Lee questioned why small business owners would want to increase rates on already stressed employees.

Senator Feldman remarked that the commission will discuss additional analysis by Wakely to see the actual impact on rates.

Individual Mandate

Mr. Stan Dorn, Senior Fellow, Families USA, submitted a presentation on the option to adopt a State-based individual mandate in Maryland, specifically whether Maryland should fill the gap left by the end of federal enforcement of the individual mandate and if so, how. Mr. Dorn noted that an original rationale of the ACA was that an individual mandate was needed to complement insurance reforms.

Mr. Dorn identified several approaches to pursuing a State-based individual mandate, and discussed the advantages and disadvantages. Options include: (1) replace federal tax-based enforcement with State-based tax enforcement; (2) same as option one, but increase the penalty; (3) same as option one, but use the State tax return to authorize data-sharing and enrollment with tax-based special enrollment period; or (4) same as option three, but allow consumers to turn their penalty payments into down payments to buy insurance; when people are offered zero-premium plans, move toward automatic enrollment.

Mr. Dorn then discussed the key elements of the down payment plan. The proposed plan would use tax filing to enroll the uninsured into coverage whenever possible, rather than just using tax filing for punishment. Enrollment incentives and automatic enrollment would replace mandate penalties whenever possible. Consumers could convert penalty payments into down payments to help buy insurance through MHBE.

Mr. Dorn noted that it is estimated that the down payment proposal could reduce the number of the uninsured by one-third, enrolling 14,300 children and 36,100 adults in Medicaid/the Maryland Children's Health Plan and connecting people with coverage through MHBE including 78,700 adults who would qualify for zero-additional premium MHBE plans, with premiums fully paid by the penalty plus federal APTCs.

Mr. Dorn discussed automatic enrollment as a feature of the down payment proposal, noting that the closer a program can get to automatic enrollment, the more of an impact it will have on the number of people receiving coverage and the impact on the risk pool. Mr. Dorn noted that automatic enrollment is currently used in Medicare, Medicaid managed care organizations, and within MHBE and other states' exchanges. Mr. Dorn clarified that the plan would not be fully automatic. Specifically, the down payment proposal plan would begin with the consent of the taxpayer to share data with MHBE and would allow consumer choice along the way.

Mr. Dorn also described some additional factors of the down payment proposal. After automatic enrollment, the percentage of young people in the individual market would increase. Additionally, the number of individuals receiving APTCs is estimated to increase by 71%. Mr. Dorn also noted that the plan is administratively complex and that the number of people with access to zero-additional premium plans will change from year to year.

Mr. Dorn concluded his presentation, stating that enforcing the individual responsibility to obtain coverage would help the market, while a down payment plan would cover numerous low- and moderate-income uninsured in Maryland, lower private health insurance costs, and stabilize the individual market. However, it will require considerable administrative effort to achieve those gains.

Commission Member Questions about Individual Mandate

Mr. Dorn received questions from members of the commission. Delegate West stated that auto enrollment sounds like a great although complicated idea but questioned the actual impact of the underlying mandate and noted that it will be interesting to see how many people will actually drop coverage this year with the federal mandate no longer being enforced. Mr. Dorn noted that it is hard to say what the impact will be on consumer behavior this year given that there are so many moving parts (premium decreases due to reinsurance, zeroing out of the federal mandate penalty, *etc.*). Delegate West noted concerns about what level a mandate penalty would need to be to successfully induce consumers to purchase coverage. Mr. Dorn noted that the down payment plan and penalties are likely to have the most impact on individuals who qualify for free or low-cost plans through a combination of the APTC and their penalty payment.

Mr. Walters asked when exactly an individual could get coverage under the proposal. Mr. Dorn provided an example that an individual could file their taxes, indicate on their tax form that they were uninsured during the tax year, authorize their data to be sent to MHBE, then enter a special open enrollment period, with coverage beginning approximately three months later. Mr. Walters noted that Maryland needs to make it as easy as possible for people to be enrolled. Mr. Dorn agreed.

Delegate Reznik commented that Maryland seems to be taking a very piecemeal approach and in the meantime, not getting to where it wants to be, even though there is an example of a system that works reasonably well and puts all of these approaches together – Massachusetts. Delegate Reznik asked why is Maryland not looking at a plan similar to Massachusetts rather than building an incremental approach year after year. Mr. Dorn noted that Massachusetts' plan is very effective but costs a significant amount of money as it provides additional State supplements to the federal APTC and CSRs, no premiums for individuals with incomes less than 150% FPG, subsidized premiums for individuals with incomes between 150% and 300% FPG, and no deductibles for individuals with incomes less than 300% FPG. Delegate Reznik stated that maybe the State needs to come to the realization that it is not going to get where it needs to be without spending some money and that it needs to spend some of the money that it currently has to get there.

Ms. Quattrocker noted that it is a conceptually terrific idea but questioned what the State can do to ensure that it works and is sustainable in terms of one-time sunk costs vs. ongoing administrative costs. In response, Ms. Eberle expressed concerns with administration as the proposal requires MHBE to function as a bank holding funds and managing people. Ms. Eberle noted that MHBE has some things in place that could help, specifically a pay now URL on the

MHBE website, the authority to create a special enrollment period at tax filing time, and the ability to continue sending out 1099 forms regarding who had coverage through MHBE during the tax year. Ms. Eberle noted that sharing information among the Comptroller, MHBE, and carriers and managing consumers is a very big administrative lift and will have a significant cost. Ms. Sarah C. Dufresne, Assistant Director, Revenue Administration Division, Office of the Comptroller, replied that their costs would mainly be for information technology (IT) (adding multiple additional fields, possibly a new schedule for the tax form).

Ms. Doyle stated that while better access to Medicaid is good, people need to be able to actually access Medicaid benefits once enrolled.

Mr. Atlas voiced the Maryland Hospital Association's support for broad-based coverage and the concept of an individual mandate as a means to enhance coverage and requested additional modeling on the impact of an individual mandate on reinsurance and would like more details on execution. Mr. Atlas commented that as Maryland hospitals enter the new Total Cost of Care model this January, they are on the hook to contain costs and would like to see other efforts to help keep premiums affordable, get carriers to better manage populations, and look at broad-based efforts to control costs.

Delegate Bonnie L. Cullison noted that Maryland should try to make any individual mandate proposal as easy as possible. Regarding automatic enrollment, Delegate Cullison remarked that only two carriers remain in the individual market, and they represent very different styles of products. Mr. Dorn responded that the approach that the proposal takes is that first a consumer has a choice to pick any plan during the special enrollment period; then, only if a consumer does not make a choice, MHBE will make a decision for them (first looking for the zero premium plan with the highest actuarial value, then the plan with the greatest coverage of pre-deductible services, then the plan with the lowest premiums, then assigned at random). Delegate Cullison noted that enrollment is complicated for consumers and asked if there has been consideration about using money to enhance the navigator presence to help enroll the uninsured and guide them through the process. Mr. Dorn noted that an estimated \$30 million may be available under the proposal to fund activities such as this.

Dr. Rockower suggested that there could be additional issues once people are enrolled if they stop paying their premiums, which places a burden on providers. Dr. Rockower noted that an IT system that allows providers to check that patients are insured at the time of service would be very helpful. Mr. Dorn noted that any down payment amount is spread out over the remainder of the year, which is intended to reduce the incidence of people dropping coverage mid-year.

Ms. Rivkin raised the issue of "silver-loading" of premiums, noting that CMS is anticipated to issue guidance soon regarding silver loading or to prohibit it altogether. Mr. Dorn replied that if silver-loading is no longer allowed and nothing takes its place, fewer people would be offered zero-additional premium coverage, causing rate shock.

Mr. Walters asked, if silver-loading goes away, what happens to the Section 1332 waiver. Mr. Cardenas responded that the waiver was approved for a reinsurance program that will offset premiums by 30% in 2019 and 2020, noting that whenever the underlying assumptions change (in this case, if silver-loading were to go away), the amount of the federal pass-through funding will have to modulate to reflect the underlying changes. Mr. Cardenas stated that were silver-loading to go away, CMS would have to advise how states should approve individual market rates and that based on the advice, states would determine the final rates that consumers would pay.

Mr. DeMarco remarked that Health Care for All strongly supports the down payment proposal mainly because tens of thousands of additional people will get insurance, which will help keep premiums lower and keep uncompensated care declining.

Ms. Kuiper stated that Kaiser feels strongly that an individual mandate is a critical piece in stabilizing the individual market in Maryland and that although it is complicated and costly, the benefits to stabilizing the individual market would far outweigh the costs.

Mr. Lee remarked that lowering rates and increasing the number of insured individuals is much needed, especially for the small business community and noted that he would really like to see the proposal work.

Public Comment

The commission received public comment from Consumer Health First and the National Restaurant Association. Ms. Leni Preston, Vice President of Consumer Health First, expressed support for option three of Ms. Quatroocki's presentation on consumer protections for individuals with preexisting conditions and concern about reinsurance program funding long-term. Ms. Preston noted that the individual mandate is an important path forward, a tool to encourage enrollment, and emphasized the importance of health literacy in individuals selecting the best plan for their circumstances. Ms. Preston also requested that the commission get additional data before pursuing merger of the individual and small group markets and asked that the commission continue to explore options for individuals with incomes greater than 400% FPG who do not receive APTCs, such as a Medicaid buy-in or additional premium subsidies. Mr. Aaron Frasier from the National Restaurant Association, submitted a presentation on a new association health plan that the association would like to offer in Maryland, which would require statutory changes to authorize.

Discussion on Next Steps

Delegate Peña-Melnyk recapped the charge of the commission and announced that commission staff would prepare a draft report to be sent out to commission members for comments by December 7, 2018, and requested that any comments be returned to staff by December 14, 2018. Delegate Peña-Melnyk remarked that many of the bills that became law in 2018 came out of commission findings and recommendations.

Senator Feldman added that commission members should have input and feel like they have a stake on these complicated issues. Senator Feldman noted that the report will serve as a resource for the General Assembly during the 2019 session and that, as a three-year commission, the commission will reconvene during the 2019 interim to continue its work.

Delegate Peña-Melnyk asked if commission members had anything else they would like commission staff to know before they draft the report or any feedback they would like staff to take. Mr. Walters expressed opposition to merging the individual and small group market at this time, prior to the Section 1332 waiver ending as there is too much unknown and too much risk.

Senator Feldman encouraged members to weigh in on issues that they would or would not like to spend additional time and resources on (such as retaining Wakely to do additional analysis on the impact of merging the individual and small group market).

Chapter 3. Findings

During the 2018 interim, the Maryland Health Insurance Coverage Protection Commission focused on three options for stabilizing the individual market: (1) establishing a standard plan; (2) the individual and small group markets; and (3) establishing a State-based individual mandate. The commission was also briefed on actions the State could take to protect individuals with preexisting conditions should the federal Patient Protection and Affordable Care Act (ACA) be ruled unconstitutional. While the commission does not endorse any specific proposal, it made several findings, identified questions for further study, and laid the ground work for continued work during the 2019 legislative session and beyond. Major findings on these three policy areas are summarized below.

Standardized Benefit Plan

The Maryland Health Benefit Exchange (MHBE) established a workgroup to study standardized benefit design and issued a report in 2017. The workgroup found a range of standardization and varying approaches to standardized benefit design in other states. The report concluded that standardization of plans could help consumers compare plans and better understand the benefits and costs associated with different plans. The workgroup and report did not result in the implementation of a standardized benefit design in Maryland.

Commissioners raised questions about the extent to which a standardized benefit design would benefit Maryland consumers, particularly given that there are only two carriers that participate in the individual market that have significantly different models of coverage. It is unclear how a standardized benefit design would assist consumers in choosing between such fundamentally different plans. It is also unclear how standardized benefit design would affect deductibles and premiums.

Merging the Individual and Small Group Markets

The ACA provides states the option to merge their individual and small group markets. Based on the work of advisory committees, the MHBE Board of Trustees recommended against merging the markets in 2011. In 2012, the General Assembly directed MHBE to formally study a potential merger and submit a report by 2016. Based on review of the 2016 report, the MHBE Standing Advisory Committee recommended deferring a policy decision at that time and revisiting the issue when more data was available. Wakely Consulting Group (Wakely) prepared a report on merging the markets for the commission in 2018. The report noted that, to date, only one state (Vermont) has fully merged its market under the federal definition, while Massachusetts and the District of Columbia have quasi-merged markets. The Wakely report laid out four policy options for merging the markets as described in Chapter 2 of this report.

Both the MHBE and Wakely reports concluded that merging the individual and small group markets would increase the stability of the risk pool, with rates in the individual market declining and rates in the small group market increasing. Both reports also identified additional potential impacts on the small group market depending on the level to which the markets are merged, including the potential to move all policies to a calendar year basis, elimination of quarterly rate adjustments, and the availability of fewer niche products from carriers. Additionally, Wakely advises that a merger would reduce the impact of reinsurance and the amount of federal pass-through funding available under the Section 1332 waiver, noting that implementation of a merged market should likely be delayed until the reinsurance program ends. Wakely indicated that it would need additional information on how Maryland was considering merging the markets before it could provide a more in-depth analysis, including the estimated impact on rates.

State-based Individual Mandate

Massachusetts adopted the first individual mandate in 2006 (prior to the ACA). A principal feature of the 2010 ACA was a federal individual mandate, effective tax year 2014, that requires individuals to have minimum essential health coverage, qualify for an exemption, or make a “shared responsibility payment” with their federal income tax return. For tax year 2018, the penalty is the greater of \$695 per individual (up to a maximum of \$2,085) or 2.5% of household income. The federal Tax Cut and Jobs Act of 2017 eliminated the tax penalty for failure to comply with the mandate effective tax year 2019. Therefore the federal individual mandate will no longer be enforced after tax year 2018.

In response, in 2018, several states considered implementing state-based individual mandates to encourage younger, healthier consumers to maintain coverage and preserve a broader risk pool. To date, only New Jersey, Vermont, and the District of Columbia have enacted individual mandates. New Jersey’s mandate, which takes effect January 1, 2019, largely mirrors the federal mandate, with penalties being used for the state’s reinsurance program. Vermont’s mandate is scheduled to take effect in 2020, but a separate working group established to develop specific penalties and enforcement mechanisms has yet to reach consensus. The District of Columbia adopted an individual mandate similar to the federal mandate but with significant additional exemptions based on income. Maryland considered but did not pass SB 1011 or HB 1167 of 2018, which mirrored the federal mandate regarding penalties and exemptions but allowed penalty payments to be used as a “down payment” for coverage.

A State-based individual mandate could take several forms. Maryland could adopt a mandate that mirrors the federal individual mandate as did New Jersey. Alternatively, Maryland could adopt a down payment plan in which the uninsured could elect to turn their penalty payment into a down payment to buy insurance.

Summary of Potential State Actions to Cover Preexisting Conditions

In *Texas v. United States*, 20 states filed suit in February 2018 arguing that the ACA (as amended by the federal Tax Cuts and Jobs Act of 2017 that eliminated the tax penalty of the individual mandate) is no longer constitutional because it is not supported by a tax penalty. The lawsuit asserts that the entire ACA is unlawful and requests that the District Court enjoin its operation. Should the ACA be ruled unconstitutional, in whole or in part, current preexisting condition protections, including guaranteed issue and renewability requirements, a ban on preexisting condition exclusions, and community rating, would no longer apply.

As discussed in Chapter 2, Maryland has several options for continuing protections for Marylanders in the absence of the ACA: (1) take no action; (2) reinstate prior ACA protections; or (3) enact actual ACA protections as stand-alone provisions in Maryland law. The third option would reduce the risk of potential legal challenge by reinforcing legislative intent to preserve ACA protections in State law. However, the impact on Maryland's insurance market should neighboring states not adopt similar provisions remains unclear. Alternatively, Maryland could reinstate the defunct Maryland Health Insurance Plan high-risk pool to protect access to health insurance for individuals with preexisting conditions.

On December 14, 2018, a federal district court judge in Texas ruled that the entire ACA is unconstitutional. This decision came after the commission's last meeting and was not discussed by commission members. The decision will be appealed and both the timing and outcome of the appeal are unknown. The commission will not meet again until after the conclusion of the 2019 session of the General Assembly. Thus, if it is determined that the State would like to implement any of the options discussed in this report in order to preempt the impact of a final decision in *Texas v. United States*, any legislation that would need to be passed to implement the option will need to be considered by the State's executive and legislative branches.

Additional Comments

Commission staff received many comments from commissioners. In response to the comments, commission staff made several stylistic and clarifying changes to the report. Additionally, commission staff received the following substantive comments:

- Mr. Eric Shope commented that based on what the commission heard regarding merging the individual and small group markets, he believes that the risk to the small group market is a nonstarter and that the State should not invest additional resources into the option; and
- Ms. Laurie Kuiper suggested that in 2019, the commission should consider long-term funding sources for the reinsurance program and whether to include incentive payments for improving quality in the State reinsurance program (**Appendix 3**).

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 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

LAWRENCE J. HOGAN, JR., Governor

Ch. 38

Chapter 38

(Senate Bill 387)

AN ACT concerning

Health Insurance – ~~Health Care Access Program – Establishment~~ Individual Market Stabilization (Maryland Health Care Access Act of 2018)

FOR the purpose of ~~requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; providing for the distribution of the assessment; requiring the assessment to be in addition to certain taxes and certain penalties or actions; establishing as a purpose of the Maryland Health Benefit Exchange to seek approval of a certain waiver on or before a certain date and carry out a certain waiver under certain circumstances; requiring the Exchange to apply to certain officials for a certain waiver on or before a certain date; requiring the Executive Director of the Exchange, in consultation with the Maryland Insurance Commissioner and with the approval of the Board of Trustees of the Exchange, to implement a certain plan; authorizing the Exchange to implement a certain waiver; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; altering certain requirements relating to the use of certain funds; requiring that certain funds be used in a certain manner; altering certain requirements relating to a certain certification of certain health benefit plans; requiring the Exchange to establish and oversee the implementation of a Health Care Access Program; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; requiring the Program, beginning on a certain date, to provide reinsurance to certain carriers and premium subsidies to certain individuals; establishing that the Program is contingent on the Centers for Medicare and Medicaid Services approving a waiver under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; requiring, beginning on a certain date, an individual to maintain certain coverage for certain individuals; requiring that an individual pay a certain penalty under certain circumstances; requiring that the penalty be in addition to a certain State income tax and included with a certain income tax return; requiring that certain individuals be jointly liable for the penalty under certain circumstances; establishing the amount of the penalty; exempting an individual who qualifies for a certain exemption under federal law from being assessed the penalty; requiring an individual to indicate certain information on a certain income tax return; requiring the Comptroller to distribute certain revenues from the penalty to a certain fund for certain purposes; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; providing for the application of certain provisions of this Act; defining certain terms; making certain provisions of this Act subject to a certain contingency; terminating certain provisions of this Act under certain circumstances; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and dental plan organizations, fraternal benefit organizations, managed care organizations, and~~

certain other persons to be subject to a certain assessment in a certain year; establishing the purpose and providing for the distribution of the assessment; establishing that certain provisions of law that apply to certain small employer health benefit plans apply to health benefit plans offered by certain entities; altering the definition of “short-term limited duration insurance” as it relates to certain provisions of law governing individual health benefit plans; altering the membership of the Maryland Health Insurance Coverage Protection Commission; requiring the Commission to study and make recommendations for individual and group health insurance market stability; requiring the Commission to engage an independent actuarial firm to assist in a certain study; requiring the Commission to include its findings and recommendations from a certain study in a certain report; making this Act an emergency measure; and generally relating to health insurance.

BY adding to

Article – Insurance

Section ~~6–102.1, 31–108(h), and 31–117.1~~

Annotated Code of Maryland

(2017 Replacement Volume)

BY repealing and reenacting, with amendments,

Article – Insurance

Section ~~31–102(e), 31–107(b) and (c) through (g), and 31–115(b)~~ 15–1202 and 15–1301(s)

Annotated Code of Maryland

(2017 Replacement Volume)

~~BY repealing and reenacting, without amendments,~~

~~Article – Insurance~~

~~Section 31–107(a), (c), and (d) and 31–115(a)~~

~~Annotated Code of Maryland~~

~~(2017 Replacement Volume)~~

~~BY adding to~~

~~Article – Tax – General~~

~~Section 10–102.2~~

~~Annotated Code of Maryland~~

~~(2016 Replacement Volume and 2017 Supplement)~~

BY repealing and reenacting, without amendments,

Chapter 17 of the Acts of the General Assembly of 2017

Section 1(b) and (g)

BY repealing and reenacting, with amendments,

Chapter 17 of the Acts of the General Assembly of 2017

Section 1(c)(6)(viii) and (ix), (h), and (i)

BY adding to

Chapter 17 of the Acts of the General Assembly of 2017
Section 1(c)(6)(x) and (h)

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

Article – Insurance

6-102.1.

~~(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED:~~

~~(2) “CARRIER” HAS THE MEANING STATED IN § 31-101 OF THIS ARTICLE.~~

~~(3) “HEALTH BENEFIT PLAN” HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(B) (1) BEGINNING JANUARY 1, 2019, A CARRIER SHALL PAY AN ASSESSMENT OF 3% ON THE CARRIER’S NEW AND RENEWAL GROSS DIRECT PREMIUMS IF THE CARRIER FAILS TO OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IN ACCORDANCE WITH TITLE 15, SUBTITLE 13 OF THIS ARTICLE.~~

~~(2) THE ASSESSMENT PAYABLE BY A CARRIER UNDER THIS SUBSECTION SHALL BE BASED ON THE CARRIER’S PREMIUMS IN ANY MARKET SEGMENT:~~

~~(I) ALLOCABLE TO THE STATE; AND~~

~~(II) WRITTEN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.~~

~~(C) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2019, THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117.1 OF THIS ARTICLE.~~

~~(D) THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE IN ADDITION TO:~~

~~(1) TAXES DUE FROM THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) PENALTIES OR ACTIONS THAT THE COMMISSIONER MAY TAKE FOR THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

(A) THIS SECTION APPLIES TO:

(1) ~~A HEALTH~~ AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, ~~OR~~ A HEALTH MAINTENANCE ORGANIZATION, A DENTAL PLAN ORGANIZATION, A FRATERNAL BENEFIT ORGANIZATION, AND ANY OTHER PERSON SUBJECT TO REGULATION BY THE STATE THAT PROVIDES A ~~HEALTH BENEFIT PLAN REGULATED PRODUCT THAT:~~

(I) IS SUBJECT TO THE FEE UNDER § 9010 OF THE AFFORDABLE CARE ACT; AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE; AND

(2) A MANAGED CARE ORGANIZATION AUTHORIZED UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.

(B) THE PURPOSE OF THIS SECTION IS TO RECOUP THE AGGREGATE AMOUNT OF THE HEALTH INSURANCE PROVIDER FEE THAT OTHERWISE WOULD HAVE BEEN ASSESSED UNDER § 9010 OF THE AFFORDABLE CARE ACT THAT IS ATTRIBUTABLE TO STATE HEALTH RISK FOR CALENDAR YEAR 2019 AS A BRIDGE TO STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.

(C) (1) IN CALENDAR YEAR 2019, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 2.75% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR CALENDAR YEAR 2018.

(2) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE DISTRIBUTED BY THE COMMISSIONER TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE.

15-1202.

(a) This subtitle applies only to a health benefit plan that:

- (1) covers eligible employees of small employers in the State; and
- (2) is issued or renewed on or after July 1, 1994, if:
 - (i) any part of the premium or benefits is paid by or on behalf of the small employer;
 - (ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;
 - (iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or
 - (iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.

(b) A carrier is subject to the requirements of § 15–1403 of this title in connection with health benefit plans issued under this subtitle.

(C) THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN OFFERED BY AN ASSOCIATION, A PROFESSIONAL ~~EMPLOYEE~~ EMPLOYER ORGANIZATION, OR ANY OTHER ENTITY, INCLUDING A PLAN ISSUED UNDER THE LAWS OF ANOTHER STATE, IF THE HEALTH BENEFIT PLAN COVERS ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS AND MEETS THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION.

15–1301.

(s) “Short–term limited duration insurance” [has the meaning stated in 45 C.F.R. § 144.103] MEANS HEALTH INSURANCE COVERAGE PROVIDED UNDER A POLICY OR CONTRACT WITH A CARRIER AND THAT:

(1) HAS A POLICY TERM THAT IS LESS THAN 3 MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE POLICY OR CONTRACT;

(2) MAY NOT BE EXTENDED OR RENEWED;

(3) APPLIES THE SAME UNDERWRITING STANDARDS TO ALL APPLICANTS REGARDLESS OF WHETHER THEY HAVE PREVIOUSLY BEEN COVERED BY SHORT–TERM LIMITED DURATION INSURANCE; AND

(4) CONTAINS THE NOTICE REQUIRED BY FEDERAL LAW PROMINENTLY DISPLAYED IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT.

~~31-107.~~

~~(a) There is a Maryland Health Benefit Exchange Fund.~~

~~(b) (1) The purpose of the Fund is to:~~

~~(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; [and]~~

~~(ii) provide funding for the establishment and operation of the State Reinsurance Program authorized under § 31-117 of this title; AND~~

~~(HH) PROVIDE FUNDING FOR THE ESTABLISHMENT AND OPERATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117.1 OF THIS TITLE.~~

~~(2) The operation and administration of the Exchange and the State Reinsurance Program may include functions delegated by the Exchange to a third party under law or by contract.~~

~~(c) The Exchange shall administer the Fund.~~

~~(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.~~

~~(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.~~

~~(e) The Fund consists of:~~

~~(1) any user fees or other assessments collected by the Exchange;~~

~~(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6-103.2 of this article;~~

~~(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;~~

~~(4) income from investments made on behalf of the Fund;~~

~~(5) interest on deposits or investments of money in the Fund;~~

~~(6) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;~~

~~(7) money donated to the Fund;~~

~~(8) money awarded to the Fund through grants; [and]~~

~~(9) THE REALLOCATION OF FEDERAL PREMIUM TAX CREDITS AS AUTHORIZED UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;~~

~~(10) TAXES RECEIVED BY THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~(11) ASSESSMENTS RECEIVED BY THE COMMISSIONER UNDER § 6-102.1 OF THIS ARTICLE; AND~~

~~[(9)] (12) any other money from any other source accepted for the benefit of the Fund.~~

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

~~(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; [and]~~

~~(2) for the establishment and operation of the State Reinsurance Program authorized under § 31-117 of this title; AND~~

~~(3) FOR THE ESTABLISHMENT AND OPERATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117.1 OF THIS TITLE.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for:~~

~~(I) Exchange operations [and for];~~

~~(II) the State Reinsurance Program; AND~~

~~(III) THE HEALTH CARE ACCESS PROGRAM.~~

~~(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.~~

~~(3) Funds received from the distribution of the premium tax under § 6-103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.~~

~~(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program AND THE HEALTH CARE ACCESS PROGRAM.~~

~~(5) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) FUNDS TRANSFERRED FROM THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~(II) FUNDS TRANSFERRED FROM THE COMMISSIONER UNDER § 6-102.1 OF THIS ARTICLE; AND~~

~~(III) FUNDS RECEIVED FROM THE INTERNAL REVENUE SERVICE UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~31-115.~~

~~(a) The Exchange shall certify:~~

~~(1) health benefit plans as qualified health plans;~~

~~(2) dental plans as qualified dental plans, which may be offered by carriers as:~~

~~(i) stand-alone dental plans; or~~

~~(ii) dental plans sold in conjunction with or as an endorsement to qualified health plans;~~

~~(3) vision plans as qualified vision plans, which may be offered by carriers as:~~

~~(i) stand-alone vision plans; or~~

~~(ii) vision plans sold in conjunction with or as an endorsement to qualified health plans; and~~

~~(4) stand-alone dental plans for sale outside the Exchange.~~

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

~~(1) except as provided in subsection (c) of this section AND AS OTHERWISE AUTHORIZED UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT, provide the essential health benefits required under § 1302(a) of the Affordable Care Act and § 31-116 of this title;~~

~~(2) obtain prior approval of premium rates and contract language from the Commissioner;~~

~~(3) except as provided in subsection (c) of this section, provide at least a bronze level of coverage, as defined in the Affordable Care Act and determined by the Exchange under § 31-108(b)(8)(ii) of this title;~~

~~(4) (i) ensure that its cost sharing requirements do not exceed the limits established under § 1302(c)(1) of the Affordable Care Act; and~~

~~(ii) if the health benefit plan is offered through the SHOP Exchange, ensure that the health benefit plan's deductible does not exceed the limits established under § 1302(c)(2) of the Affordable Care Act;~~

~~(5) be offered by a carrier that:~~

~~(i) is licensed and in good standing to offer health insurance coverage in the State;~~

~~(ii) IF THE CARRIER PARTICIPATES IN THE SHOP EXCHANGE, offers in [each Exchange, the Individual and] the SHOP[, in which the carrier participates,] EXCHANGE at least one qualified health plan:~~

~~1. at a bronze level of coverage;~~

~~2. at a silver level of coverage; and~~

~~3. at a gold level of coverage;~~

~~(iii) if the carrier participates in the Individual Exchange [and offers any health benefit plan in the individual market outside the Exchange, offers at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange], OFFERS IN THE INDIVIDUAL EXCHANGE AND IN THE INDIVIDUAL MARKET OUTSIDE THE EXCHANGE AT LEAST ONE QUALIFIED HEALTH PLAN AT A GOLD LEVEL OF COVERAGE IN ACCORDANCE WITH THE STANDARDIZED BENEFIT DESIGN ESTABLISHED BY THE EXCHANGE;~~

~~(iv) if the carrier participates in the SHOP Exchange and offers any health benefit plan in the small group market outside the SHOP Exchange, offers at least~~

~~one qualified health plan at the silver level and one at the gold level in the small group market outside the SHOP Exchange;~~

~~(v) charges the same premium rate for each qualified health plan regardless of whether the qualified health plan is offered through the Exchange, through an insurance producer outside the Exchange, or directly from a carrier;~~

~~(vi) does not charge any cancellation fees or penalties in violation of § 31-108(d) of this title; and~~

~~(vii) complies with the regulations adopted by the Secretary under § 1311(d) of the Affordable Care Act and by the Exchange under § 31-106(c)(1)(iv) of this title;~~

~~(6) meet the requirements for certification established under the regulations adopted by:~~

~~(i) the Secretary under § 1311(e)(1) of the Affordable Care Act, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance; and~~

~~(ii) the Exchange under § 31-106(c)(1)(iv) of this title;~~

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

~~(8) provide any other benefits as may be required by the Commissioner under any applicable State law or regulation; and~~

~~(9) meet any other requirements established by the Exchange under this title, including:~~

~~(i) transition of care language in contracts as determined appropriate by the Exchange to ensure care continuity and reduce duplication and costs of care;~~

~~(ii) criteria that encourage and support qualified plans in facilitating cross-border enrollment; and~~

~~(iii) demonstrating compliance with the federal Mental Health Parity and Addiction Equity Act of 2008.~~

~~31-117.1.~~

~~(A) THE EXCHANGE SHALL ESTABLISH AND OVERSEE THE IMPLEMENTATION OF A HEALTH CARE ACCESS PROGRAM IN ACCORDANCE WITH § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(B) THE HEALTH CARE ACCESS PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH-RISK INDIVIDUALS ON RATES FOR HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET IN THE STATE, BOTH INSIDE AND OUTSIDE THE EXCHANGE.~~

~~(C) BEGINNING JANUARY 1, 2019, THE HEALTH CARE ACCESS PROGRAM SHALL PROVIDE:~~

~~(1) REINSURANCE TO CARRIERS THAT ISSUE HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET IN THE STATE; AND~~

~~(2) PREMIUM SUBSIDIES TO LOW-TO-MODERATE-INCOME INDIVIDUALS AS AUTHORIZED UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(D) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE, THE HEALTH CARE ACCESS PROGRAM IS CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(E) ON OR BEFORE JANUARY 1, 2019, THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~Article Tax General~~

~~10-102.2.~~

~~(A) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE AND A NONRESIDENT DEPENDENT.~~

~~(B) BEGINNING JANUARY 1, 2019, AN INDIVIDUAL SHALL MAINTAIN FOR THE INDIVIDUAL, AND FOR EACH DEPENDENT OF THE INDIVIDUAL, MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN § 15-1301 OF THE INSURANCE ARTICLE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, AN INDIVIDUAL SHALL PAY A PENALTY IN THE AMOUNT DETERMINED UNDER SUBSECTION (D) OF THIS SECTION IF THE INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR 3 OR MORE MONTHS OF THE TAXABLE YEAR.~~

~~(2) ANY PENALTY IMPOSED UNDER THIS SUBSECTION FOR ANY MONTH IN WHICH AN INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE:~~

~~(I) IN ADDITION TO THE STATE INCOME TAX UNDER § 10-105(A) OF THIS SUBTITLE; AND~~

~~(II) INCLUDED WITH THE STATE INCOME TAX RETURN FOR THE INDIVIDUAL UNDER SUBTITLE 8 OF THIS TITLE FOR THE TAXABLE YEAR THAT INCLUDES THE MONTHS IN WHICH COVERAGE WAS NOT MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.~~

~~(3) IF AN INDIVIDUAL WHO IS SUBJECT TO A PENALTY UNDER THIS SECTION FILES A JOINT STATE INCOME TAX RETURN UNDER § 10-807 OF THIS TITLE, THE INDIVIDUAL AND THE INDIVIDUAL'S SPOUSE SHALL BE JOINTLY LIABLE FOR THE PENALTY.~~

~~(D) THE AMOUNT OF THE PENALTY IMPOSED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE EQUAL TO THE GREATER OF:~~

~~(1) 2.5% OF THE SUM OF THE INDIVIDUAL'S FEDERAL MODIFIED ADJUSTED GROSS INCOME, AS DEFINED IN 42 U.S.C. § 1395R, AND THE FEDERAL MODIFIED ADJUSTED GROSS INCOME OF ALL INDIVIDUALS CLAIMED ON THE INDIVIDUAL'S INCOME TAX RETURN; OR~~

~~(2) THE FOLLOWING FLAT RATES PER INDIVIDUAL, WHICH SHALL BE ADJUSTED ANNUALLY FOR INFLATION:~~

~~(I) \$695 PER ADULT; AND~~

~~(II) \$347.50 PER CHILD UNDER 18 YEARS OLD.~~

~~(E) AN INDIVIDUAL MAY NOT BE ASSESSED A PENALTY UNDER SUBSECTION (C) OF THIS SECTION IF THE INDIVIDUAL QUALIFIES FOR AN EXEMPTION UNDER 26 U.S.C. § 5000A(E).~~

~~(F) AN INDIVIDUAL SHALL INDICATE ON THE INCOME TAX RETURN FOR THE INDIVIDUAL, IN THE FORM REQUIRED BY THE COMPTROLLER, WHETHER MINIMUM ESSENTIAL COVERAGE WAS MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR:~~

~~(1) THE INDIVIDUAL;~~

~~(2) THE INDIVIDUAL'S SPOUSE IN THE CASE OF A MARRIED COUPLE;~~
~~AND~~

~~(3) EACH DEPENDENT CHILD OF THE INDIVIDUAL, IF ANY.~~

~~(G) NOTWITHSTANDING § 2-609 OF THIS ARTICLE AND AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117.1 OF THE INSURANCE ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:~~

~~Article Insurance~~

~~§ 1-102.~~

~~(e) The purposes of the Exchange are to:~~

~~(1) reduce the number of uninsured in the State;~~

~~(2) facilitate the purchase and sale of qualified health plans in the individual market in the State by providing a transparent marketplace;~~

~~(3) assist qualified employers in the State in facilitating the enrollment of their employees in qualified health plans in the small group market in the State and in accessing small business tax credits;~~

~~(4) assist individuals in accessing public programs, premium tax credits, and cost sharing reductions; [and]~~

~~(5) supplement the individual and small group insurance markets outside of the Exchange; AND~~

~~(6) IN CONSULTATION WITH THE COMMISSIONER:~~

~~(i) ON OR BEFORE JULY 1, 2018, SEEK APPROVAL FROM THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES AND THE UNITED STATES SECRETARY OF THE TREASURY OF A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT TO IMPLEMENT INNOVATIONS RELATING TO THE PROVISION OF HEALTH INSURANCE COVERAGE IN THE STATE; AND~~

~~(ii) IF APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, CARRY OUT THE WAIVER, INCLUDING DEVELOPING A~~

~~STANDARDIZED BENEFIT PLAN FOR GOLD LEVEL COVERAGE THAT A CARRIER IS REQUIRED TO OFFER UNDER § 31-115 OF THIS TITLE.~~

~~31-108.~~

~~(H) (1) ON OR BEFORE JULY 1, 2018, THE EXCHANGE SHALL APPLY TO THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES AND TO THE UNITED STATES SECRETARY OF THE TREASURY UNDER § 1332 OF THE AFFORDABLE CARE ACT FOR A WAIVER OF APPLICABLE PROVISIONS OF THE AFFORDABLE CARE ACT RELATING TO HEALTH INSURANCE COVERAGE IN THE STATE FOR A PLAN YEAR BEGINNING ON OR AFTER JANUARY 1, 2019.~~

~~(2) THE EXECUTIVE DIRECTOR, IN CONSULTATION WITH THE COMMISSIONER AND WITH THE APPROVAL OF THE BOARD, MAY IMPLEMENT A STATE PLAN MEETING THE WAIVER REQUIREMENTS:~~

~~(I) IN A MANNER CONSISTENT WITH STATE AND FEDERAL LAW;~~
~~AND~~

~~(II) AS APPROVED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES AND THE UNITED STATES SECRETARY OF THE TREASURY.~~

~~(3) THE EXCHANGE MAY IMPLEMENT ANY FEDERALLY APPROVED WAIVER REQUESTED BY THE EXCHANGE UNDER THIS SUBSECTION.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That, on or before December 31, 2018, the Maryland Insurance Commissioner may waive any notification or other requirements on a carrier under the Insurance Article that apply in calendar year 2018 and that the Commissioner determines cannot reasonably be met due to the carrier's or the State's implementation of a waiver approved under § 1332 of the Affordable Care Act.~~

~~SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect contingent on the receipt by the Maryland Health Benefit Exchange of approval of a waiver under § 1332 of the Patient Protection and Affordable Care Act of applicable provisions of the Patient Protection and Affordable Care Act relating to health insurance coverage in the State by the United States Secretary of Health and Human Services or the United States Secretary of the Treasury. If approval is received on or before July 1, 2023, Section 1 of this Act shall take effect on the date notice of the approval is received by the Department of Legislative Services in accordance with this section. If the Maryland Health Benefit Exchange does not receive approval for the waiver on or before July 1, 2023, Section 1 of this Act, with no further action required by the General Assembly, shall be null and void. The Maryland Health Benefit Exchange, within 5 days after receiving notice of approval or denial of a waiver, shall forward a copy of the notice to the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401.~~

~~SECTION 5. AND BE IT FURTHER ENACTED, That, if Section 1 of this Act becomes null and void under Section 4 of this Act, Section 2 of this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect on the date that Section 1 becomes null and void.~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Chapter 17 of the Acts of 2017

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

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

(c) The Commission consists of the following members:

(6) the following members:

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

(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; AND

(X) ONE REPRESENTATIVE OF A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN THE INDIVIDUAL MARKET, APPOINTED BY THE GOVERNOR.

(g) (1) The Commission shall:

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

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

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

(2) The 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 changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All-Payer Model;

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

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

(H) (1) THE COMMISSION SHALL STUDY AND MAKE RECOMMENDATIONS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE MARKET STABILITY, INCLUDING:

(I) THE COMPONENTS OF ONE OR MORE WAIVERS UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ENSURE MARKET STABILITY THAT MAY BE SUBMITTED BY THE STATE;

(II) WHETHER TO PURSUE A STANDARD PLAN DESIGN THAT LIMITS COST SHARING;

(III) WHETHER TO MERGE THE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS IN THE STATE FOR RATING PURPOSES;

(IV) WHETHER TO PURSUE A BASIC HEALTH PROGRAM;

(V) WHETHER TO PURSUE A MEDICAID BUY-IN PROGRAM FOR THE INDIVIDUAL MARKET;

(VI) WHETHER TO PROVIDE SUBSIDIES THAT SUPPLEMENT PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS DESCRIBED IN § 1402(C) OF THE AFFORDABLE CARE ACT; AND

(VII) WHETHER TO ADOPT A STATE-BASED INDIVIDUAL HEALTH INSURANCE MANDATE AND HOW TO USE PAYMENTS COLLECTED FROM INDIVIDUALS WHO DO NOT MAINTAIN MINIMUM ESSENTIAL COVERAGE, INCLUDING USE OF THE PAYMENTS TO ASSIST INDIVIDUALS IN PURCHASING HEALTH INSURANCE.

(2) THE COMMISSION SHALL ENGAGE AN INDEPENDENT ACTUARIAL FIRM TO ASSIST IN ITS STUDY UNDER THIS SUBSECTION.

(3) THE COMMISSION SHALL INCLUDE ITS FINDINGS AND RECOMMENDATIONS FROM THE STUDY REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (J) OF THIS SECTION.

[(h)](I) The Commission may:

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

(2) convene workgroups to solicit input from stakeholders.

[(i)](J) On or before December 31 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 ~~6~~ 3. AND BE IT FURTHER ENACTED, That, ~~subject to Section 4 of this Act,~~ this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and, ~~except as provided in Section 4 of this Act,~~ shall take effect from the date it is enacted.

Approved by the Governor, April 10, 2018.



Appendix 3

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

December 14, 2018

Delegate Joseline Pena-Melnyk, *Co-Chair*
Senator Brian Feldman, *Co-Chair*
Maryland Health Insurance Coverage Protection Commission
Annapolis, MD 21401

Re: Draft 2018 Report of the Maryland Health Insurance Coverage Protection Commission

Dear Co-Chairs Pena-Melnyk and Feldman:

On behalf of Kaiser Permanente, I want to offer my sincere thanks for your work to date to consider approaches to stabilize the individual health insurance market. As a member of the Maryland Health Insurance Coverage Protection Commission, I appreciate the time and resources that you and your staff have devoted to studying various options that the Maryland legislature may want to consider.

Kaiser Permanente is committed to the individual market and to consumers who do not have access to group coverage. We continue to support Maryland's existing efforts to develop a state-based reinsurance program. We're also hopeful that the Maryland Health Insurance Coverage Protection Commission's work in 2018 will lead to the passage of a state-based individual mandate that provides an option for consumers to pay a penalty or purchase coverage.

As the Maryland Health Insurance Coverage Protection Commission continues its work, Kaiser Permanente offers the following suggestions for future consideration by the Commission in 2019:

LONG-TERM FUNDING SOURCE FOR REINSURANCE

Maryland's reinsurance program will significantly impact Kaiser Permanente and our members. As one of two carriers currently operating in the individual market in Maryland, Kaiser Permanente provides care and coverage to 46 percent of Maryland's on-exchange individual market as of April 2018. We experienced losses of \$117 million in the individual market, or an average loss of 28 percent annually, between 2014 and 2017.¹

As you're aware, the reinsurance program will be funded by a 2.75% state assessment that carriers will be required to pay in 2019. The state assessment is structured to mirror the federal Health Insurance Provider (HIP) fee which was suspended for one year by Congress and the Trump Administration. Under the state assessment, however, Kaiser Permanente is required to pay nearly 3 times more than the 1% assessment that we paid to the federal government for the HIP fee.

¹ This represents Kaiser Permanente's loss on the Individual market from 2014-2016 plus an estimate for 2017.

Kaiser Permanente requests that, in 2019, the Maryland Health Insurance Coverage Protection Commission consider alternative, long-term funding sources for the reinsurance program that are more broad-based and equitable.

INCENTIVE PAYMENTS FOR IMPROVING QUALITY

Kaiser Permanente believes that, beginning in 2020, the state reinsurance program should include an incentive for carriers to align with Maryland's policy goal related to improving health care quality. The state's Medicaid program and the federal Medicare program include incentive payments for both clinical quality and consumer satisfaction. Kaiser Permanente participates in both programs and we believe the use of incentives benefits consumers and is an effective approach to achieving policy goals.

Kaiser Permanente requests that, in 2019, the Maryland Health Insurance Coverage Protection Commission consider approaches to incorporating an incentive payment in the reinsurance program to improve health care quality. The incentive payment should be structured so total funding for the state reinsurance program would not change but would be redistributed to those carriers eligible for reinsurance that meet the quality requirements.

* * *

Thank you for your time and consideration. Please do not hesitate to contact me at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions or require additional information.

Sincerely,

Laurie Kuiper
Senior Director of Government Relations
Kaiser Permanente