Standing Advisory Committee Meeting

April 14, 2022

MHBE Policy Department

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

2:00-2:20 | Welcome and Introductions
Ken Brannan, SAC Chair, and Dana Weckesser, SAC Board Liaison

2:20-2:30 | SAC Bylaws and Co-Chair Vote
Ken Brannan

2:30-3:00 | Health Equity Workgroup Recommendations
Dania Palanker, Center on Health Insurance Reforms, Georgetown University

3:00-3:10 | Executive Update
Michele Eberle, MHBE Executive Director

3:10-3:25 | Legislative Update
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management

3:25-3:35 | Affordability Workgroup
Johanna Fabian-Marks

3:35-3:50 | Monthly Data Report Refresh
Andy Ratner, MHBE Chief of Staff

3:50-4:00 | Public Comment

4:00 | Adjournment

MARYLAND HEALTHBENEFIT EXCHANGE

Welcome & Introductions

SAC Bylaws and Co-Chair Vote

SAC Bylaws - Proposal to Increase Co-Chair Term to Two Years

ARTICLE IV

Co-chairs

Section 1. Election of Co-chairs. The Members shall elect from their membership two Co-chairs.

Section 2. Term. Co-chairs so elected shall serve a term of no more than two years ~~one year~~, or until their own term of service on SAC has expired, whichever comes first. If a Co-chair is elected to fill the unexpired officership of a predecessor, such service shall not count against the limitation on tenure set forth above.

Section 3. Duties. The Co-chairs of SAC shall, in addition to presiding at meetings, have such other duties as may from time to time be assigned by the MHBE Board or otherwise prescribed by these Bylaws.

Proposed Votes

Staff proposes that the SAC amend the bylaws to allow co-chairs to serve up to 2 years. Bylaw amendment requires 2/3 vote.

- Potential motion: I move to approve the amendment to the SAC bylaws as presented.

- Vote to elect co-chairs

Health Equity Workgroup Recommendations

Background

- August - December 2021
- 20 members (consumer advocates, navigators, physicians, insurers, state agencies, hospitals, and universities; geographic diversity)
- Eight meetings
  - Topics prioritized by members
  - Expert guest speakers on most topics
  - Presentations from each QHP issuer
  - Models from other states
  - Member expertise and feedback
- **Recommendations unanimously approved** by responding members

Health Equity Workgroup Members

Member	Affiliation
Richard Amador	HealthCare Access MD
William Ashley	LifeBridge Health System
Noel Brathwaite	MDH Office of Minority Health & Health Disparities
Alyssa Brown	MDH Office of Health Care Financing
Shari Curtis	Prince George's Healthcare Action Coalition
Bryan Gere	University of Maryland Eastern Shore
Diana Hsu	Maryland Hospital Association
Kim Jones-Fearing	Kim Jones-Fearing MD LLC
Stephanie Klapper	Maryland Citizens' Health Initiative
Nicole Mallette	Maryland Insurance Administration
Allison Mangiaracino	Kaiser Permanente

Member	Affiliation
Jomy Mathew	United Healthcare
Joshua Morris	HealthCare Access MD
Marie-Therese Oyalowo	University of Maryland Eastern Shore
Dania Palanker*	Center on Health Insurance Reforms, Georgetown University
Ligia Peralta	Casa Ruben, Inc.
Megan Renfrew	Health Services Cost Review Commission
Patricia Swanson	CareFirst BlueCross BlueShield
Barbara Tighe	HealthCare Access MD
Nikki Highsmith Vernick	The Horizon Foundation
Sheila Woodhouse*	University of Maryland Medical Capital Region Health Medical Group

*Co-chairs

Race & Ethnicity Data Collection

- **Redesign race and ethnicity questions on MHC application**
  - Current response rate: <70%
  - Best practices:
    - Adding a “prefer not to say” response option
    - Requiring a selection
    - Adding more specific race & ethnicity response options
- Follow-up recommendations:
  - Convene data-focused workgroup
  - Support targeted marketing/outreach strategy
  - Collaborate with insurers on race/ethnicity enrollment goals
  - Redesign sex and gender MHC application questions

NCQA Multicultural Health Care Distinction

- **Plan certification standard for PY2024: Carriers achieve distinction in Multicultural Health Care from the National Committee for Quality Assurance**
  - DC and CA have this requirement (MD & DC individual markets share carriers)
  - Note: NCQA shifting from Multicultural Health Care Distinction to Health Equity Accreditation

  "NCQA evaluates how well an organization complies with standards for:
  - *Collecting race/ethnicity and language data.*
  - *Providing language assistance.*
  - *Cultural responsiveness.*
  - *Quality improvement of culturally and linguistically appropriate services (CLAS).*
  - *Reduction of health care disparities."*

Health Insurance Literacy

- **Partner with community organizations to develop or offer health insurance literacy curriculum**
- **Enhance MHBE website to assist with plan choice and use of benefits**
  - Program chatbot and add tooltips to explain key insurance terms, plan shopping considerations
  - Add pages on how to use benefits to MHC
  - Conduct focus groups with consumers to test accessibility of materials/resources
- **Audit MHC and MHBE websites for accessibility by consumers whose primary language is not English (particularly Spanish-speakers)**
  - Website copy translation
  - Search engine optimization

Support Financing of Community Health Workers

- **MHBE and insurers should continue discussing alternative payment models (APMs) that support community health workers (CHWs)**
  - Support navigators and CHWs to share resources and refer clients to each other
  - MHBE challenge– limited authority at the point of care

Reduce Cost-Sharing for High-Disparity Conditions

- **Apply 2022 value plan standards for diabetes supplies to all private plans on MHC starting in PY2024 (eliminate insulin and glucometer cost-sharing)**
  - Diabetes disproportionately impacts Black Marylanders
  - Follow DC's model
- **Continue exploring the feasibility of reducing cost-sharing for high-disparity conditions**
  - Start with small changes that minimize impact to actuarial value and do not increase patient cost-sharing
  - Affordability Workgroup to discuss this spring

Implicit Bias

- **Establish regular implicit bias training for MHBE staff**
- **Support other state implicit bias work**
  - MHHD: developing list of approved implicit bias training
  - MIA: incorporating implicit bias into network adequacy regulations
- **Continue to explore the extent of QHP carriers' efforts around implicit bias**

Partnership & Collaboration

- **Hold listening sessions with connector entities, other community partners that work directly with consumers, consumers themselves. Use insights to inform strategy.**
  - Compensate participants
- **Continue coordinating with MIA and other state agencies**
- **Form new partnerships with community organizations**

Support coverage for immigrants

Continue exploration and discussion of coverage options for individuals who are currently ineligible for existing programs—specifically undocumented immigrants.

Motion

Would the Standing Advisory Committee like to take a vote to express its support for the recommendations of the Health Equity Workgroup? A majority vote is necessary for passage.

- Potential motion: I move to support the recommendations of the Health Equity Workgroup as presented.

Questions & Discussion

MHBE Executive Update

Legislative Update

2022 Legislative Session Update

Bill	Summary	Status
HB 413	**Extends 1% provider fee** to fund state reinsurance program in the second 1332 waiver period (2024-2028)	To Governor
SB 632	Requires MHBE to form a **Small Business and Nonprofit Health Insurance Subsidies Program Workgroup**	To Governor
HB 1082	Allocates $300-400k to UMD Horowitz Center for Health Literacy to establish a **Consumer Health Information Hub**	To Governor
HB 937	Establishes an abortion clinical care training program and requires Medicaid and other payers to cover abortion. MHBE required to **expand Young Adult Subsidy to result in $0 premiums** for those eligible for 0% expected contribution.	Enacted
SB 728 / HB 1035	Directed MHBE to submit a 1332 waiver application to allow individuals ineligible for federal subsidies to enroll in QHPs and created a state subsidy program.	Did not move forward

Affordability Workgroup

2022 Affordability Workgroup

Consumer cost-sharing like deductibles and copays continue to be a challenge for some enrollees even as premiums have been stabilized by the state reinsurance program. The workgroup will develop recommendations for MHBE to continue to improve affordability, including through:

1. Assessing the first year of results from the Young Adult Subsidy Pilot Program, which originated with the first Affordability Workgroup;
2. Revisiting MHBE's Value Plan requirements; and
3. Considering how MHBE might adjust cost sharing to promote health equity.

Meetings are expected to be held May - August 2022.

Data Reporting

What is data?

1640s: Plural from the Latin word “datum” – the “thing given”

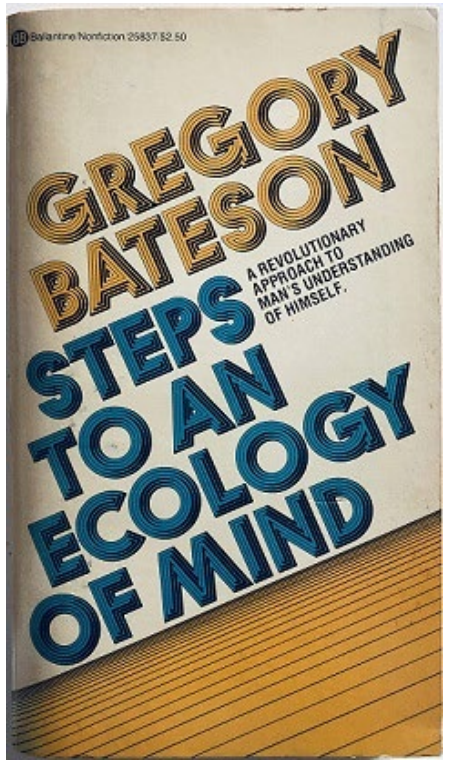
Derived from the Latin verb “dare” – “to give”

Data = observations given

1897: “Numerical facts collected for future reference.”
1946: “Transmittable and storable information by which computer operations are performed”
1954: “data-processing”
1962: “database”
1970: “data-entry”

“Information is a difference that makes a difference”

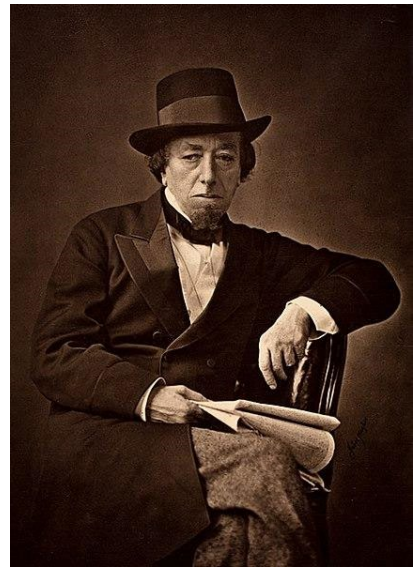
Anthropologist Gregory Bateson, “Steps to an Ecology of Mind,” 1972



Focus on statistics than can improve your operation and measure its progress.

“There are three kinds of lies: lies, damned lies, and statistics”

Credited to 17th-century British prime minister Benjamin Disraeli (right), although some claim the phrase has existed as long as the word “statistics” was first used in the English language in 1749.



Emphasis isn’t a lie … but it is subjective.

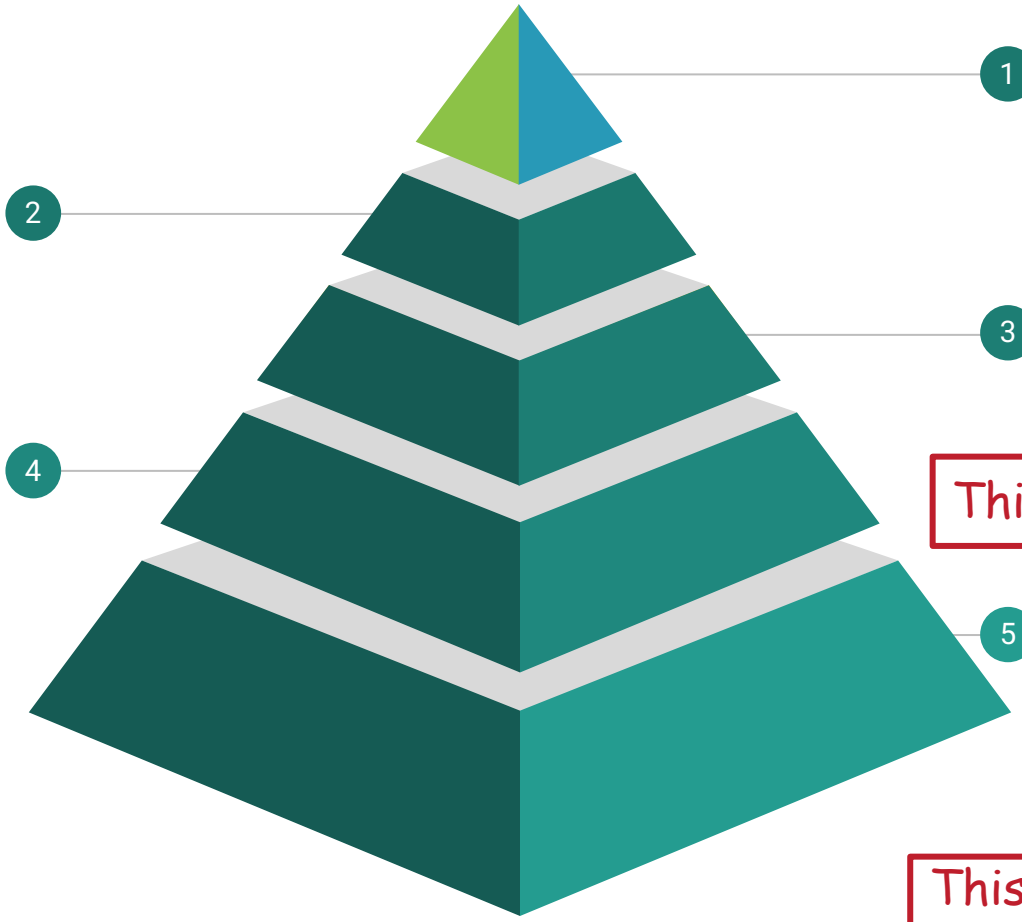
Where Maryland's 6 million+ get their health insurance

MHC can help 2/3rds of them.

350,000 remain without

1.5 million are insured through Medicaid (MAGI + non-MAGI)

This has grown +300,000 to the ACA expansion.



250,000 buy their own health insurance (on + off exchange)

1 million in Medicare + other federal programs

This has grown w/ aging population.

3.3 million are insured through their employer

This has shrunk as jobs without coverage (service) have replaced jobs with (manufacturing).

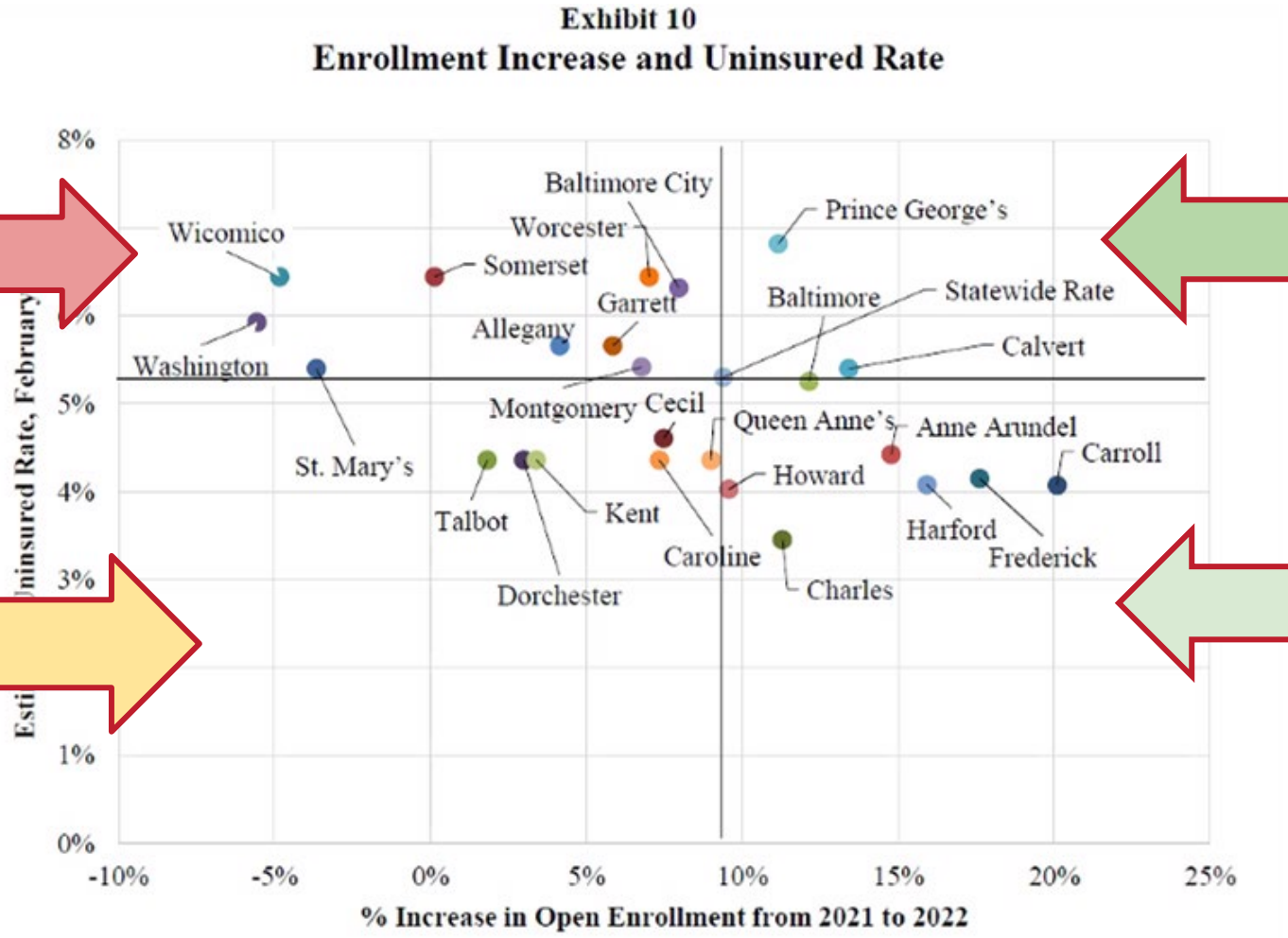
MARYLAND HEALTHBENEFIT EXCHANGE

Sources: MHBE, MIA, SHADAC

Look for better ways to “see” & understand our data

Places with high uninsured rate and low/medium 2022 enrollment gain

Places with low/medium uninsured rate and low/medium 2022 enrollment gain



Places with higher uninsured and high 2022 enrollment gain

Places with lower uninsured rate and high 2022 enrollment gain

Source: Dept. of Legislative Services Analysis, February 2022

MARYLAND HEALTHBENEFIT EXCHANGE

Monthly Data Reports

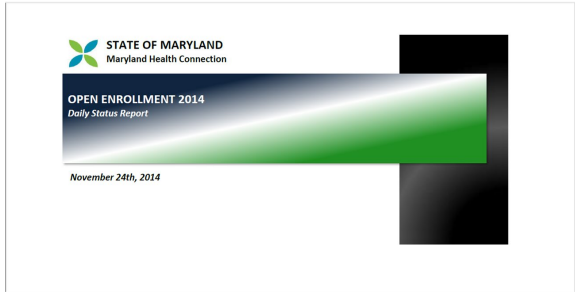
marylandhbe.com/news-resources/reports-data/

MHBE Monthly Data Reports

The report fulfills two objectives:

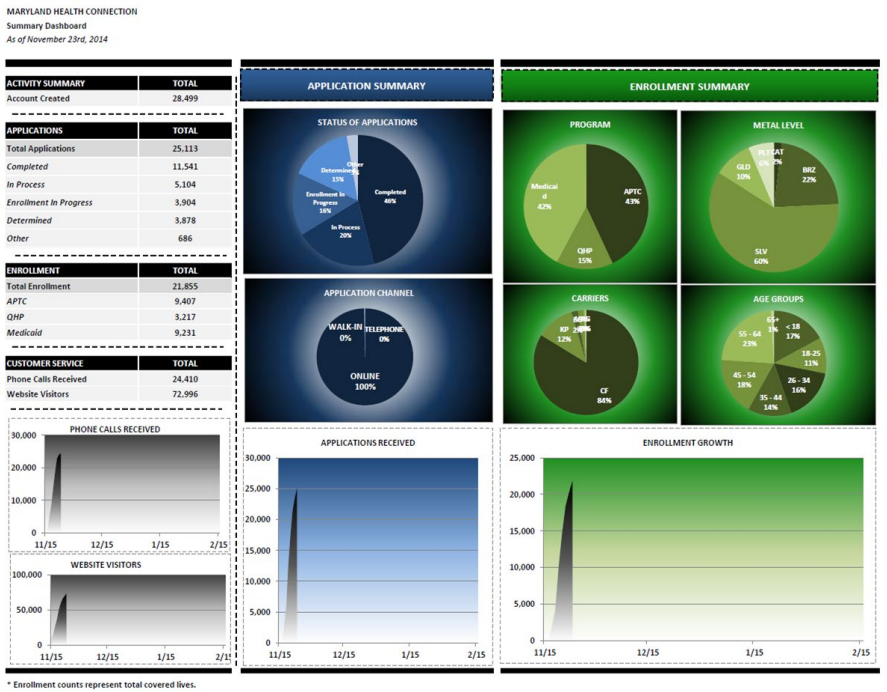
1. External communications so that the public, the board, stakeholders and electeds can access current data on how the marketplace (both QHP and MA) is faring in enrollments, effectuation, health equity, young adult enrollment / risk balance, consumer assistance, financial assistance.
2. Agency operations, so managers can assess trends or changes that warrant attention / action.

Original Data Report (2014-2018)



MARYLAND HEALTH CONNECTION
Daily Activity Statistics
As of November 23rd, 2014

ACTIVITY DATE	ACCOUNTS CREATED	TOTAL APPLICATIONS	APPLICATIONS COMPLETED	APPLICATIONS NOT COMPLETED	TOTAL PEOPLE ENROLLED	ENROLLED (APTC)	ENROLLED (QHP)	ENROLLED (MEDICAID)	PHONE CALLS RECEIVED	WEBSITE VISITORS
11/15/2014	171	121	80	41	139	89	14	36	706	8,566
11/16/2014	192	141	89	52	151	98	15	38	890	15,382
11/17/2014	3,653	2,749	1,258	1,491	1,901	835	395	671	4,903	26,811
11/18/2014	7,145	5,794	2,667	3,127	4,144	1,762	780	1,602	8,345	36,566
11/19/2014	14,903	12,820	6,032	6,788	10,124	4,346	1,639	4,139	13,702	50,211
11/20/2014	20,420	17,760	8,281	9,479	14,777	6,274	2,266	6,237	18,542	59,290
11/21/2014	24,519	21,468	9,952	11,516	18,386	7,785	2,709	7,892	22,837	65,961
11/22/2014	26,729	23,492	10,784	12,708	20,272	8,669	2,966	8,637	24,012	69,546
11/23/2014	28,499	25,113	11,541	13,572	21,855	9,407	3,217	9,231	24,410	72,996

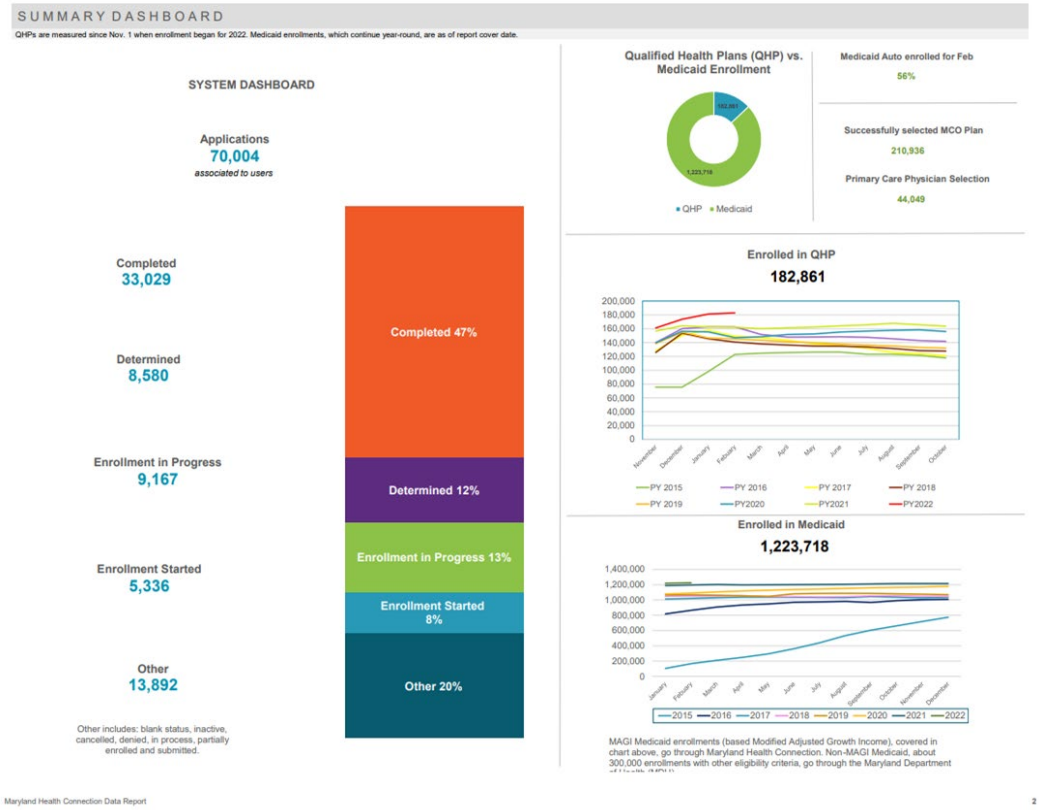


Current Data Report (since 2018)

maryland health connection

DATA REPORT

Febuary 28, 2022



SUMMARY DASHBOARD

QHPs are measured since Nov. 1 when enrollment began for 2022. Medicaid enrollments, which continue year-round, are as of report cover date.

SYSTEM DASHBOARD

Applications
70,004
associated to users

Completed
33,029

Determined
8,580

Enrollment in Progress
9,167

Enrollment Started
5,336

Other
13,892

Other includes: blank status, inactive, cancelled, denied, in process, partially enrolled and submitted.

Completed 47%

Determined 12%

Enrollment in Progress 13%

Enrollment Started 8%

Other 20%

Qualified Health Plans (QHP) vs. Medicaid Enrollment

QHP Medicaid

Medicaid Auto enrolled for Feb
56%

Successfully selected MCO Plan
210,936

Primary Care Physician Selection
44,049

Enrolled in QHP
182,861

PY 2015 PY 2016 PY 2017 PY 2018 PY 2019 PY2020 PY2021 PY2022

Enrolled in Medicaid
1,223,718

2015 2016 2017 2018 2019 2020 2021 2022

MAGI Medicaid enrollments (based Modified Adjusted Growth Income), covered in chart above, go through Maryland Health Connection. Non-MAGI Medicaid, about 300,000 enrollments with other eligibility criteria, go through the Maryland Department

Maryland Health Connection Data Report

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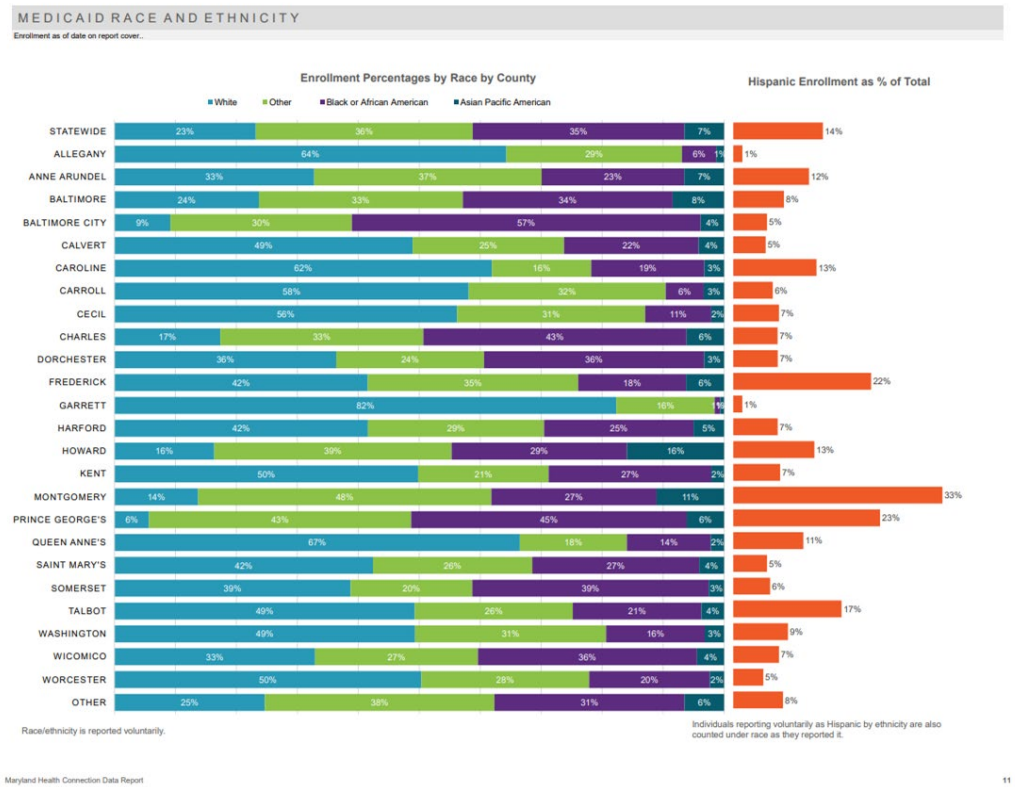

MEDICAID RACE AND ETHNICITY

Enrollment as of date on report cover..

Enrollment Percentages by Race by County

White Other Black or African American Asian Pacific American

	White	Other	Black or African American	Asian Pacific American
STATEWIDE	23%	36%	35%	7%
ALLEGANY	64%	29%	6%	1%
ANNE ARUNDEL	33%	37%	23%	7%
BALTIMORE	24%	33%	34%	8%
BALTIMORE CITY	9%	30%	57%	4%
CALVERT	49%	25%	22%	4%
CAROLINE	62%	16%	19%	3%
CARROLL	58%	32%	6%	3%
CECIL	56%	31%	11%	2%
CHARLES	17%	33%	43%	6%
DORCHESTER	36%	24%	36%	3%
FREDERICK	42%	35%	18%	6%
GARRETT	82%	16%	1%	
HARFORD	42%	29%	25%	5%
HOWARD	16%	39%	29%	16%
KENT	50%	21%	27%	2%
MONTGOMERY	14%	48%	27%	11%
PRINCE GEORGE'S	6%	43%	45%	6%
QUEEN ANNE'S	67%	18%	14%	2%
SAINT MARY'S	42%	26%	27%	4%
SOMERSET	39%	20%	39%	3%
TALBOT	49%	26%	21%	4%
WASHINGTON	49%	31%	16%	3%
WICOMICO	33%	27%	36%	4%
WORCESTER	50%	28%	20%	2%
OTHER	25%	38%	31%	6%

Hispanic Enrollment as % of Total

STATEWIDE	14%
ALLEGANY	1%
ANNE ARUNDEL	12%
BALTIMORE	8%
BALTIMORE CITY	5%
CALVERT	6%
CAROLINE	13%
CARROLL	6%
CECIL	7%
CHARLES	7%
DORCHESTER	7%
FREDERICK	22%
GARRETT	1%
HARFORD	7%
HOWARD	13%
KENT	7%
MONTGOMERY	33%
PRINCE GEORGE'S	23%
QUEEN ANNE'S	11%
SAINT MARY'S	5%
SOMERSET	6%
TALBOT	17%
WASHINGTON	9%
WICOMICO	7%
WORCESTER	5%
OTHER	8%

Race/ethnicity is reported voluntarily.

Individuals reporting voluntarily as Hispanic by ethnicity are also counted under race as they reported it.

Maryland Health Connection Data Report

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maryland health connection

Some possible changes

- Highlights on Page One to act as a quick Executive Summary at a glance.
- More comparisons versus one year earlier.
- Add % Change by Race and Ethnicity to better measure health equity trend.
- Can we better show how advanced technology is leading to more consumer self-service?
- Collaborate with MHCC to show consumer satisfaction with various plans? Information about quality?
- Others?

Other State-Based Exchanges

New York

- **NEW YORK** issues a small Annual Report with limited data; most recent is 2020.
- Also recently produced an extensive report on the consumer impact of ARPA analyzed by Congressional District.

nystateofhealth
The Official Health Plan Marketplace

By the Numbers

Health Insurance Coverage Update

March 2022

NY State of Health in Congressional District 1:

Millions of New Yorkers have benefitted from access to affordable Marketplace health insurance coverage since March 2020 thanks to flexibilities permitted during the COVID-19 Public Health Emergency (PHE) and enhanced tax credits available under the American Rescue Plan Act of 2021 (ARPA) that expire in 2022 if Congress doesn't take action.

These policies ensured that consumers had the security of affordable, comprehensive health coverage when consumers lost their jobs and/or income during the pandemic, assuring access to health care when they needed it the most.

A successful transition from the PHE and extension of the ARPA subsidies are essential to keeping New York's uninsured rates one of the lowest in the country. The coverage and cost implications for New Yorkers are significant:

297,176
New Yorkers in Congressional District 1 enrolled in free or low-cost NY State of Health coverage, who could become uninsured when the PHE winddown occurs.*

8,517
New Yorkers in Congressional District 1 who are benefitting from enhanced ARPA tax credits, whose premiums will go up if these savings are not extended.

$1,399
Average annual amount residents in Congressional District 1 could lose when ARPA subsidies expire.

49%
The percentage by which premiums will increase for tax credit eligible consumers when they enroll in Fall 2022, if ARPA savings expire.

*Figure may include individuals who live in a ZIP Code that is in more than one Congressional District.

Without the extension of ARPA Savings, coverage will be too expensive for enrollees moving from public programs to Qualified Health Plans (QHP) with subsidies, leading to significant increases in uninsured New Yorkers.

Statewide, here are the numbers:

6.4 million
New Yorkers enrolled in free or low-cost coverage through NY State of Health, who could become uninsured when the PHE winddown occurs.

138,008
New Yorkers who are benefitting from enhanced ARPA tax credits, whose premiums will go up if these savings are not extended.

$1,453
Average annual amount New Yorkers could lose when ARPA subsidies expire.

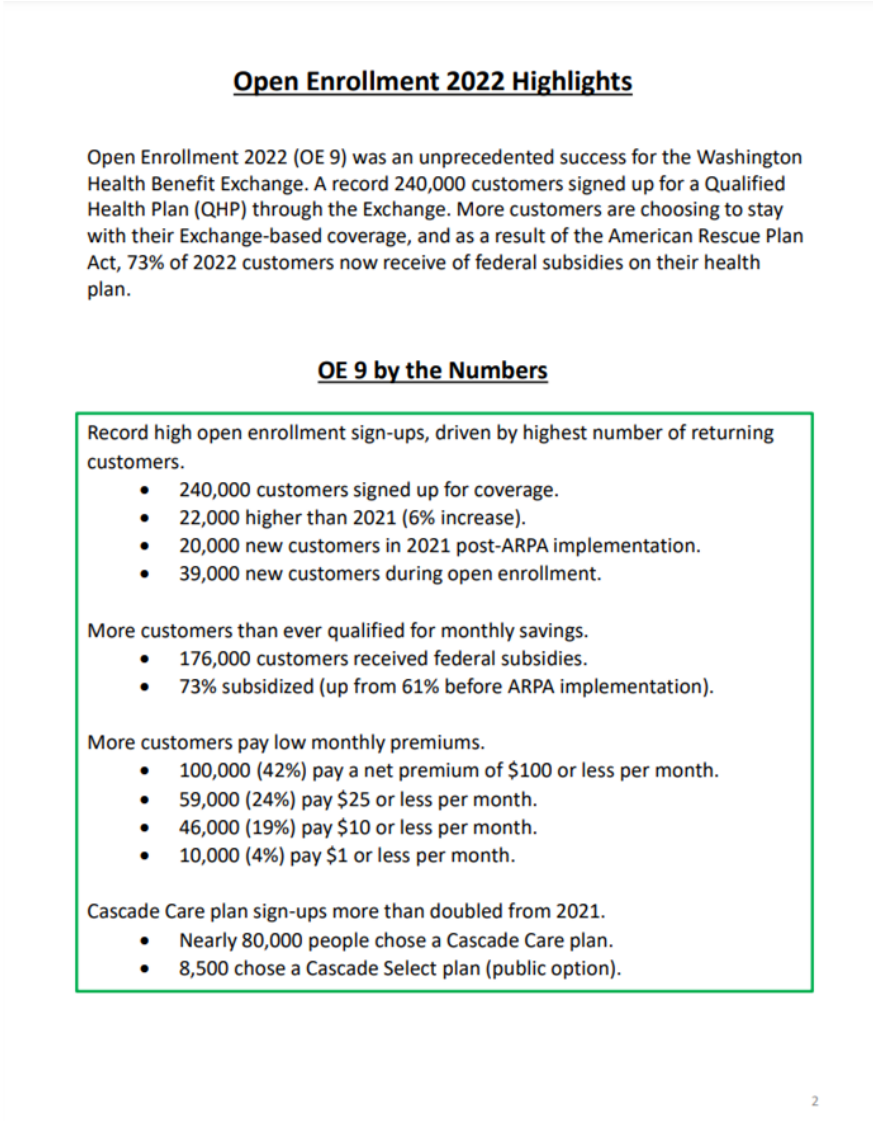
58%
The percentage by which premiums will increase for tax credit eligible consumers when they come back to enroll in Fall 2022, if ARPA savings expire.

California

- **CALIFORNIA** doesn't issue a comparable monthly data report. It does report data mostly through Excel files on its website, but may be more useful for researchers but less user-friendly for the public, electeds and stakeholders.
- Its Annual Report to the governor and legislature is as long as Maryland's, but much more focused on budget details (which might seem superfluous for us since the Budget office already compiles those details for its own reporting to the Executive and Legislative branches.)

Washington state

- **WASHINGTON** State issues data reports on a quarterly or semi-annual basis, sometimes in Excel form, other times as Word docs.
- Not as presentable as Maryland or Colorado.



Open Enrollment 2022 Highlights

Open Enrollment 2022 (OE 9) was an unprecedented success for the Washington Health Benefit Exchange. A record 240,000 customers signed up for a Qualified Health Plan (QHP) through the Exchange. More customers are choosing to stay with their Exchange-based coverage, and as a result of the American Rescue Plan Act, 73% of 2022 customers now receive of federal subsidies on their health plan.

OE 9 by the Numbers

Record high open enrollment sign-ups, driven by highest number of returning customers.

- 240,000 customers signed up for coverage.
- 22,000 higher than 2021 (6% increase).
- 20,000 new customers in 2021 post-ARPA implementation.
- 39,000 new customers during open enrollment.

More customers than ever qualified for monthly savings.

- 176,000 customers received federal subsidies.
- 73% subsidized (up from 61% before ARPA implementation).

More customers pay low monthly premiums.

- 100,000 (42%) pay a net premium of $100 or less per month.
- 59,000 (24%) pay $25 or less per month.
- 46,000 (19%) pay $10 or less per month.
- 10,000 (4%) pay $1 or less per month.

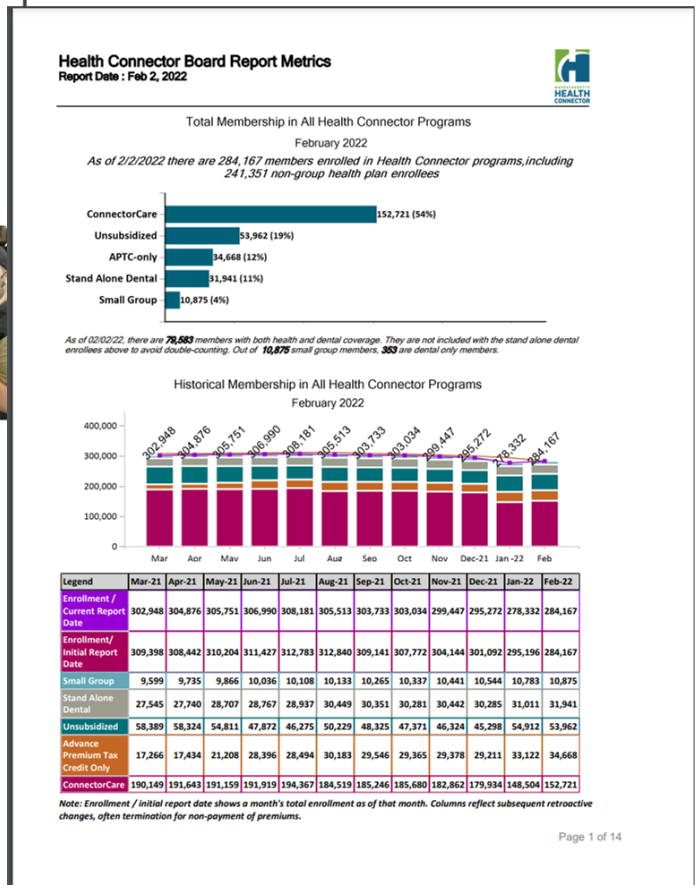
Cascade Care plan sign-ups more than doubled from 2021.

- Nearly 80,000 people chose a Cascade Care plan.
- 8,500 chose a Cascade Select plan (public option).

2

Massachusetts

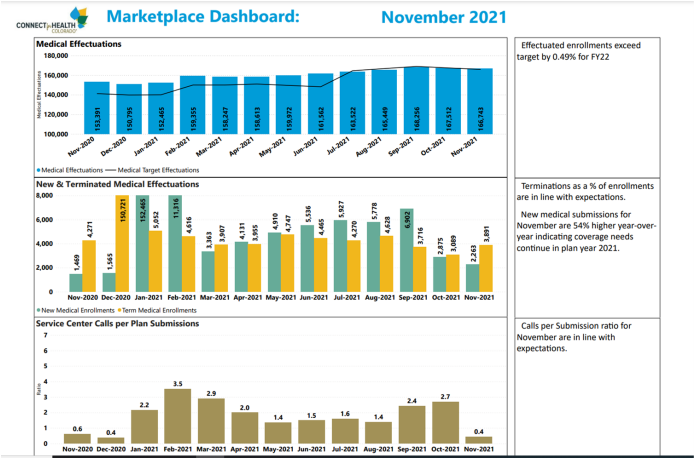
- **MASSACHUSETTS** has an “Annual Report to the Legislature,” issued in January. It is comparable to Maryland’s in scope (blander in presentation).
- They also do a good job of putting data in their board meeting documents (far right) each month.

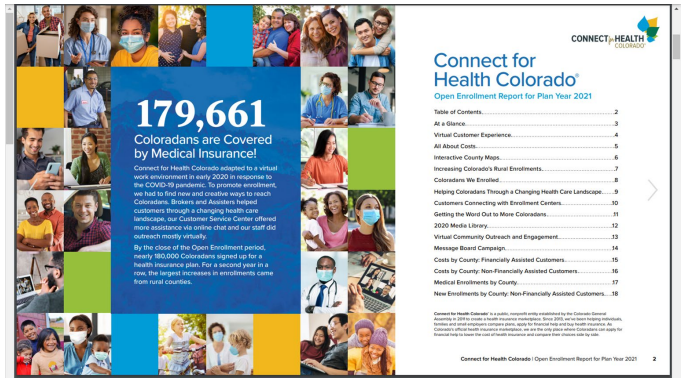


Legend	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Enrollment / Current Report Date	302,948	304,876	305,751	306,990	308,181	305,513	303,733	303,034	299,447	295,272	278,332	284,167
Enrollment/ initial Report Date	309,398	308,442	310,204	311,427	312,783	312,840	309,141	307,772	304,144	301,092	295,196	284,167
Small Group	9,599	9,735	9,866	10,036	10,108	10,133	10,265	10,337	10,441	10,544	10,783	10,875
Stand Alone Dental	27,545	27,740	28,707	28,767	28,937	30,449	30,351	30,281	30,442	30,285	31,011	31,941
Unsubsidized	58,389	58,324	54,811	47,872	46,275	50,229	48,325	47,371	46,324	45,298	54,912	53,962
Advance Premium Tax Credit Only	17,266	17,434	21,208	28,396	28,494	30,183	29,546	29,365	29,378	29,211	33,122	34,668
ConnectorCare	190,149	191,643	191,159	191,919	194,367	184,519	185,246	185,680	182,862	179,934	148,504	152,721

Colorado

- **COLORADO** releases a simpler, two-page monthly report (top). It's clean but doesn't cover demographic or geographic trends, or MA trends.
- It issues an "Annual Report" (middle) by Jan. 15 to meet a statutory deadline, focused mostly on policy, strategic initiatives and future planning, little data.
- It issues a second similarly designed but more data-driven post-"Open Enrollment Report, (bottom) each spring.





How Maryland compares in 2022

Sources: CMS 2022 Public Use Files, ACASignups.net

5th highest growth among 18 State-Based Marketplaces

Maryland's 2022 growth of **10%** year over year was **5th** best among the **18 State-Based Marketplaces**, behind:

1.	Nevada	24
2.	New Jersey	20
3.	Pennsylvania	11
4.	Colorado	11

(Other non-SBM states that did not expand Medicaid typically had larger growth rates in 2022 because MA was not an option for many there during pandemic.)

Tied for **2nd lowest** average premium in nation: $447 a month

Maryland's average premium in 2022 was tied for 2nd lowest in the nation:

- Utah $408
- New Hampshire $447

But Maryland was tied for 24th in nation **after** APTC per month

1. Utah	$62	14. Virginia	$126
2. Mississippi	72	15. Tennessee	128
3. Florida	80	16. Arkansas	134
4. Texas	86	17. Iowa	135
5. Wyoming	88	18. Rhode Island	135
6. South Dakota	91	19. Missouri	137
7. Oklahoma	93	20. Montana	142
8. Alabama	96	21. Kansas	149
9. North Carolina	96	22. California	150
10. North Dakota	100	23. Louisiana	157
11. Georgia	105	24. Alaska	158
12. South Carolina	107	**24. Maryland**	**158***
13. Nebraska	121		

*Income-related

maryland health connection

5th in nation in proportion of **Gold** plans: 46% of total enrollment

Maryland was behind only:

1.	Wyoming	64%
2.	New Mexico	58
3.	Alaska	47
4.	Delaware	47

All State-Based Marketplaces averaged 14% Gold.
All states averaged 10% Gold

Why is that important? Gold policies have lower deductibles than silver and bronze and cover roughly 80% of the average enrollee's in-network health care expenses in a year. This metric reveals **affordability.**

Did MD's additional subsidy propel 26-34 year olds to enroll?

- Maryland grew **9% in the 26-34** year-old bracket. But that % ranked **34th** nationally.
- In that age range, TX grew 46%. AL, AR, AZ, FL, GA, MS, NV, SC, and TN all grew +30%. FFM states (on Healthcare.gov) overall averaged 26% growth among 26-34s.
- It's likely that the pandemic fueled desire for private insurance especially in states where expanded Medicaid eligibility was not an option. Also, the Public Health Emergency meant no one was rolling off Medicaid as before.
- But even in the **SBM states** (all MA Expansion), growth among 26-34s **averaged +13%**.

On a closer inspection, perhaps it did …

- Maryland's 26-34 as a share of total enrollment was the **third best** in the country in both 2021 and 2022 at 19%.
- Only DC at 34% (unique population - skews young) and MA at 22% (extensive state subsidies) ranked higher.
- DC's 26-34s as share of total enrollment fell from 2021 to 2022 (30% to 28%), while MA's held steady at 22%
- DC's total 26-34 enrollment fell by 14% and MA's fell by 16% from '21 to '22, so **MD's +10% growth compares favorably**.

Maryland's Hispanic enrollment growth was impressive, but …

- Maryland grew **14%, best ever**. But that % was **41st** of the 51 marketplaces (including DC). PA grew +200%. MN grew +500%. States on the federal platform grew 26%.
- One probable factor for the boost: Reduction of fear over ACA enrollment / repercussions for citizenship.
- Maryland's **total** Hispanic enrollment – 20,396 – ranked **10th** in the country.
- Maryland's total Hispanic enrollment is also **larger** than in more than a **half-dozen states with larger** Hispanic populations: New York, Colorado, New Mexico, Pennsylvania, Nevada, Washington state, Massachusetts and Nevada.
- From Kaiser Foundation: **Hispanic uninsured rate in MD in 2019 was 21.4%**, compared to 6.9% uninsured overall in MD. In 2009, gap was larger: 33.9% Hispanic uninsured vs. 13% overall.

Maryland's Black enrollment was also unclear viewed nationally

- Maryland grew **11%, best ever**. But that % was **37th** in nation. SD grew 60%. TX grew 50%. MN,GA, DE, MS, OH and VT all grew +40%.
- Maryland's **total** Black enrollment – 30,776 – was **8th** in the country.
- Maryland for 2022 had larger Black enrollment (double) than some states with larger Black populations such as New York and Illinois.
- From Kaiser Foundation: in 2019, Black **uninsured rate in MD estimated at 6.2%**, compared to 6.9% uninsured overall.
- In 2009, gap was: 13.9% Black vs. 13% overall

Questions?

(*Data often produces more than you started with)

Public Comment

Health Equity Appendix Slides

Plan Certification and Affordability Initiatives

Value Plan Standards

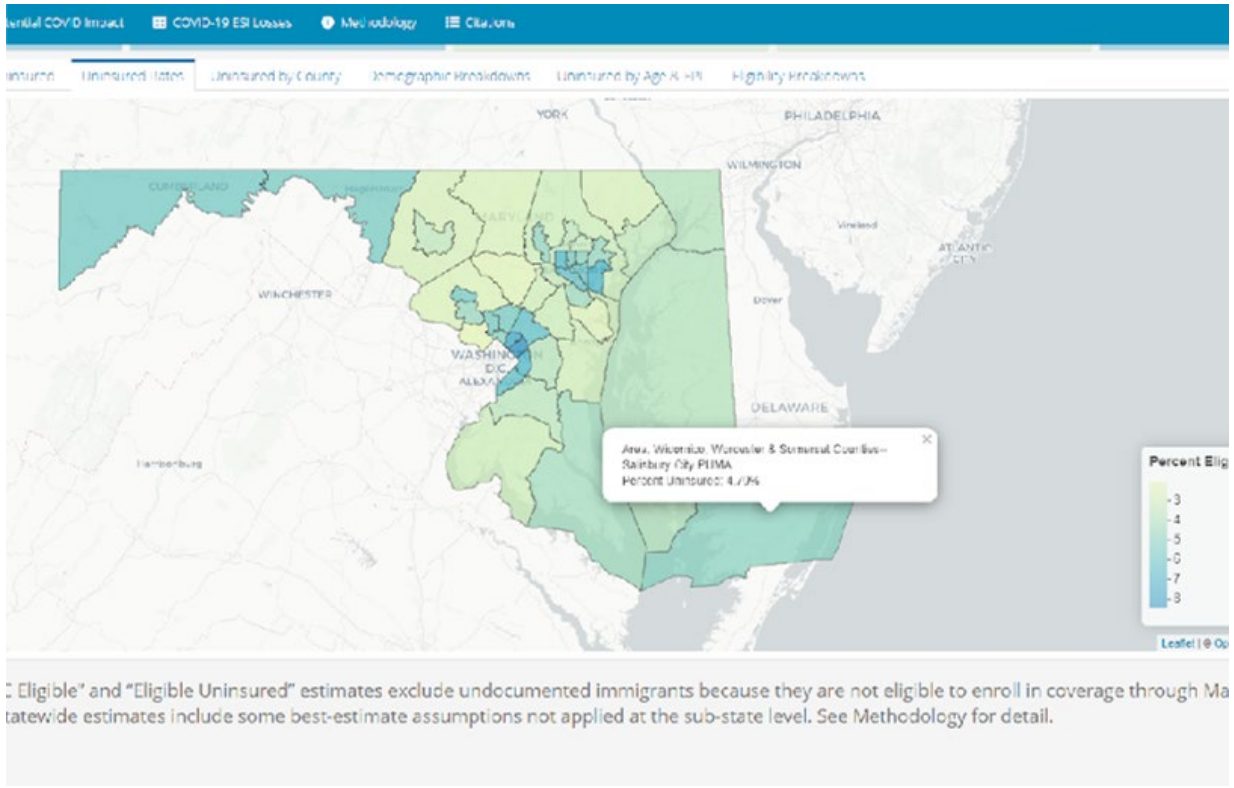
- Diabetes disproportionately affects people of color in Maryland. For PY 2022, MHBE worked to better support Maryland's diabetes initiatives by requiring silver and gold value plans to offer diabetes supplies without cost sharing

Young Adult Subsidy

- Black and Hispanic young adults in Maryland are 2x-3x more likely to be uninsured than White young adults

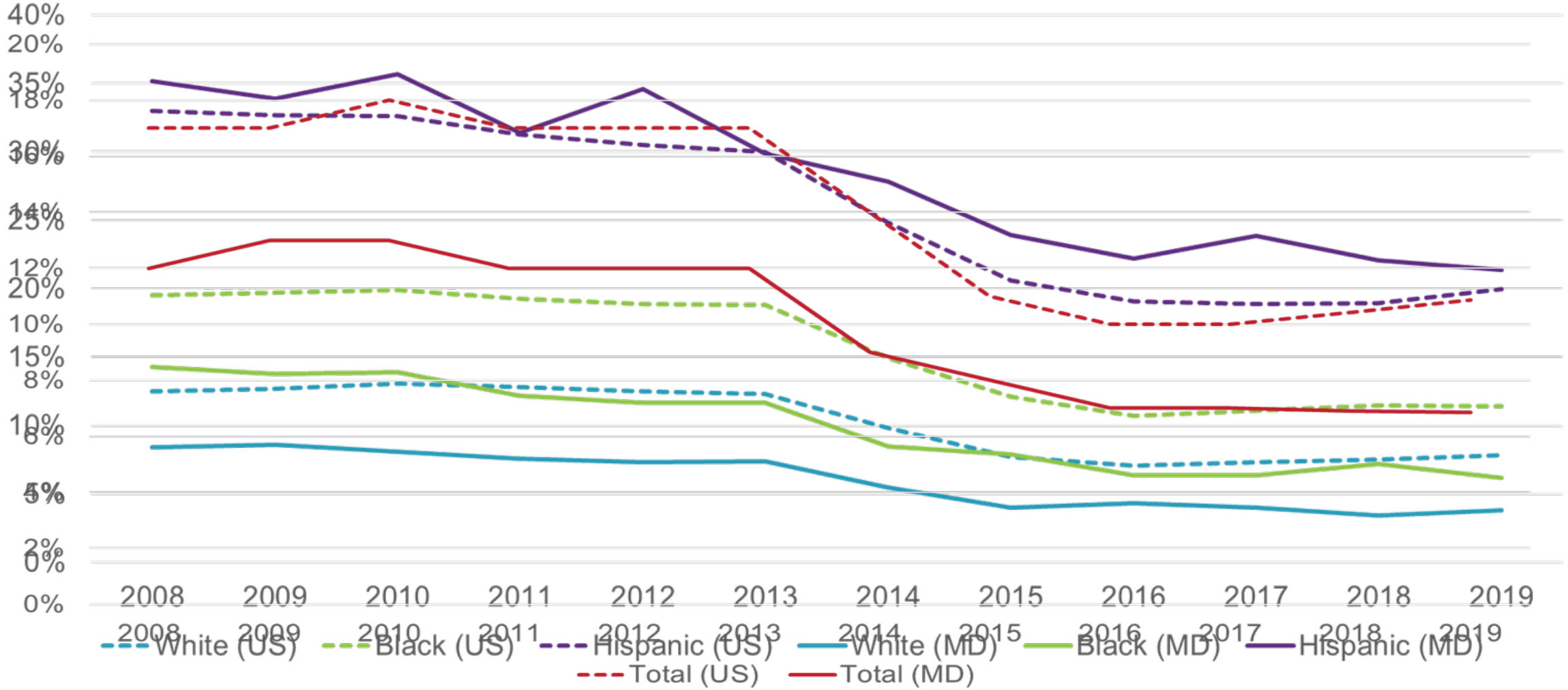
MHBE Uninsured Dashboard

Interactive MHBE Uninsured Dashboard available at: https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html



MARYLAND HEALTHBENEFIT EXCHANGE

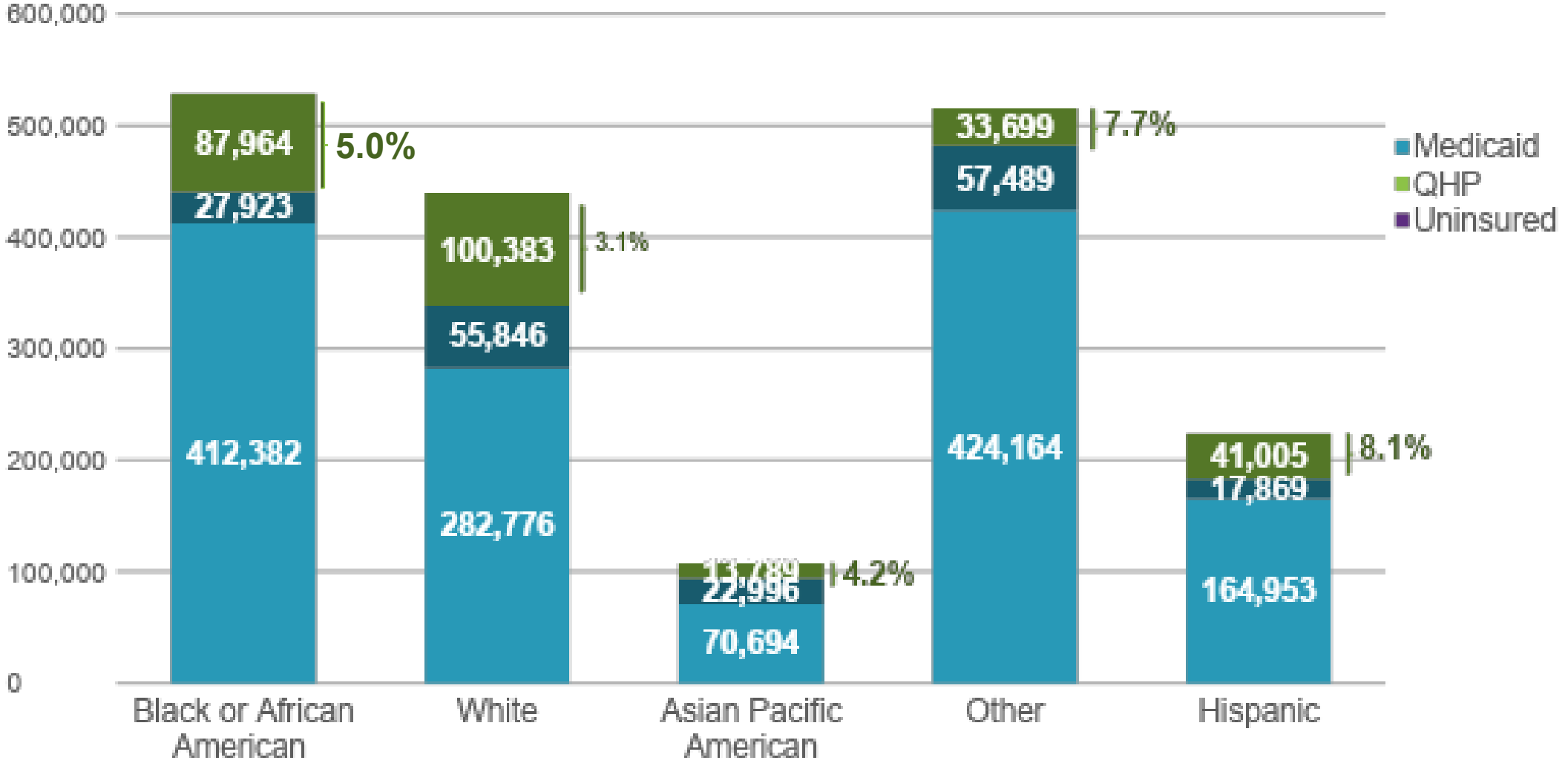
Percent Uninsured by Race and Ethnicity, MD and US



Data from Kaiser Family Foundation, Uninsured Rates for the Nonelderly by Race/Ethnicity, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity

MARYLAND HEALTHBENEFIT EXCHANGE

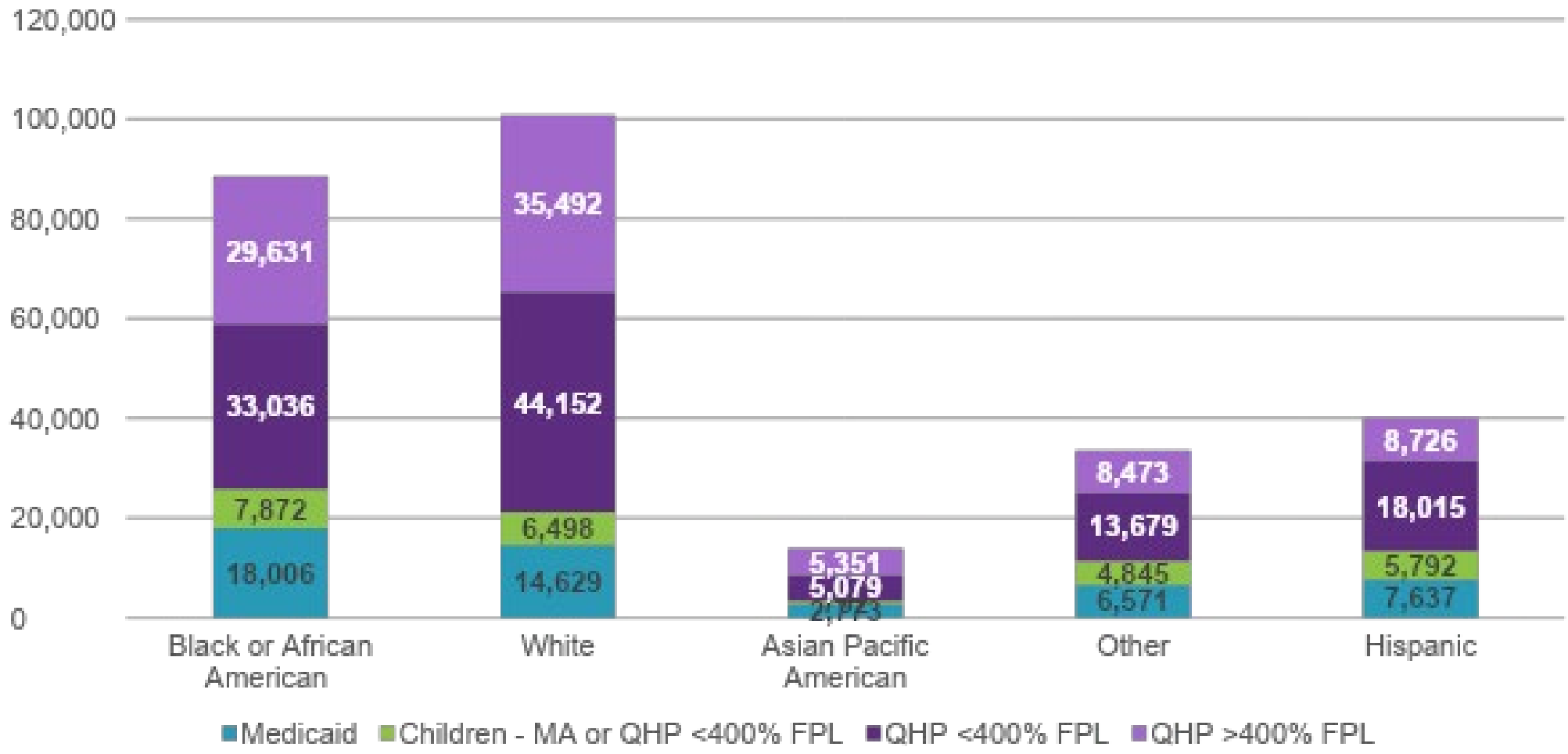
MHBE Medicaid Enrollment, QHP Enrollment, and Uninsured by Race and Ethnicity



MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.

MARYLAND HEALTHBENEFIT EXCHANGE

Uninsured by Eligibility for Financial Assistance, by Race and Ethnicity



MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.

Eligibility & Immigration Status

- Maryland is home to an estimated:
  - 244,693 total undocumented individuals
  - 115,856 **uninsured** undocumented individuals
- MHBE is working on a report on coverage options for undocumented immigrants, as requested by the legislature
  - Staff will notify workgroup members about upcoming briefings
- Resources:
  - Enrollment and Eligibility Information for Immigrant Families (MHC)
  - UNDERSTANDING IMMIGRATION STATUS UNDER THE ACA (MDH)
  - Immigration Fast Facts (CMS)

Eligibility & Immigration Status

Immigration statuses eligible for Individual Marketplace coverage:

- Qualified immigrants under the “5-year bar” (also eligible for APTC)
  - 5-year bar: otherwise-qualified immigrants must be lawfully present for 5 years before they are eligible for Medicaid (with some exceptions)
- Immigrants exempt from 5-year bar
  - Children, pregnant women, asylees, refugees, etc.
- Lawfully residing non-qualified immigrants / individuals with valid nonimmigrant status
  - Student/work visas, temporary resident status, pending application for asylum, etc.

Not eligible for Marketplace coverage:

- Undocumented immigrants
- DACA recipients (7,560 in MD)

Financial assistance eligibility:

- Lawfully present immigrants with income between 138% and 400% FPL
- Qualified immigrants under the 5-year bar with income up to 400% FPL

Highest-Cost Conditions among Reinsurance Claims

- MHBE requires carriers to report on the most frequently occurring and highest-cost conditions and on care management efforts to improve certain conditions
- Highlighted conditions have a significant, disproportionate impact on Black Marylanders

Highest Cost Conditions
Cancers, including breast, prostate, lung brain, colorectal, and metastatic
Congestive Heart Failure
Diabetes
Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Respiratory Arrest, Failure, and Shock
Asthma and COPD
Specified Heart Arrythmias
End Stage Renal Disease
Non-Traumatic Coma, Brain Compression/Anoxic Damage
Protein-Calorie Malnutrition
Coagulation Defects and Other Specified Hematological Disorders
Hemophilia
Inflammatory Bowel Disease
Autistic Disorder
Multiple Sclerosis