



DRAFT Maryland 1332 Waiver Application

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**Maryland Health Benefit Exchange
April 20, 2018**

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Executive Overview

Waiver Request

On behalf of the state of Maryland, the Maryland Health Benefit Exchange (MHBE) respectfully submits this 1332 state innovation waiver application to the United States Department of the Treasury and the United States Department of Health and Human Services. Maryland is requesting to waive Section 1312(c)(1) of the Affordable Care Act (ACA) for a period of five years to implement a state reinsurance program. The waiver would cover plan years 2019 through 2023. The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, which will decrease premiums and federal payment of advance premium tax credits (APTCs). The waiver will not affect any other ACA provisions.

Rationale and Goals of the Reinsurance Program

While Maryland has made great strides in improving access to health care coverage, its individual health insurance market is experiencing some challenges that are jeopardizing affordability and viability. Over recent years, a number of carriers have exited the individual health insurance market, creating less competition in the market and leaving fewer choices for consumers. Only two carriers remain, and only one offers coverage statewide. At the same time, premiums have risen dramatically and are expected to continue to increase without further stabilization efforts. The proposed reinsurance program would help stabilize the market by offsetting the rate impact of high cost claims.

Impact and Operation of the Reinsurance Program

House Bill 1795 was signed into law on April 5, 2018, establishing the Maryland reinsurance program, which will be operated by the MHBE. Total program costs for 2019 are expected to be approximately \$462 million. House Bill 1782, signed into law on April 10, 2018, creates a 2.75 percent assessment on certain health insurance plans and state regulated Medicaid managed care organizations to help fund the reinsurance program; the assessment fee is estimated to collect \$365 million in 2019. Through this waiver application, Maryland is seeking federal pass-through funding through net APTC savings to fund the remainder of the program costs.

The reinsurance program will operate as a traditional, claims-based reinsurance program that will reimburse qualifying health insurers for a percentage of an enrollee's claims between an attachment point and cap. Maryland is proposing a cap of \$250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders during the public comment and hearing processes. The MHBE will establish the payment parameters each year. It is estimated that the reinsurance program will reduce premiums by 30 percent in 2019. Operationally, the MHBE can administer the program with existing resources.

Compliance with Section 1332

Waiver of Section 1312(c)(1) will not affect the comprehensiveness of coverage in Maryland's insurance markets. The reinsurance program will decrease premiums by approximately 30

percent in 2019, making insurance more affordable. In turn, enrollment in the individual market is expected to increase by 5.8 percent in 2019. The decreased premiums will decrease federal spending on APTCs. The actuarial analysis estimates that federal savings will be \$280 million, \$293 million, and \$32 million in 2019, 2020, and 2021, respectively.

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I. Maryland 1332 Waiver Request

Since the enactment of the Affordable Care Act (ACA), the state of Maryland has made great strides in improving access to health care coverage, with the uninsured rate decreasing from 10.2 percent in 2013 to 6.1 percent in 2016.¹ As of January 2018, over 150,000 residents were enrolled in qualified health plans (QHPs) offered through the Maryland Health Benefit Exchange (MHBE), and over 315,000 were enrolled in the ACA Medicaid expansion. With these coverage expansions, hospital uncompensated care has also decreased from 7.2 percent of gross patient revenue in state fiscal year 2013 to 4.6 percent in 2016. This in turn reduced the all-payer costs for uncompensated care built into hospital rates under Maryland's hospital rate-setting system.²³

Prior to the ACA, Maryland's individual health insurance market was underwritten, meaning that insurance carriers could deny coverage to individuals based on health status. At that time, the state operated a high-risk pool—the Maryland Health Insurance Program—that offered coverage to certain individuals who could not otherwise qualify for individual market coverage due to pre-existing health conditions. With the ACA reforms, this program was phased out, and participants could transition into QHPs. To mitigate the premium impact of the uncertainty of the health status of new entrants into the individual market and the transition of high-risk pool enrollees, the ACA created several premium stabilization programs, including the:

- Permanent risk adjustment program
- Temporary risk corridors program
- Temporary reinsurance program

Both of the temporary programs have expired under the terms of the ACA. Maryland also supplemented the federal transitional reinsurance program for plan years 2015 and 2016 by increasing the coinsurance rate. Despite these initial premium stabilization programs, Maryland's individual health insurance market as in other states— is experiencing some challenges that are jeopardizing its affordability and viability.

Over the past several years, a number of carriers have exited the individual health insurance market, creating less competition in the market and leaving fewer choices for consumers. Carrier participation decreased from a high of five in the 2015 and 2016 plan years to only two in 2018. Of the two remaining carriers, only one is statewide, and 13 of Maryland's 24 counties have only one carrier. At the same time, premiums have risen dramatically. Average rates increased by as much as 53.6 percent between 2017 and 2018 alone.⁴ Without further stabilization efforts,

¹ U.S. Census Bureau. Current Population Survey. Retrieved from <https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html>

² Maryland Health Services Cost Review Commission (2016, October). *Report to the Governor: Fiscal Year 2016*. Retrieved from <http://www.hscrc.state.md.us/Documents/pdr/ar/Gov-Report-FY2016-102516.pdf>.

³ Maryland Health Services Cost Review Commission. (2017, April 12). *Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2016*. Retrieved from <http://www.hscrc.state.md.us/Documents/pdr/ar/HSCRC-Disclosure-Report-FY-2016.pdf>.

⁴ Maryland Insurance Administration. (2017, October 25). *Maryland Insurance Administration Approves Amended 2018 Premium Rates for Silver On-Exchange Plans Sold in the Individual Market*. Retrieved from <http://www.mdinsurance.state.md.us/Pages/newscenter/NewsDetails.aspx?NR=2017172>

premiums are expected to continue to increase at an unsustainable rate, raising concerns about the future viability of the market, a loss of access to coverage for consumers, and potential downstream implications for Maryland’s hospital all-payer model.

Therefore, Maryland is requesting to waive Section 1312(c)(1) of the ACA to implement a state reinsurance program. Section 1312(c)(1) states that a “health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.” The waiver would allow Maryland to include expected state reinsurance payments when establishing the market wide index rate. A lower index rate would in turn decrease premiums and decrease the premium subsidy amount that the federal government would have paid for eligible consumers. Maryland is requesting a five-year waiver for plan years 2019 through 2023 to implement a state-operated reinsurance program to stabilize the individual market by making premiums more affordable.

Table 1 below summarizes the potential impact of the waiver program on premiums, enrollment, and net federal savings in 2019, as estimated by the Wakely Consulting Group. It is estimated that the program will reduce premiums by 30 percent, increase non-group market enrollment by 5.8 percent, and generate \$280 million in federal savings.

Table 1. Potential Impact of the Maryland Reinsurance Waiver on 2019 Premiums, Enrollment, and Federal Deficit

	Premium Impact	Non-Group Enrollment	Federal Savings
Effects of Reinsurance	-30.0%	+5.8%	\$280 million

II. Compliance with Section 1332 Guardrails

The actuarial analysis estimated that the proposed waiver program meets all four of the required Section 1332 guardrails in 2019, as well as each subsequent year of the required 10-year window. See Attachment 4 for the full analyses.

Comprehensive Coverage Requirement (1332(b)(1)(A))

The first guardrail for 1332 waivers is that health care benefits must be at least as comprehensive as they would have been without the waiver. The proposed program will have no impact on covered benefits and will not change the essential health benefit benchmark plan or actuarial value requirements. All ACA-compliant plans in the state are required to provide essential health benefits.⁵ The program will have no impact on the scope of benefits in other health insurance markets in the state.

⁵ Ins. Art. § 31-115(b)(1), Ann. Code of MD.

Affordability Requirement (1332(b)(1)(B))

The second guardrail is that health care coverage must be as least as affordable as it would have been without the waiver. The proposed program will decrease premiums by an estimated 30 percent in 2019, and premiums will be lower than or equal to what they otherwise would have been during each subsequent year of the waiver. Coverage and cost sharing protections against excessive out-of-pocket spending will remain the same and within federal requirements. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, the Children’s Health Insurance Program (CHIP), small or large group market insurance, or other types of coverage. Employer contributions and employee wages are not expected to be affected by the waiver.

Scope of Coverage Requirement (1332(b)(1)(C))

The third guardrail is that the state must cover at least a comparable number of people as it would have covered without the waiver. As noted above, the proposed program will reduce individual market premiums in 2019. This lower cost will in turn allow a greater number of consumers to newly purchase or maintain coverage in the individual market than without the waiver. Enrollment is expected to increase by approximately 5.8 percent in 2019. In subsequent years, enrollment is projected to be greater than or equal to what it would have been absent the waiver. Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, small or large group market insurance, or other types of coverage, will have the same access to coverage.

Federal Deficit Requirement (1332(b)(1)(D))

The fourth guardrail is that the waiver program cannot increase the federal deficit. The proposed reinsurance program will reduce individual market premiums in Maryland in 2019, including premiums for the second lowest cost silver plan. As the federal advanced premium tax credit (APTC) is based on the second lowest cost silver plan, the federal government will pay less for APTCs in Maryland than it would have paid without the waiver. The actuarial analysis estimates that the aggregate amount of APTCs will be less than or equal to what the federal government would have paid absent the waiver for each year of the required 10-year budget window. Federal savings are estimated to be \$280 million, \$293 million, and \$32 million in 2019, 2020, and 2021, respectively.

III. Description of the 1332 Waiver Proposal

Enabling Legislation

The Maryland General Assembly passed two bills during the 2018 legislative session related to the establishment of the reinsurance program (see Attachment 1 for full copies of the enabling legislation). The Maryland General Assembly passed HB 1795, *Maryland Health Benefit Exchange-Establishment of a Reinsurance Program*, on March 26, 2018, and Governor Larry Hogan signed the legislation on April 5, 2018. The bill directs the MHBE, in consultation with the Maryland Insurance Administration (MIA), to establish a state reinsurance program for carriers that offer individual market health insurance coverage in Maryland. The goal of the

program is to mitigate the impact of high-risk individuals on premium rates in the individual market. The bill authorizes the MHBE to develop payment parameters for the reinsurance program beginning with the 2019 plan year, including the attachment point, coinsurance rate, and reinsurance cap. The bill authorizes funds for the program from (1) federal pass-through funds under an approved 1332 waiver, (2) any funds designated by the federal government to provide reinsurance to individual market carriers, and (3) any funds designated by the state. Finally, the bill requires the MHBE to apply for a federal 1332 waiver to carry out the program, and implementation is contingent upon federal approval of this waiver. The bill grants the MHBE the authority to adopt regulations to implement the program. On April 16, 2018, the MHBE Board of Trustees voted to approve a state reinsurance program for 2019 with an attachment point that will be determined based on funding availability and consideration of stakeholder feedback, a coinsurance rate of 80 percent, and a cap of \$250,000.

The second bill, HB 1782, *Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018)*, was passed on April 5, 2018 and signed by Governor Hogan on April 10, 2018. It creates a health plan assessment for the 2019 plan year to help fund the reinsurance program. Section 9010 of the ACA created a federal health insurance provider fee for covered entities engaged in the business of providing health insurance. The fee is based on the entity's net premiums for the year and was intended to help fund exchanges. The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019.⁶ HB 1782 applies a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state, and essentially allows the state to collect certain funds that the federal government would have collected under Section 9010.

Program Features

Maryland is proposing to use a traditional, claims-based reinsurance program that would help pay claims associated with high-cost participants. The program will reimburse individual market carriers for a percentage of the costs (coinsurance rate) for participants with annual claims costs exceeding a specified threshold (attachment point) and up to specified ceiling (reinsurance cap). Based on estimated funding and costs of the program, Maryland is proposing a reinsurance program with a cap of \$250,000 and a coinsurance rate of 80 percent for the 2019 plan year. The attachment point will be determined after further analyses and in consultation with stakeholders during the public comment and hearing processes. This will allow active stakeholder engagement and reflect the latest data available so that estimated reinsurance payments match the funding available. If the 2019 experience is more expensive than predicted, the MHBE may adjust these payment parameters. On the other hand, if the 2019 experience is less expensive than predicted, the MHBE may reserve the funds for future years. The program's authorizing legislation grants the MHBE the authority to establish the payment parameters each year.

Funding Mechanism

Total program costs for 2019 are expected to be about \$462 million. Through this waiver application, Maryland requests federal pass-through funding through net APTC savings. The

⁶ H.R. 195, 115th Cong. § 4003 (2017) (enacted).

remaining program costs will be funded through the state health insurance assessment described above, which is estimated to collect \$365 million.

IV. Waiver Implementation Timeline

The MHBE will implement and operate the reinsurance program. The MHBE will receive the federal pass-through and state funds, collect and review reinsurance claims from carriers, and make payments to carriers for eligible claims. The MHBE already has experience with this process, as it implemented a state supplemental reinsurance program that wrapped around the federal transitional reinsurance program for the 2015 and 2016 plan years. The MHBE proposes the following draft implementation timeline for the initial years of the program.

Table 2. Draft Implementation Timeline

Date	Milestone
March 1, 2018	Individual market carrier form filing deadline with the MIA for the 2019 plan year.
April 5, 2018	Reinsurance program is signed into law.
April 16, 2018	MHBE Board votes
April 20, 2018	Waiver application is released for public comment. Although there are no federally-recognized tribes in the state, state-recognized tribes are encouraged to participate.
April 26, 2018	Public hearing is held on the Eastern Shore
May 1, 2018	Individual market carrier rate filing deadline with the MIA for the 2019 plan year.
May 3, 2018	Public hearing is held in Central Maryland
May 7, 2018	Public hearing is held in Western Maryland
May 10, 2018	Public hearing is held in Southern Maryland
May 18, 2018	Public comment period closes.
May 22, 2018	Incorporate public comment and submit waiver application to the federal government.
July 6, 2018	Application deemed complete by the federal government. Federal approval period begins.
July 2018	MHBE begins state regulations promulgation process.
August 6, 2018	Desired federal approval date.
August 2018	MIA approves rates for the 2019 plan year.
October 1, 2018	MHBE certifies QHPs for the 2019 plan year.
November 1, 2018	Open enrollment begins.
January 1, 2019	State regulations to operate the program become effective, final date program parameters for 2019 are determined.
March 1, 2019	Individual market carrier form filing deadline with the MIA for the 2020 plan year.
March 15, 2019	Premium assessment collection by the Maryland Insurance Administration.
April 15, 2019	MHBE submits quarterly report to the federal government.
May 1, 2019	Individual market carrier rate filing deadline with the MIA for the 2020 plan year.
June 2019	MHBE holds required 6-month public forum.
July 15, 2019	MHBE submits quarterly report to the federal government.
August 2019	MIA approves rates for the 2020 plan year.
October 1, 2019	MHBE certifies QHPs for the 2020 plan year.

Date	Milestone
October 15, 2019	MHBE submits quarterly report to the federal government.
December 31, 2019	Premium assessment funds transferred to Maryland Health Benefit Exchange no later than the indicated date.
January 15, 2020	MHBE submits quarterly report to the federal government.
March 1, 2020	Individual market carrier form filing deadline with the MIA for the 2021 plan year.
April 1, 2020	MHBE submits first annual report to the federal government.
April 15, 2020	MHBE submits quarterly report to the federal government.
June 1, 2020	Individual market carrier rate filing deadline with the MIA for the 2021 plan year. Carriers submit 2019 claims to MHBE for reimbursement.
June 2020	MHBE holds required annual public forum.
July 15, 2020	MHBE submits quarterly report to the federal government.
August 2020	MIA approves rates for the 2021 plan year.
October 1, 2020	MHBE certifies QHPs for the 2021 plan year.
October 15, 2020	MHBE submits quarterly report to the federal government.
December 31, 2020	MHBE reimburses carriers for eligible 2019 claims.

V. Actuarial and Economic Analysis

The State of Maryland Department of Legislative Services (DLS), through Bolton Partners, retained the Wakely Consulting Group, LLC (Wakely). Through a Memorandum of Understanding with DLS, MHBE has engaged with Wakely to address the actuarial analysis, actuarial certifications, economic analysis, data, and assumptions requirements for a 1332 waiver. Wakely collected 2016, 2017, and emerging 2018 data directly from Maryland insurers to develop the base data for the analyses. See Attachment 4 for Wakely’s full report.

VI. Additional Information

Administrative Burden

This waiver program will pose a minor administrative burden to the federal government and to the state. Within the federal government, staff from the Department of the Treasury and the Centers for Medicare & Medicaid Services (CMS) will have the increased burden of:

- Reviewing and approving the waiver application
- Determining and transferring pass-through funds to the state
- Reviewing state reports, including the required quarterly and annual reports
- Periodically evaluating the program
- Reviewing any documented complaints related to the waiver that may arise

The waiver will not affect the calculation or payment of APTCs.

Within Maryland, the waiver program will have no administrative impact on employers or consumers, and consumers will continue to shop for and purchase plans through the same vehicles as available now. The program will have a small administrative impact on individual market insurance carriers in terms of identifying and submitting documentation of reinsurance claims for reimbursement. These carriers, however, have previously implemented these processes under the federal transitional and Maryland supplemental reinsurance programs, and the financial benefit of reinsurance payments will far outweigh these administrative costs.

Finally, the waiver program will have a minor impact on state agency burden. The MHBE will be responsible for administering the program, including administering funds, reviewing and collecting claims information from carriers, paying carriers for eligible claims, ongoing program monitoring, and complying with federal reporting and public comment requirements. The MHBE can assume these tasks with existing resources. The MHBE previously administered a state supplemental reinsurance program for the 2015 and 2016 plan years and can leverage and build upon these pre-existing resources. The MIA may have minor increased burden related to reviewing and approving carrier rate filings, and state health insurance premium tax collection but this can also be absorbed by current staff resources.

Impact on Other ACA Provisions

The program will have no impact on other provisions of the ACA.

Impact on Access to Out-of-State Services

Maryland shares borders with Virginia; West Virginia; Washington, D.C.; Pennsylvania; and Delaware. Of the two carriers in Maryland's individual insurance market, one offers coverage statewide, and the other offers coverage in 11 of 24 counties. Both carriers' networks contain providers in border states. This waiver will not affect provider networks or access to services out-of-state.

Compliance, Fraud, Waste, and Abuse

The MIA is responsible for regulating and monitoring the solvency of individual market insurance carriers and performing market conduct analysis, examinations, and investigations. The MHBE is responsible for certifying individual market QHPs for participation on the exchange. The MIA and MHBE will continue these existing processes under the waiver program.

The MHBE has a robust compliance program and will administer the reinsurance program in accordance with its existing compliance and auditing procedures. The Maryland Office of Legislative Audits conducts a financial audit of the MHBE every three years, and per ACA requirements, the MHBE contracts with an independent, external auditor each year to audit financial and program activities. As a state-based exchange, the MHBE is also subject to audits by the U.S. Government Accountability Office, CMS, and the Internal Revenue Service. The MHBE also maintains internal and external stakeholder hotlines for reporting of fraud, waste, and abuse concerns.

The federal government is responsible for calculating the savings resulting from this waiver and for ensuring that this waiver does not increase federal spending.

VII. State Reporting Requirements and Targets

The MHBE will comply with the quarterly and annual waiver reporting requirements as defined in 45 CFR §155.1324. States must submit quarterly reports in accordance with the terms and conditions specified in the waiver. These reports must include, but are not limited to reports of any ongoing operational challenges and plans for/results of associated corrective actions. Unless otherwise specified in the waiver approval, the MHBE will submit its first quarterly report in April 2019.

States must also submit an annual report that documents the following:

- The progress of the waiver
- Data on compliance with the four Section 1332 guardrails, similar to the data presented in Attachment 4
- A summary of the required annual post-award public forum, including all public comments received on the progress of the waiver and action taken in response to such concerns or comments
- Other information as required by the terms and conditions of the waiver
- The premium for the second lowest cost silver plan under the waiver and an estimate of what the premium would have been without the waiver for a representative consumer in each rating area

The annual report is due no later than 90 days after the end of each waiver year, or as otherwise specified in the terms and conditions. The MHBE will submit its first annual report by April 1, 2020, unless otherwise specified. The MHBE is committed to ensuring that the quarterly and annual reports will conform to the measures and formats to be specified by CMS.

VIII. Public Comments and Tribal Consultations

Public Comments

The MHBE opened the public comment process for this waiver application on April 20, 2018, by posting notice of the opportunity to comment on the agency's website at marylandhbe.com/policy-legislation/public-comment/1332-waiver. In addition, the MHBE sent an email notice to its stakeholder distribution list. The email notification is included as Attachment 2.

Public Hearings

The MHBE will conduct four public hearings across the state to obtain stakeholder input:

1. On the Eastern Shore, the MHBE will conduct a public hearing on April 26, 2018 in the Chesapeake Room at the Talbot County Department of Parks and Recreation located at 10028 Ocean Gateway, Easton, MD 21601.
2. Within central Maryland, the MHBE will conduct a public hearing on May 3, 2018 in the Training room at the Maryland Health Benefit Exchange, located at 750 E Pratt Street in Baltimore, Maryland 21202.
3. Within Western Maryland, the MHBE will conduct a public hearing on May 7, 2018, at the Frederick County Health Department, located at 350 Montevue Ln., Frederick, MD 21702.
4. Within Southern Maryland, the MHBE will conduct a public hearing on May 10, 2018 at the Charles County Health Department, located at 4545 Crain Highway, White Plains, MD 20695.

See Attachment 3 for the details of each hearing.

Tribal Consultation

Maryland does not have any federally-recognized tribes and is thus exempt from the 1332 waiver requirement to consult with federal-recognized tribes. However, the MHBE encouraged Maryland-recognized tribes to participate in the state public comment process. See the notification language in Attachment 2 for more details.

Attachments

1. Enabling Legislation
2. Public Comment Process
3. Public Hearing Process
4. Actuarial and Economic Analysis

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Attachment 1. Enabling Legislation

- For HB 1795, Maryland Health Benefit Exchange-Establishment of a Reinsurance Program, see http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_6_hb1795T.pdf
- For HB 1782, Health Insurance-Individual Market Stabilization (Maryland Health Care Access Act of 2018), see http://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_37_hb1782E.pdf

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Chapter 6

(House Bill 1795)

AN ACT concerning

Maryland Health Benefit Exchange – Establishment of a Reinsurance Program

FOR the purpose of repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the prohibition on the Exchange's assuming responsibility for the program corridors for health benefit plans in certain exchanges established under certain provisions of the Affordable Care Act; repealing the requirement that the Exchange operate or oversee the operation of a transitional reinsurance program in accordance with certain regulations for certain coverage years; repealing the requirement that the Exchange operate or oversee the operation of a certain risk adjustment program; repealing the requirement that the Exchange, beginning in a certain year, strongly consider using a certain model for a certain purpose; altering the purposes of the Maryland Health Benefit Exchange Fund; altering the contents of the ~~Maryland Health Benefit Exchange~~ Fund; providing that certain funds may be used only for the purposes of the State Reinsurance Program; requiring, rather than authorizing, the Exchange, in consultation with the Maryland Insurance Commission and as approved by the Maryland Health Benefit Exchange Board, to establish and implement a State Reinsurance Program to provide reinsurance to certain carriers and that meets certain requirements and is consistent with certain laws; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; requiring the Exchange, in consultation with the Commissioner and as approved by the Board and based on available funds, to establish certain parameters for reinsurance in certain years; authorizing the Exchange, in consultation with the Commissioner and as approved by the Board, to alter the parameters under certain circumstances; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made ~~from certain sources by using certain funds; requiring that, beginning on a certain date and under certain circumstances, certain State funding~~ the implementation of the Program for the reinsurance of the individual market ~~through the Program~~ be contingent on the ~~Centers for Medicare and Medicaid Services'~~ U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury approving a waiver application under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; ~~authorizing~~ requiring the Exchange ~~and the Maryland Insurance~~, in consultation with the Commissioner and as approved by the Board, to submit a waiver and seek certain funding under certain provisions of federal law as soon as practicable but not later than a certain date; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; making this Act an emergency measure; and generally relating to the establishment of a reinsurance program by the Maryland Health Benefit Exchange.

BY repealing

Article – Insurance
 Section 31–117
 Annotated Code of Maryland
 (2017 Replacement Volume)

BY repealing and reenacting, with amendments,

Article – Insurance
Section 31–107
Annotated Code of Maryland
(2017 Replacement Volume)

BY adding to

Article – Insurance
 Section 31–117 and 31–117.1
 Annotated Code of Maryland
 (2017 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 31–117 of Article – Insurance of the Annotated Code of Maryland be repealed.

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

Article – Insurance

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.

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

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

[(6) (5) 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) (6) money donated to the Fund;

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

(8) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(9) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

(10) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

[(9) (11) 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].

(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the State Reinsurance 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.]

(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF FUNDING THE STATE REINSURANCE PROGRAM:

(I) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(II) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

(III) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:

(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or

(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.

(2) Notwithstanding § 7–304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6–103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.

(3) If operating expenses of the Exchange may be charged to either State or non–State fund sources, the non–State funds shall be charged before State funds are charged.

(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.

(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

31–117.

(A) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH AND IMPLEMENT A STATE REINSURANCE PROGRAM;

(1) TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

(2) THAT MEETS THE REQUIREMENTS OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT; AND

(3) THAT IS CONSISTENT WITH STATE AND FEDERAL LAW.

(B) THE STATE REINSURANCE PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH–RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.

(C) (1) BASED ON AVAILABLE FUNDS, THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL ESTABLISH REINSURANCE PAYMENT PARAMETERS FOR CALENDAR YEAR 2019 AND EACH SUBSEQUENT CALENDAR YEAR THAT INCLUDE:

- (I) AN ATTACHMENT POINT;
- (II) A COINSURANCE RATE; AND
- (III) A COINSURANCE CAP.

(2) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, MAY ALTER THE PARAMETERS ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION AS NECESSARY TO SECURE FEDERAL APPROVAL FOR A WAIVER SUBMITTED IN ACCORDANCE WITH § 31-117.1(A) OF THIS TITLE.

~~(c)~~ (D) BEGINNING JANUARY 1, 2019, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE STATE REINSURANCE PROGRAM MAY BE MADE FROM BY USING:

- ~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~
- ~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

(1) ANY PASS-THROUGH FUNDS RECEIVED FROM THE FEDERAL GOVERNMENT UNDER A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT;

(2) ANY FUNDS DESIGNATED BY THE FEDERAL GOVERNMENT TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE; AND

(3) ANY FUNDS DESIGNATED BY THE STATE TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

~~(D)~~ (E) BEGINNING JANUARY 1, 2019, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING THE IMPLEMENTATION OF A STATE REINSURANCE PROGRAM FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE STATE REINSURANCE PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES' APPROVING A WAIVER APPROVAL FROM THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND THE U.S. SECRETARY OF THE TREASURY OF A STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT.

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

31-117.1.

(A) ~~THE AS SOON AS PRACTICABLE BUT NOT LATER THAN JULY 1, 2018, THE EXCHANGE AND THE COMMISSIONER MAY, IN CONSULTATION WITH THE COMMISSIONER AND AS APPROVED BY THE BOARD, SHALL SUBMIT A WAIVER STATE INNOVATION WAIVER APPLICATION UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ESTABLISH A PROGRAM FOR REINSURANCE AND SEEK FEDERAL PASS-THROUGH FUNDING UNDER § 26B OF THE INTERNAL REVENUE CODE AND § 1402 OF THE AFFORDABLE CARE ACT.~~

(B) ON OR BEFORE DECEMBER 31, 2018, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2018 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.

SECTION 3. AND BE IT FURTHER ENACTED, That 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 shall take effect from the date it is enacted.

Approved by the Governor, April 5, 2018.

Chapter 37

(House Bill 1782)

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 the State Health Services Cost Review Commission, for a certain fiscal year, to assess on each hospital a certain fee for a certain purpose; prohibiting the State Health Services Cost Review Commission from raising certain hospital rates as part of a certain update factor to offset the fee; prohibiting the fee from exceeding a certain percentage of certain revenue; requiring each hospital to remit the fee to the Maryland Health Benefit Exchange Fund; requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; requiring the assessment to be in addition to certain taxes and certain penalties or actions; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to pay, in a certain calendar year, a certain additional assessment for a certain purpose; providing for the distribution of the assessments; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; requiring that certain funds be used in a certain manner; repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the authority of the Exchange to establish a State Reinsurance Program; requiring the Exchange to establish a Health Care Access Program to provide reinsurance to certain carriers; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made from certain sources; requiring that, beginning on a certain date and under certain circumstances, certain State funding for the reinsurance of the individual market through the Program be 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; authorizing the Exchange and the Maryland Insurance Commissioner to submit a waiver under a certain provision of federal law in accordance with the recommendations of the Maryland Health Insurance Coverage Protection Commission; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; 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; defining certain terms; repealing certain provisions of law rendered obsolete by certain provisions of this Act; requiring the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group market stability; requiring the Maryland Health Insurance Coverage Protection Commission to engage an independent actuarial firm to assist in its study; requiring the Maryland Health Insurance Coverage Protection Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly 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 repealing and reenacting, with amendments,
Article – Health – General
Section 19–214(d)
Annotated Code of Maryland
(2015 Replacement Volume and 2017 Supplement)~~

BY adding to
Article – Insurance
Section 6–102.1, ~~6–102.2, 31–117, and 31–117.1~~
Annotated Code of Maryland
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section ~~31–107~~ 15–1202 and 15–1301(s)
Annotated Code of Maryland
(2017 Replacement Volume)

~~BY repealing~~

~~Article — Insurance
Section 31 — 117
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 ~~(xi)~~ and (h)

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

~~Article — Health — General~~

~~19 — 214.~~

~~(d) (1) Each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.~~

~~(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.~~

~~2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15 — 701 of this article.~~

~~(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.~~

~~(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.~~

~~(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.~~

~~(4) (i) IN ADDITION TO THE RATES IMPOSED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND SUBJECT TO SUBPARAGRAPHS (ii) AND (iii) OF THIS PARAGRAPH, FOR FISCAL YEAR 2019, THE COMMISSION SHALL ASSESS A UNIFORM, BROAD BASED AND REASONABLE FEE ON EACH HOSPITAL FOR THE PURPOSE OF SUPPORTING THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~(ii) THE COMMISSION MAY NOT RAISE HOSPITAL RATES AS PART OF THE ANNUAL UPDATE FACTOR FOR FISCAL YEAR 2019 TO OFFSET THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH.~~

~~(iii) THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH MAY NOT EXCEED 0.5% OF EACH HOSPITAL'S NET PATIENT REVENUE.~~

~~(iv) EACH HOSPITAL SHALL REMIT THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THE INSURANCE ARTICLE.~~

Article - Insurance

6-102.1.

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

~~(2) "CARRIER" HAS THE MEANING STATED IN § 15-1201 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 SECTION 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 OF THIS ARTICLE.~~

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

~~(1) TAXES OWED BY THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) ANY PENALTIES IMPOSED OR ACTIONS TAKEN BY THE COMMISSIONER IN RESPONSE TO THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

~~6-102.2.~~

(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] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(2) The operation and administration of the Exchange and the [State Reinsurance Program] HEALTH CARE ACCESS 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) ASSESSMENTS COLLECTED BY THE COMMISSIONER UNDER §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(5) ASSESSMENTS REMITTED IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(6) PENALTIES COLLECTED BY THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~[(4)] (7) income from investments made on behalf of the Fund;~~

~~[(5)] (8) interest on deposits or investments of money in the Fund;~~

~~[(6)] (9) 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)] (10) money donated to the Fund;~~

~~[(8)] (11) money awarded to the Fund through grants; 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] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the [State Reinsurance Program] 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.]~~

~~(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) ASSESSMENTS DISTRIBUTED TO THE FUND IN ACCORDANCE WITH §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(II) ASSESSMENTS REMITTED TO THE FUND IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(III) PENALTIES DISTRIBUTED TO THE FUND IN ACCORDANCE WITH § 10-102.2 OF THE TAX GENERAL ARTICLE; AND~~

~~(IV) ANY FUNDS THAT THE STATE RECEIVES FROM THE FEDERAL GOVERNMENT UNDER ANY FEDERALLY SPONSORED OR DEVELOPED PROGRAM TO PROMOTE OR ENHANCE STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.~~

~~(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:~~

~~(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or~~

~~(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.~~

~~(2) Notwithstanding § 7-304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6-103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the~~

~~premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.~~

~~(3) If operating expenses of the Exchange may be charged to either State or non-State fund sources, the non-State funds shall be charged before State funds are charged.~~

~~(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.~~

~~(2) Any investment earnings of the Fund shall be credited to the Fund.~~

~~(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.~~

~~(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.~~

~~§ 31-117.~~

~~(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state-specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.~~

~~(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.~~

~~(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.~~

~~(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high-risk individuals.~~

~~(3) (i) The Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, may establish a State Reinsurance Program to take effect on or after January 1, 2014.~~

~~(ii) The purpose of the State Reinsurance Program is to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the Exchange.~~

~~(iii) The Exchange shall use funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, to fund the State Reinsurance Program.~~

~~(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:~~

~~(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;~~

~~(ii) increase the incentive for carriers to enhance the quality and cost-effectiveness of their enrollees' health care services; and~~

~~(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high-risk individuals.~~

~~(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.]~~

~~31-117.~~

~~(A) THE EXCHANGE SHALL ESTABLISH A HEALTH CARE ACCESS PROGRAM TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.~~

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

~~(C) BEGINNING JANUARY 1, 2020, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM MAY BE MADE FROM:~~

~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~

~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

~~(D) BEGINNING JANUARY 1, 2020, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(E) THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~31-117.1.~~

~~(A) THE EXCHANGE AND THE COMMISSIONER MAY SUBMIT A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION ESTABLISHED UNDER CHAPTER 17 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2017.~~

~~(B) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2019 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~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, 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, 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 OF THE INSURANCE ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) (1) The Maryland Health Insurance Coverage Protection Commission, established under Chapter 17 of the Acts of the General Assembly of 2017, shall study and make recommendations for individual and group health insurance market stability, including:~~

~~(i) the components of a waiver under § 1332 of the Affordable Care Act to ensure market stability;~~

~~(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; and~~

~~(v) whether to pursue a Medicaid buy-in program for the individual market.~~

~~(2) The Maryland Health Insurance Coverage Protection Commission shall engage an independent actuarial firm to assist in its study under this subsection.~~

~~(b) On or before October 1, 2018, the Maryland Health Insurance Coverage Protection Commission shall issue a report on its findings and recommendations, including any legislative proposals, under subsection (a) of this section to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange shall adopt the regulations required under § 31-117 of the Insurance Article, as enacted by Section 1 of this Act, on or before January 1, 2019.~~

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; AND

~~(XI) ONE REPRESENTATIVE OF THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, TO BE APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE.~~

(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 ~~4~~ 3. AND BE IT FURTHER ENACTED, That 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 shall take effect from the date it is enacted.

Approved by the Governor, April 10, 2018.

Attachment 2. Public Comment Process

To be completed after the public comment period closes.

DRAFT

Attachment 3. Public Hearing Process

To be completed after the public hearings are conducted.

DRAFT

Attachment 4. Actuarial and Economic Analysis Report

DRAFT



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State of Maryland

Section 1332 State Innovation Waiver Actuarial and Economic Analysis

DRAFT

April 13, 2018

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Introduction

The individual health insurance market in the state of Maryland (“Maryland”) has shown symptoms of destabilization in recent years. For example, the state experienced rate increases in excess of 40% in 2018. In order to mitigate further potential destabilization, Maryland is submitting a Section 1332 State Innovation Waiver (“1332 waiver” or “waiver”). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Maryland’s 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four “guard rails”. The four guard rails are defined as:

1. Coverage (there must be at least a comparable number of individuals with coverage under the waiver);
2. Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);
3. Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and
4. Deficit neutrality (the waiver should not increase the federal deficit).

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2019. The reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at \$250,000, and coinsurance rate at 80%, and the attachment point will be solved for but is currently estimated to be around \$20,000.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, an assessment equal to 2.75% of 2019 premiums and Federal pass-through dollars. Reinsurance funding for the 2019 benefit year is not to exceed approximately \$462 million for the 2019 plan year.

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one insurer as well as to lower premiums for the individual market in total (as most of the reinsurance funding will come from sources outside the individual market). In doing so, the reinsurance program would incentivize enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to residents of Maryland, the

reinsurance program would also reduce federal outlays through lower premium tax credits.

As part of its 1332 waiver, Maryland is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Maryland’s reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Advance Premium Tax Credits (APTCs) Marylanders receive over the next ten years. APTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of APTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in APTCs will also be reduced.

This report demonstrates that the savings on aggregate APTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather would improve Marylanders access to affordable and comprehensive coverage. The waiver requests that Maryland receive the amount of federal savings from APTCs, net of other costs, as a result of the reinsurance program.

The state of Maryland retained Wakely Consulting Group, LLC (Wakely), through Bolton Partners, to analyze the potential effects of a state-based reinsurance program on the 2019 individual Affordable Care Act (ACA) market. This document has been prepared for the sole use of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Maryland’s 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Some exhibits required by checklist (such as the estimate change in second lowest-cost silver by rating area) will be included in the final waiver application. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

Analysis Results

As described previously, the four guard rails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely’s analysis estimated that the waiver meets each of the four guard rails not only in 2019 but in each subsequent year over the 10-year window. The high-level 2019 guard rail results are shown in Table 1.

Table 1: 2019 High-Level Guard Rail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2019)	Relative premium decrease of 28.5% to 34.6%
Comprehensiveness	No change to EHBs
Deficit Neutrality (2019)	Federal savings between \$262 million and \$347 million

Also, there are no additions to the Federal deficit for each year of the 10-year window.

Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from Congressional Budget Office (CBO)⁷ as the Council of Economic Advisors⁸ has noted that premium decreases should result in enrollment increases. As the reinsurance program has no impact on other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

Deficit Impact

The following tables display the impact of the reinsurance program on Maryland’s individual market both for 2019 and for the 10-year budget window. Based on the best estimate assumptions, in 2019, the waiver reduces premiums by -30.0%⁹, increases non-group enrollment by 5.8%, and creates \$280 million in federal savings (which incorporates APTC savings net of other federal revenue). Based on the assumption for 2019 premium increases prior to reinsurance and the premium impact as a result of reinsurance, net 2019 premiums are expected to change, relative to 2018, by -16.0%. These results are shown in Table 2. The results are similar for years 2020 to 2028 as is shown in Appendix C.

Table 2: 2019 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premium Impact	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-30.0%	+5.8%	\$280 Million

⁷ <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf>

⁸ https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

⁹ The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2019. They do not show 2019 premium changes relative to 2018.

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in Table 3¹⁰.

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit (\$ millions)
Difference in APTCs	\$614
Difference in Mandate Penalty	\$0
Difference in User Fees	\$0
Difference in HIT	-\$9
Estimated Net Federal Savings	\$605

Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Maryland’s individual market both for 2019 and for the 10-year deficit window.

1. Wakely’s model incorporates 2016, 2017, and emerging 2018 experience as base data, which was provided by Maryland insurers.

Wakely sent a data call to all Maryland insurers that offered individual market ACA-compliant plans in 2016, 2017, or 2018. The data call requested full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates. The 2017 premiums and enrollment were summarized to create a baseline picture of Maryland’s market. The 2018 enrollment, APTC, and premium data were adjusted to account for expected attrition to estimate average enrollment. The summarized amounts are shown in Table 4.

¹⁰ Issuers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as percent of Exchange premium. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. There is a moratorium on the fee in 2019. Individual mandate penalties were set to \$0 effective for the 2019 benefit year.

Table 4: 2017 to 2019 Baseline Average Enrollment and Premium Data / Estimates

Baseline	2017	2018	2019
Average Annual Enrollment			
Total Non-Group Enrollment	224,921	190,607	171,526
Exchange Enrollment	130,409	129,047	121,503
APTC Enrollment	99,523	107,039	103,620
Non-APTC Exchange Enrollment	30,886	22,008	17,883
Off-Exchange Enrollment	94,512	61,559	50,023
Total Non-APTC Enrollment	125,398	83,567	67,906
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	\$419.37	\$604.50	\$725.66
Exchange Premium PMPM	\$439.36	\$633.10	\$759.98
Gross Premiums PMPM for APTC Members	\$463.86	\$658.36	\$750.80
Net Premiums PMPM for APTC Members	\$147.14	\$125.57	\$126.83
APTC PMPM	\$316.72	\$532.79	\$623.97
Total Annual Dollars			
Total Non-Group Premiums	\$1,131,897,734	\$1,382,661,373	\$1,493,625,346
Total APTCs	\$378,248,946	\$684,354,798	\$775,866,854

2. The 2019 enrollment, premium, and APTC amounts were estimated using 2017 and February 2018 insurer information submitted to Wakely, as well as 2017 data from the Center for Medicaid and Medicare Services (CMS).
 - a. The state average premium was based on the February 2018 insurer information. The 2018 average premiums were increased by the average estimated 2019 rate increase, which includes increases to account for trend, mix changes, market morbidity changes, lower premiums due to the delay in the health insurance tax (also known as the health provider fee or the HIT), the assessment to fund reinsurance, and an overall uncertainty factor. Further details are included in Appendix A.
 - b. To estimate the average 2019 APTC amounts, Wakely used the emerging 2018 APTC information from Maryland Health Exchange including APTC

amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We then inflated gross premiums for APTC enrollees by the estimated 2019 premium increase, but then reduced the amounts by 5% to account for slower growth in the second-lowest cost silver relative to overall premiums, to account for potential competitive pressures. Net premiums were increased by 1% from 2018 to 2019 as an approximation for APTC indexing. The 2019 average gross premium is then reduced by the 2019 average net premium (since enrollees’ share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts.

- c. The 2019 individual market enrollment was calculated using 2017 and 2018 data from Maryland insurers. The data was compared to CMS reports to confirm consistency. It was adjusted to account for changes in enrollment due to net attrition throughout 2018 and expected 2019 premium changes, as discussed in Appendix A. APTC enrollment was increased 1% to account for continued up-take of those that are eligible for subsidies but have not yet enrolled.
 - d. Finally, to account for the effective repeal of the individual mandate, enrollment was decreased 10%. This amount aligns with recent survey work by the Kaiser Family Foundation¹¹. The proration of how this decrease affected subsidized versus unsubsidized enrollees was calculated using Maryland specific enrollment data. The resulting increase in morbidity was included in the premium estimates. The estimated 2019 information is shown in Table 5.
3. To estimate the effects of the reinsurance program, Wakely assumed that \$462 million dollars would be spent to reduce premiums in 2019. None of the funds were assumed to cover administrative costs for Maryland to operate the program. The best estimate assumptions resulted in a reduction in premiums of 30.0% due to the reinsurance program and a resulting change in morbidity.

Table 5: Projected 2019 Average Enrollment and Premium Amounts, After Reinsurance

After Reinsurance	
Reinsurance Funding	\$462,000,000
Reduction in Premiums (Reinsurance Funding)	-30.9%

¹¹ <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

After Reinsurance	
Reinsurance Assessment	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%
Total Non-Group Premium PMPM	\$508.03
Exchange Premium PMPM	\$532.07
APTC PMPM	\$398.81
Change in Total Non-Group Enrollment	5.8%
Total Non-Group Enrollment	181,522
Exchange Enrollment	124,136
APTC Enrollment	103,620
Total Premiums	\$1,106,629,629
Total APTCs	\$495,892,132

2. Enrollment was re-estimated with the lower post-reinsurance premium, using Maryland specific data, input from Maryland’s Insurance Administration, and an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a revised individual market average enrollment. The initial enrollment change is estimated to be 5.6%.
3. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.
 - a. Multiple studies, such as a health reform study from Massachusetts,¹² indicated that enrollees who leave the market have lower costs relative to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program.
 - b. The result is an additional 1.4% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program. Applying the additional 1.4% reduction to the 30.9% reduction in premiums (from the \$462 million in reinsurance funding), and the 2.75% assessment, results in an overall premium

¹²[https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_c
ea_issue_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_c
ea_issue_brief.pdf)

reduction estimate of 30.0% (under the best estimate scenario). The results of the best estimate can be seen in Table 5.

- a. After adjusting the premium impact by the assessment and morbidity impact, Wakely again applied the enrollment function (described in item 4). It resulted in an additional 0.2% increase in enrollment, causing the total enrollment growth from the baseline to be 5.8%. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of this iteration.
4. The following were the assumptions incorporated for the 10-year estimates:
- c. Premiums were trended using National Health Expenditure Data from CMS¹³. In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.
 - d. In 2020, the individual market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function comparing 2020 premiums to 2019 premiums. Similarly, the 2020 premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase 0.5% to account for further take-up of those eligible for subsidies but have not yet take up coverage. In years 2021 and beyond, total enrollment was decreased each year by the expected effects of premium increases as calculated by the CEA take-up function, and the corresponding worsening morbidity was incorporated into the premiums.
 - e. Reinsurance total funding amounts are \$459.0 million in 2020 and \$49.4 million in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond, no reinsurance funds are estimated to be expended. To the extent unexpected funds become available, they would be used in 2022 and/or 2023 (the fourth and fifth years of the program).

The results of these assumptions, such as enrollment (both in total and various distributions), and impact on the federal deficit are discussed in Appendix A and

¹³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/> - Table 17. Premiums were trended by spending per enrollee for direct purchase.

Appendix C. For the final report, we will include the effects of the waiver on the SLCSP by rating area and on enrollment by FPL.

Scenario Testing

Wakely performed scenario testing which primarily involved changing the enrollment and premium assumptions for 2019. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis.

We tested for a scenario (Scenario 2) in which the effective repeal of the individual mandate had a larger impact (which resulted in less enrollment and higher premiums) and a scenario (Scenario 3) in which individual mandate repeal had minimal impact on enrollment and premiums.

Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth and the second lowest cost silver premiums increased at the same rate as the market premiums.

Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. This scenario also assumes higher premium rate increases.

Finally, we tested a scenario (Scenario 6) that was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound.

Further details regarding the scenario testing can be found in Appendix A and Appendix C.

The high-level results of the scenario testing are shown in Table 6. Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

Table 6: High-Level Results of Scenario Testing

Scenario	1 – Best Estimate	2	3	4	5	6
Description	Moderate Mandate Impact	Higher Mandate Impact	No Mandate Impact	Scenario 1 with Conservative Assumptions (Overall Low)	Highest Mandate Impact	Highest Mandate Impact (Overall High)
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Total Reduction in Premiums	-30.0%	-30.8%	-28.5%	-31.5%	-34.6%	-31.6%
Estimated Net Federal Savings	\$279,974,722	\$286,339,380	\$268,903,802	\$262,128,430	\$323,036,708	\$346,691,518

Appendix A

Data and Methodology

2019 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely collected and summarized the 2016 EDGE premium, claims, and enrollment data. The data was compared to CMS reports to confirm consistency. An additional data request was collected from the insurers consisting of full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates.
2. Wakely used the 2017 insurer data to calculate average enrollment and average premium.

Wakely incorporated February 2018 Maryland insurer data for enrollment, including splits by Exchange status and subsidized / unsubsidized. Wakely assumed that overall enrollment had attrition comparable to historical attrition patterns which was then applied by month from February through December. The total attrition, equal to -8.2% comparing the resulting yearly average enrollment to February data, was applied to all market segments equally to calculate average 2018 enrollment.

Wakely incorporated February 2018 Maryland insurer data and March 2018 Maryland Health Exchange data for the following components: state average premium, average APTC amount, gross premiums for individuals with APTC, and net premium for individuals with APTC. The data was compared to CMS reports to confirm consistency. These amounts were assumed to be consistent with the full year 2018 averages and no attrition adjustments were made to the data.

3. For the best estimate, overall enrollment in 2019 was estimated using 2018 enrollment in conjunctions with the Kaiser Family Foundation survey data to estimate the size of the enrollment drop. APTC enrollment was first increased by 1% relative to 2018 to account further take-up among eligible for APTC but have not yet done so. Then overall enrollment was decrease by 10% to account for the effect for the mandate repeal.¹⁴ It was assumed that individuals that would drop due to premium increases were the same group of people that would drop due to the mandate repeal. The proportion of individuals who are subsidized that dropped was set equal to proportion of non-group enrollees individuals who have incomes between 250% FPL and 400% FPL relative all non-group enrollees above 250% FPL.
4. For 2019, premiums were estimated using the 2018 insurer submitted data. The average 2018 premium was increased by 20% to account for all rating factors such

¹⁴ <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

as trend, metal level mix changes, insurer uncertainty, change in morbidity, and to account for the health insurance tax delay for the 2019 benefit year.

5. To estimate 2019 APTC PMPMs, we used 2018 Maryland insurer data to calculate the average net premium among APTC enrollees (that is the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) 1% to conform with the indexing of the contribution rate. We then inflated gross premiums for APTC enrollees (the 2018 APTC amounts plus net premiums) by the 2019 estimated premium increase (20%) but then reduced 5% to account for slower growth in the second-lowest cost silver relative to overall premiums to account for potential competitive pressures. This new gross premium amount is reduced by the net premium amount (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

2019 Waiver Effects

The impact of the \$462 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount by the total estimated 2019 baseline individual market. This resulted in an approximate 30.9% reduction to premiums. In addition, an adjustment was made to account for younger, healthier members remaining covered due to the implementation of the reinsurance program. This reduced premium another 1.4%. Finally, premiums were adjusted to account for the assessment. The premium adjustments due to reinsurance were made equally to gross premiums for individuals with APTC (to calculate APTC), on-Exchange premiums, and off-Exchange premiums. The total aggregate reduction of premiums was 30.0%.

The decrease in premiums is expected to produce an increase in enrollment relative to what Maryland would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function and compared to other data sources and actuarial judgement for reasonability to the Maryland specific context (as discussed previously). APTC enrollment is assumed to stay the same as the baseline estimates since these members are generally unaffected by rate changes.¹⁵ Consequently, the new enrollees are expected to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that

¹⁵ This assumption does not preclude normal churn that occurs within the individual market. Normal churn, enrollees leaving for employer-sponsored insurance or enrollees joining the individual market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2019 as had coverage in 2018.

enrollees who stay in the market due to the implementation of reinsurance will be healthier and/or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.¹⁶ These results were discussed previously and are shown in Table 5.

Alternative Scenarios

Wakely estimated five additional 2019 scenarios to analyze the robustness of the initial 2019 findings. The following were the enrollment scenarios that were modeled, as they compare to Scenario 1, as discussed previously.

- Scenario 2 which shows the impact if the effective repeal of the individual mandate had a larger impact (which resulted in less enrollment and higher premiums). In this scenario, we estimated that the national attrition rate would be 10% but that Maryland, because of its demographic and economic characteristics, were more susceptible to the effects of the effective mandate repeal than the national average. We further assumed that individuals dropping coverage would be more expensive on average than those that remained. Finally, we assumed that the SLCP would grow 5% slower than the rate of premium growth.
- Scenario 3 was modeled to reflect the scenario in which individual mandate repeal had minimal impact on enrollment and premiums. In this scenario, enrollment decreases relative to 2018 entirely as a function of premium increases as projected by the CEA take-up function.
- Scenario 4 tested for a reasonable lower bound scenario. The total enrollment drop relative to 2018 was the same as Scenario 1 except the enrollment decreased the same percent for subsidized and non-subsidized members. Scenario 4 also had slightly lower premium growth at 15% and the second lowest cost silver premiums increased 5% slower than average premium.
- Scenario 5 assumes a much more significant enrollment impact due to the mandate, based on the CBO projections. CBO estimates for national projected enrollment losses were applied to Maryland, which was assumed to have a worse than the national average experience enrollment losses. This scenario also assumes higher premium rate increases (30%) relative to Scenario 1. The SLCP was adjusted to grow 5% lower than state average premium.

¹⁶<https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/>

- Scenario 6 was similar to Scenario 5 but had even higher premium rate increases and also had higher APTC enrollment. This scenario was developed to be a reasonable upper bound. In this scenario, premiums were expected to grow at 40%, with no differential rate of growth between the state average premium and the second lowest cost silver. APTC enrollment was expected to be 5% higher than Scenario 5.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: \$462 million in reinsurance funding was applied to the individual market and enrollment was re-estimated using the CEA take-up function. Each scenario produced a decrease in the state average premiums PMPM in 2019 between 28.5% and 34.6%. In each scenario, the lower premiums resulted in more enrollees in the individual market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars being spent in 2019 as a result of the reinsurance program. The detailed results of the scenario testing are shown in Table 7.

Scenario 1 is the best estimate scenario including reactive enrollment and premiums to match Maryland's recommended premium increases. This scenario was used for the 10-year economic analysis.

Table 7: Summary of Alternative Scenario Results for 2019

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Baseline						
Total Non-Group Enrollment	171,526	164,989	185,857	171,546	138,727	139,209
Exchange Enrollment	121,503	118,458	128,585	116,143	107,482	109,855
APTC Enrollment	103,620	101,823	108,110	96,336	96,311	99,360
Total Non-Group Premium PMPM	\$725.66	\$735.62	\$702.78	\$695.14	\$780.71	\$846.08
Exchange Premium PMPM	\$759.98	\$770.42	\$736.03	\$728.03	\$817.65	\$886.10
APTC PMPM	\$623.97	\$634.28	\$600.30	\$592.40	\$680.93	\$794.63
Total Non-Group Premiums	\$1,493,625,346	\$1,456,435,659	\$1,567,400,734	\$1,430,988,776	\$1,299,673,506	\$1,413,371,636
Total APTCs	\$775,866,854	\$775,011,288	\$778,782,444	\$684,829,540	\$786,979,751	\$947,460,791
After Reinsurance						
Reinsurance Funding	\$462,000,00	\$462,000,000	\$462,000,00	\$462,000,00	\$462,000,00	\$462,000,000
Reduction in Premiums (Reinsurance Funding)	0 -30.9%	-31.7%	0 -29.5%	0 -32.3%	0 -35.5%	-32.7%
Reinsurance Assessment	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-1.4%	-1.7%	-1.3%	-1.1%
Total Premium Impact	-30.0%	-30.8%	-28.6%	-31.6%	-34.7%	-31.6%
Total Non-Group Premium PMPM	\$508.03	\$509.12	\$502.44	\$475.99	\$510.56	\$579.09
Exchange Premium PMPM	\$532.07	\$533.21	\$526.21	\$498.50	\$534.72	\$606.49
APTC PMPM	\$398.81	\$399.94	\$393.03	\$365.65	\$401.43	\$503.86

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Based on Survey Data	Adjusted Survey Data	Take-up Function	Moderate Decrease; Same Decrease for all Subsidy Levels	Mandate Impact - CBO	Mandate Impact - CBO; Higher APTC Enrollment Increases
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Lower Increase	Higher Increase	Highest Increase
Percent Change in Total Enrollment	5.8%	5.8%	5.8%	6.9%	5.4%	4.5%
Total Non-Group Enrollment	181,522	174,587	196,625	183,369	146,150	145,404
Exchange Enrollment	124,136	120,986	131,421	119,256	109,436	111,486
APTC Enrollment	103,620	101,823	108,110	96,336	96,311	99,360
Total Premiums	\$1,106,629,629	\$1,066,640,334	\$1,185,518,554	\$1,047,373,717	\$895,425,612	\$1,010,431,346
Total APTCs	\$495,892,132	\$488,671,908	\$509,878,642	\$422,701,111	\$463,943,043	\$600,769,272
Savings						
Estimated APTC Savings	\$279,974,722	\$286,339,380	\$268,903,802	\$262,128,430	\$323,036,708	\$346,691,518
Estimated Net Federal Savings	\$279,974,722	\$286,339,380	\$268,903,802	\$262,128,430	\$323,036,708	\$346,691,518
Estimated Pass Through	60.6%	62.0%	58.2%	56.7%	69.9%	75.0%

Beyond 2019

For years beyond 2019, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as Gross Premium Amounts for individuals with APTC were trended by the Office of the Actuaries National Health Expenditure spending for each year of the 10 year window.¹⁷
- APTC Net Premiums were increase 1% annually to account for indexing.
- In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.9% based on 2018 rate filing information.
- In 2020 and beyond, the individual market enrollment was estimated to have attrition equal to what would be predicted using the CEA take-up function based on the pre-reinsurance premium growth each year. Similarly, the premium was adjusted for the worsening morbidity due to the aforementioned attrition. APTC enrollment was also assumed to increase 0.5% in 2020 only to account for further take-up of those eligible for subsidies but have not yet take up coverage.
- Reinsurance or total funding amounts are \$459.0 in 2020 and \$49.4 in 2021. The 2020 amounts were calculated to align with a similar reduction in premiums as occurred in 2019 and then any remaining state funds would be expended in 2021. Consequently, for years 2022 and beyond no reinsurance funds are estimated to be expended. To the extent unexpected funds are available they would be used in 2022 and/or 2023 (the fourth and fifth years of the program).

For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2019. The detailed results are shown in Table 8.

¹⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/> Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 8: Baseline Data and Detailed Results after Reinsurance, by Year¹⁸

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$725.66	\$776.34	\$816.00	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Gross Premium PMPM for APTC Mbrs	\$750.80	\$803.23	\$844.27	\$888.26	\$933.60	\$981.23	\$1,030.25	\$1,082.61	\$1,137.60	\$1,195.36
Net Premium PMPM for APTC Mbrs	\$126.83	\$128.09	\$129.37	\$130.67	\$131.98	\$133.30	\$134.63	\$135.97	\$137.33	\$138.71
APTC PMPM	\$623.97	\$675.14	\$714.89	\$757.60	\$801.63	\$847.94	\$895.62	\$946.63	\$1,000.27	\$1,056.65
Total Premiums	\$1,493,625,346	\$1,581,638,554	\$1,650,194,003	\$1,723,288,558	\$1,798,214,776	\$1,876,517,192	\$1,956,686,587	\$2,041,894,570	\$2,130,944,926	\$2,224,015,748
Total APTCs	\$775,866,854	\$843,687,345	\$893,370,470	\$946,732,345	\$1,001,757,394	\$1,059,629,619	\$1,119,215,115	\$1,182,962,583	\$1,249,986,144	\$1,320,449,879
After Reinsurance										
Reinsurance Funding	\$462,000,000	\$459,000,000	\$49,400,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Reduction in Premiums (Reinsurance Funding)	-30.9%	-29.0%	-3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reinsurance Assessment	2.75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Reduction in Premiums (Improved Morbidity)	-1.4%	-1.4%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Non- Group Premium PMPM	\$508.03	\$543.36	\$790.58	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
APTC PMPM	\$398.81	\$434.09	\$688.60	\$757.60	\$801.63	\$847.94	\$895.62	\$946.63	\$1,000.27	\$1,056.65
Change in Total Non-Group Enrollment	5.8%	5.7%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

¹⁸ Please Appendix C for total federal savings net of federal losses under the reinsurance program.

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Total Non-Group Enrollment	181,522	179,439	169,342	167,273	166,069	164,888	163,753	162,619	161,507	160,416
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Premiums	\$1,106,629,629	\$1,169,998,256	\$1,606,544,128	\$1,723,288,558	\$1,798,214,776	\$1,876,517,192	\$1,956,686,587	\$2,041,894,570	\$2,130,944,926	\$2,224,015,748
Total APTCs	\$495,892,132	\$542,459,045	\$860,506,253	\$946,732,345	\$1,001,757,394	\$1,059,629,619	\$1,119,215,115	\$1,182,962,583	\$1,249,986,144	\$1,320,449,879

Appendix B

Reinsurance Parameters

Reinsurance Parameters

As noted previously, the reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Maryland has set the reinsurance cap at \$250,000, and coinsurance rate at 80%, and the attachment point is anticipated to be approximately \$20,000.

Wakely used continuance tables provided for 2017 calendar year from the two remaining insurers in 2018 to estimate the attachment point for the program. In addition, 2016 calendar year continuance tables and 2016 EDGE files served as a cross-check for reasonability and consistency.

To obtain a 2019 continuance table consistent with the best estimate scenario, various adjustments to the data were performed including enrollment, morbidity, and annual claim increases. The following components were considerations in adjusting the 2017 continuance tables, incorporating sources of public data, sensitive / proprietary data, and actuarial judgement.

1. The best estimate scenario enrollment drop of 19.3% from 2017 to 2019 was applied to the data.
2. The morbidity change from 2017 to 2019 was modeled under the assumption that members leaving the market were healthier relative those staying in the market.
3. The claims were increased annually from 2017 to 2019. This annual claim increase includes adjustments outside of trend such as metal mix changes and unit cost shifts.
4. The resulting medical loss ratio in 2019 was reviewed (prior to the impact of the reinsurance program and after the impact of reinsurance) to ensure reasonability.

Enrollment and morbidity were modeled in tandem by removing membership and associated claims from the continuance tables to obtain the projected changes of 19.3% decrease in enrollment and a corresponding increase in morbidity (estimated by an increase in paid claims). This was modeled using an attrition distribution assuming lower cost membership is more likely to terminate coverage than higher cost membership.

In some instances, the trend and / or morbidity was higher than anticipated; however, it was necessary in order to achieve the level of premium increase we understood to be reasonable from Maryland and / or the insurers. The premium levels may be higher than otherwise expected as a result of uncertainty in the market. Trend and / or morbidity were adjusted similarly to achieve appropriate Medical Loss Ratios (MLRs).

The resulting 2019 continuance table was used to determine the reinsurance parameters. Wakely used a fixed coinsurance rate of 80% and cap \$250,000. Assuming

a funding level of \$462,000,000 and the preceding parameters, Wakely estimates that the attachment point will be approximately \$20,000, based on the 2019 estimated data. The attachment point may change if methodology, assumptions, or other changes are incorporated.

It is important to note that the assumptions in this estimate are inherently uncertain. The resulting parameters will vary from these estimates to the degree the actual enrollment, morbidity, trend, and other assumptions vary from those used in this analysis. In addition, if there are significantly more or fewer high cost claimants in 2019 compared to 2016 and 2017, the results from this analysis may also vary. Finally, insurers are expected to have differing impacts from the reinsurance program based on how they vary from the market average in their historical claims and assumptions discussed previously in this section.

Appendix C

Guard Rail Requirements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. We expect enrollment to be greater than or equal to each year relative to what would have occurred if the reinsurance program were not in place in each year of the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least comparable number of enrollees (and most likely a greater number of individuals covered).

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be approximately 30% lower in 2019, and lower than or equal to what they otherwise would have been each year of the waiver as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive of coverage for residents.

Deficit Neutrality

APTCs

Since APTCs are benchmarked to the SLCSF, the decrease in premiums (specifically the SLCSF) will result in lower per person APTC amounts in 2019. Since enrollees who have APTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with APTCs. Due to the combination of a

non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to APTC amounts, Wakely's analysis estimates that the overall aggregate amount of APTCs will be lower or equal to what they otherwise would have been each year over the 10-year window. Wakely further estimates that the total federal savings of APTC expenditures will be \$280 million, \$301 million, and \$33 million in 2019, 2020, and 2021, respectively. APTC savings net of other Federal losses will be \$280 million, \$293 million, and \$32 million in 2019, 2020, and 2021, respectively. These results are shown in Table 9.

Table 9: Detailed Results of Federal Savings, by Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	171,526	169,776	168,525	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	121,503	121,042	120,713	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$725.66	\$776.34	\$816.00	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Exchange Premium PMPM	\$759.98	\$813.06	\$854.60	\$899.14	\$945.03	\$993.24	\$1,042.86	\$1,095.86	\$1,151.52	\$1,209.99
APTC PMPM	\$623.97	\$675.14	\$714.89	\$757.60	\$801.63	\$847.94	\$895.62	\$946.63	\$1,000.27	\$1,056.65
After Reinsurance										
Total Non-Group Enrollment	181,522	179,439	169,342	167,273	166,069	164,888	163,753	162,619	161,507	160,416
Exchange Enrollment	124,136	123,587	120,928	120,383	120,066	119,755	119,456	119,157	118,865	118,577
APTC Enrollment	103,620	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138	104,138
Total Non-Group Premium PMPM	\$508.03	\$543.36	\$790.58	\$858.52	\$902.34	\$948.38	\$995.75	\$1,046.36	\$1,099.51	\$1,155.34
Exchange Premium PMPM	\$532.07	\$569.06	\$827.98	\$899.14	\$945.03	\$993.24	\$1,042.86	\$1,095.86	\$1,151.52	\$1,209.99
APTC PMPM	\$398.81	\$434.09	\$688.60	\$757.60	\$801.63	\$847.94	\$895.62	\$946.63	\$1,000.27	\$1,056.65
Federal Savings Calculations										
Exchange User Fees	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HIT	0.0%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
Difference in APTCs	\$279,974,722	\$301,228,300	\$32,864,217	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in Mandate Penalty	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in User Fees	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Difference in HIT	\$0	(\$7,821,166)	(\$829,348)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Estimated Net Federal Savings	\$279,974,722	\$293,407,134	\$32,034,869	\$0						

Offsets to APTC Savings

Individual Responsibility Requirement

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. However, as part of the Tax Cuts and Jobs Act of 2017, the individual responsibility requirement was set to \$0 for 2019 and future years. Therefore, it will not directly affect federal savings.

Exchange User Fee

Given Maryland's status as a State-Based Exchange, Wakely notes that there will not be a loss of revenue to the Federal government for Federally-facilitated Exchange user fees (also known as user fees) due to the reduction in premium amounts.

Health Insurance Providers Fee

The reinsurance program would also impact the health insurance provider fee, or HIT. Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling \$14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. As part of the Tax Cuts and Jobs Act of 2017 the HIT was suspended for the 2019 benefit year. We estimate that Maryland's reinsurance program will have minimal impact on national premium growth rate. To estimate the decrease in collected fees, Wakely first estimated the baseline collection using the 2018 rate filing information. Weighting the 2018 fee by expected enrollment yielded an estimated 1.9% HIT on premiums. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total HIT (defined as total premiums multiplied by 1.9%) for the baseline and the waiver scenario to arrive at the federal costs due to the health insurance provider fee for the implementation of the waiver. These estimates are conservative as the losses on Maryland's insurers may be partially or fully captured by taxes on non-Maryland health insurance providers given that statutory construction of the fee.

Other Federal Impacts

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac or Excise tax, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.¹⁹

¹⁹ <http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf>

Employer Markets

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

Deficit Neutrality in Alternative Scenarios

In addition, Wakely calculated the impact of the federal savings under the alternative 2019 scenarios discussed previously. As can be seen previously in Table 7, there was no 2019 scenario in which net federal savings, as a result of the reinsurance program, was less than \$262 million.

Appendix D

Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- Insurer submitted premium and enrollment information by metal and exchange status for 2017 and January/February/March 2018 (one insurer did not submit March data)
- Insurers submitted APTC information, including enrollment and premiums, for January/February/March 2018
- Insurer submitted paid claim continuance tables for 2016 and 2017
- A complete set of 2016 EDGE Server XML data was collected from each individual market insurer, including:
 - The inbound enrollment, medical, pharmacy, and supplement files that were submitted by each insurer to the EDGE Server
 - The corresponding response files that apply an accept/reject status to the claims in the inbound files
 - The final outbound files that were produced in May 2016. These files include the risk adjustment, reinsurance, and enrollee claims detail/enrollee claims summary reports

- The June 30th Risk Adjustment and Reinsurance Report for the 2016 benefit year produced by CMS²⁰
- The 2016 , 2017, and 2018 Open Enrollment Report PUF produced by HHS^{21 22 23}
- Effectuated Enrollment Reports released by CMS²⁴
- Kaiser Family Foundation Survey²⁵
- CBO Analysis on Impact of Repeal of the Mandate²⁶
- OACT Analysis on Impact of Repeal of the Mandate^{27 28}
- Additional data and feedback from Maryland’s insurers, Maryland Insurance Administration, and the Maryland Health Benefit Exchange.

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Maryland for reasonability.

The following are additional reliances and caveats that could have an impact on results:

- Data Limitations. Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering individual market ACA-compliant plans. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.

²⁰ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>

²¹ <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>

²² https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

²³ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

²⁴ <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

²⁵ <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>

²⁶ <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>

²⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf>

²⁸ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf>

- **Political Uncertainty.** There is significant policy uncertainty. Future federal actions or requirements in regards to short term duration plans, association health plans, reinsurance funds, income verification, and/or CSR payments could dramatically change premiums and enrollment in 2019 or future years. In particular, CSR funding or changes to rules about how CSR requirements are accounted for in premium (i.e., “Silver-loading”) could dramatically decrease the pass-through percentage relative to what was estimated in this report.
- **Enrollment Uncertainty.** Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. This includes implementation of new income verification policy as encapsulated in the 2019 Notice of Benefit and Payment Parameters, which could influence APTC enrollment. All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Premium Uncertainty.** Given that several regulations (association plans, short-term duration plans, etc.) have not been finalized, there is uncertainty in how insurers may respond in their 2019 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.
- **Pass-Through Uncertainty.** Ultimately the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely’s models, differences in the pass-through amounts are possible.
- **Reinsurance Operations.** If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely’s analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results. Furthermore, if less than amount specified is spent, for example because some funds are used for reinsurance operations, then effects may be different.

Appendix E

Disclosures and Limitations

Responsible Actuary. Julie Peper and Danielle Hilson are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of Maryland. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Wakely used conservative pass-through assumptions. The extent to which the enrollment experience for 2018 or 2019 is different than expected could affect results. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Maryland will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Maryland.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2018 experiences. Change in emerging 2018 enrollment and experience could impact the results. Additional changes in regulations (e.g., association health plans, short term limited duration plans) could impact findings. For example, since neither of the proposed regulations on these topics have been finalized, they were not included in the analysis.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are

in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication