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MARYLAND HEALTH BENEFIT EXCHANGE

December 30, 2022

The Honorable Guy Guzzone
Chairman
Senate Budget and Taxation Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

The Honorable Ben Barnes
Chairman
House Appropriations Committee
House Office Building, Room 121
6 Bladen Street
Annapolis, MD 21401

Re: Joint Chairmen's Report – Reinsurance Program Costs and Forecast

Dear Chairman Guzzone and Chairman Barnes:

Pursuant to page 46 of the Joint Chairmen's Report for the 2022 Session, the Maryland Health Benefit Exchange (MHBE) submits this report on the payments made for the reinsurance program for plan year 2021, an updated forecast of spending and funding needs over the waiver period, and a discussion of the waiver renewal timeline and forecast of spending and funding over a second waiver period.

If you have any questions regarding this report, please contact Johanna Fabian-Marks, Director of Policy and Plan Management at (443) 890-3518 or at johanna.fabian-marks@maryland.gov

Sincerely,

Michele Eberle

Michele Eberle
Executive Director
Maryland Health Benefit Exchange

Joint Chairmen's Report:

Reinsurance Program Costs and Forecast

Maryland Health Benefit Exchange

December 30, 2022

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I. Introduction

The 2022 Joint Chairmen's Report on the Fiscal 2023 State Operating Budget (SB 290) and the State Capital Budget (SB 291) and Related Recommendations[1] requests that the Maryland Health Benefit Exchange (MHBE) provide a report on the State Reinsurance Program (SRP) costs and future spending. Specifically, MHBE is requested to provide for the reinsurance program:

> "a report that provides an updated forecast of spending and funding needs."

The purpose of the SRP is to mitigate the premium impact of high-cost enrollees in the individual market. The SRP has been highly successful, having reduced rates by more than 30% since the program's launch and providing relief for Marylanders who had experienced significant premium increases in the years before the SRP took effect.

II. Background

During the 2018 legislative session, the Maryland General Assembly passed House Bill 1795 – Establishment of a State Reinsurance Program (HB 1795), which was then signed into law by Gov. Larry Hogan on April 5, 2018. HB 1795 was an emergency measure that directed the Maryland Health Benefit Exchange to submit a Section 1332 State Innovation Waiver to the U.S. Secretaries of Health and Human Services (HHS) and the Treasury to establish a State Reinsurance Program.

Senate Bill 387, Health Insurance – Individual Market Stabilization (Maryland Health Care Access Act of 2018) (Ch. 37, Acts 2108), also passed during the 2018 session. It created a new § 6-102.1 of the Insurance Article and established a health plan assessment to be collected in 2019 to help fund the SRP. Section 9010 of the Affordable Care Act (ACA) created a federal health insurance provider fee ("9010 fee") for covered entities engaged in the business of providing health insurance. The 9010 fee was based on the entity's net premiums for the year and was estimated at about 2.75% to 3%.[2] The federal spending bill enacted in January 2018 suspended the collection of this federal fee for 2019. SB 387 applied a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations that are regulated by the state and allows the state to collect certain funds that the federal government would have collected under Section 9010.

On May 18, 2018, the MHBE submitted an application to HHS to waive Section 1312(c)(1) of the ACA for a period of five years to implement the SRP. The waiver proposed to cover plan years 2019 through 2023 and allow Maryland to include expected state reinsurance payments when establishing the market wide index rate, decreasing premiums and federal payments of advance premium tax credits (APTCs).

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[1] Available at https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2022rs-budget-docs-jcr.pdf

[2] Levitis, Jason. Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee. State Health and Value Strategies. Jan 30, 2020. https://www.shvs.org/considerations-for-a-state-health-insurer-fee-following-repeal-of-the-federal-9010-fee/

MHBE proposed that the SRP would operate as a traditional, claims-based reinsurance program that reimburses qualifying health insurers for a percentage of an enrollee's claims between an attachment point and cap. For plan year 2019, Maryland implemented a cap of $250,000, a coinsurance rate of 80 percent, and an attachment point of $20,000.

On August 22, 2018, the Centers for Medicare and Medicaid Services (CMS), on behalf of HHS and the Department of the Treasury, approved Maryland's State Innovation waiver for a period of January 1, 2019 through December 31, 2023.[3]

During the 2019 Session, House Bill 258/Senate Bill 239 was passed to establish a state-based health insurance provider assessment of 1% to fund the SRP through 2023. In 2020, the U.S. Congress enacted the Further Consolidated Appropriations Act, which repealed the federal 9010 fee for calendar years beginning after December 31, 2020. Consequently, the General Assembly passed a technical correction to the applicability of the assessment (Senate Bill 124 of 2020, Maryland Health Benefit Exchange – Assessment Applicability and State–Based Individual Market Health Insurance Subsidies) to remove the language from House Bill 258/Senate Bill 239 that attached Maryland's assessment to the now repealed 9010 fee and to ensure that the state-based health insurance provider assessment continued to apply as intended.

During the 2022 Session, House Bill 413/Senate Bill 395 was passed to extend the 1% health insurance provider assessment through calendar year 2028, in order to facilitate the state's application to the federal government to extend the SRP for a second 5-year waiver period, through 2028, and to provide state reinsurance funds to support the SRP during that time. The legislation also tasks the Maryland Insurance Administration, in consultation with MHBE and the Maryland Health Care Commission, with submitting a report to the General Assembly by December 1, 2023 on the impact of the SRP, including the adequacy and appropriateness of the 1% assessment, the SRP's program design, and market reforms needed to provide affordable health coverage in the individual market.

III. Impact of the State Reinsurance Program

The SRP continues to stabilize the individual market: premiums are down, enrollment is up, and a new carrier entered the individual market for 2021 and expanded to serve the individual market statewide for 2022. After four years of average premium increases in the double digits, premiums fell by double digits for three years, from 2019-2021, as the full impact of the SRP was gradually factored into rates. Rates for 2022 increased slightly, by 2.1%, and continued to rise for 2023, by 6.6%. In total, premium rates in that market decreased by an average of more than 30% in the first three years of the program; after the last two years of single-digit increase, premiums are still 25% below 2018 averages. The return to moderate rate increases beginning with 2022 rates was

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf

not unexpected. The reinsurance program was initially projected to decrease rates for individual insurance by 30% over three years, with future changes tied to claim trends.

Prior to implementation of the SRP, on-exchange enrollment declined in 2017 and 2018 by 3.1% and 2.6%, respectively, while total individual market enrollment declined by 15.0% and 14.9%. In contrast, enrollment has increased significantly since the inception of the program. As of June 2022, on-exchange enrollment is up 24.9% compared to June 2019.[4] Looking more broadly at both on and off exchange individual market enrollment, we also see substantial gains, with total individual market enrollment up about 22.1% between June 2019 and June 2022.[5] Although multiple factors have contributed to on-exchange enrollment increases, including the Easy Enrollment Program that started in 2020, the COVID-19 special enrollment period in place from March 2020 through August 2021, and the enhanced federal premium subsidies launched in April 2021 under the American Rescue Plan Act, the SRP's reduction in baseline health insurance premiums has made purchasing health insurance more attainable. Without the reinsurance program, premiums would be an estimated 50 percent or more higher.

In addition, in May 2020 UnitedHealthcare announced that it was rejoining the individual market, making 2021 the first year with an increase in the number of individual market carriers since 2015. In 2022, UnitedHealthcare expanded its service area to cover the full state of Maryland, leading all individual market enrollees to have at least 2 carriers from which to choose. This indicates that carrier confidence in the Maryland individual market has grown as a result of the SRP.

Table 1. MHBE On-Exchange Summary Data, 2014-2022

Benefit Year	Participating carriers (#)	Enrollment[6]	Subsidized/ Unsubsidized (%)[7]	Average Premium Change (%)
2014	4	81,553	80/20	-
2015	5	131,974	70/30	10%
2016	5	162,652	70/30	18%
2017	3	157,637	78/22	21%
2018	2	153,571	79/21	50%
2019	2	156,963	77/23	-13%
2020	2	158,934	76/24	-10%
2021	3	166,038	73/27	-12%
2022	3	182,861	79/21	2%

[4] Maryland Health Connection Data Reports, July 31, 2019, and July 31, 2022. Enrollment increased from 137,828 to 172,183. Data available at http://www.marylandhbe.com/wp-content/uploads/2021/08/Executive-Report_07312021.pdf and https://www.marylandhbe.com/wp-content/uploads/2019/09/Executive-Report_07_31_2019.pdf.

[5] Enrollment increased from 190,409 to 232,553. Data provided by the Office of Chief Actuary, Maryland Insurance Administration on 9/12/22.

[6] Enrollment reported as of the end of open enrollment preceding the applicable plan year.

[7] The American Rescue Plan Act removed the 400% federal poverty limit cap on eligibility for federal premium subsidies, leading to an increase in the percent of enrollees receiving subsidies in 2022.

IV. Program Costs for Plan Year 2021

A. 2021 Program Spending and Funding

In July 2021, Lewis & Ellis projected total program costs for 2021 of approximately $432.6 million.[8] Actual program costs for 2021, finalized in July 2022, consisted of approximately $467.7 million in payments to carriers (approximately 8% higher than projected in 2021) and $56,994 in program administration.[9] It appears that the primary reason for the 8% difference is that 2021 actual claims were higher than expected due to the ongoing COVID-19 pandemic.

On September 7, 2021, HHS notified the MHBE that the Department of the Treasury's final administrative determination for pass through funding would be about $474.5 million for calendar year 2021.[10] The 2021 health insurance provider assessment of 1% collected $124,158,202 for the state reinsurance fund. Spending and funding numbers for 2021 are presented below in Table 2 and additional detail on spending is provided in Table 3.

Table 2. 2021 SRP Payments to Carriers, Federal Funding, Individual Market Enrollment, and Average Premium

Total Payments to Carriers	Total Federal Funding	Total Individual Market Enrollment[11]	Average Individual Market Premium PMPM[12]
$467,658,488	$474,542,755	222,049	$424

Table 3. 2021 SRP Cost Breakdown

Spending	Value	Comments
Amount of Federal pass-through funding spent on individual claims payment to issuers from the reinsurance program	$467,658,488	
CareFirst BlueChoice, Inc.	$300,322,022	
CareFirst of Maryland, Inc.	$48,197,830	
GHMSI	$33,137,252	

[8] In August 2019, the MHBE contracted with Lewis & Ellis, Inc. to provide ongoing actuarial analysis to inform administration of the SRP. Lewis & Ellis updates SRP spending and funding forecasts at least annually, using updated data and assumptions.
[9] Federal pass-through funding may be used to cover program administration costs.
[10] Maryland 2021 Pass-Through Funding Letter. September 7, 2021. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-MD-ARP-2021.pdf
[11] 2021 total individual market enrollment calculated by MHBE as the 2021 individual market member-months reported in the 2021 Reinsurance Summary Report provided by CMS to MHBE, divided by 12.
[12] 2021 average individual market premium PMPM was calculated by MHBE using the 2021 total individual market premium and 2021 individual market member-months reported in the 2021 Reinsurance Summary Report provided by CMS to MHBE.

Kaiser Foundation Health Plan, Mid-Atlantic, Inc.	$81,956,876	
Optimum Choice, Inc.	$4,044,509	
Amount of Federal pass-through funding spent on operation of the reinsurance program	$56,994	$8,000.00 on EDGE Server fees and $48,994 on actuarial support services
Amount of any unspent balance of Federal pass-through funding for the reporting year	$74,202,179	
Amount from the state reinsurance fund needed to fully fund the program for the reporting year	$0	No funds from the state reinsurance fund were necessary for plan year 2021, as federal funding was sufficient to cover the cost of the program

V. Program Forecast through 2023

A. Projected Program Spending and Projected Federal Funding

Table 4 below presents the most recent October 2022 SRP spending and funding projections through the end of 2023, the end of the current waiver period, as modeled by Lewis & Ellis.

The reinsurance program is in a different financial situation than was projected in the initial years of the program, when it was projected that federal funding could be sufficient to cover the cost of the program through 2023. This stems from a number of factors. At a high level, program cost projections have increased, and federal funding projections have decreased, while special funds from the state reinsurance fund available to support the program have also decreased. MHBE still projects that the program will be fully funded through 2023 but anticipates that special funds from the state reinsurance fund will be required to support the program, with a remaining state reinsurance fund balance at the end of 2023 of approximately $373M.

i. Program Expenditures

Program costs continue to grow due to increasing enrollment in the individual market, the impact of the pandemic on claims in 2020 and 2021, medical trend, and, for 2023, a reduction in the attachment point from $20,000 to $18,500. (The impact of the reduced attachment point is offset by a $50 million reduction in state reinsurance funds that had been slated to be transferred to Medicaid but will instead remain in the state reinsurance fund). Additionally, in the 2021 legislative session a significant amount of funding was withdrawn from the state reinsurance fund or earmarked for future withdrawals to support other state initiatives. Note that these initiatives may only be funded through the state funding generated by the state-based health insurance

provider assessment; federal pass-through funding may not be used for programs other than the SRP. The state reinsurance program funding dedicated to other state initiatives includes $100M in FY 21 and $50M (as noted above, reduced from a previously planned $100M) in FY 22 to support the Medicaid program, a total of $40M across three fiscal years (two plan years) to support a state young adult premium subsidy ($10M in FY 22, $20M in FY 23, $10M in FY 24; projected actual spend for FY 22 is $6.6M), $15M per year in FY 23-25 to support health equity resource zone grants, $8M per year for FY 23 and FY 24 for the Community Health Resources Commission (CHRC), and $1.9M in FY 22 for the Senior Prescription Drug Affordability Program, for a total reduction in state funding of $218.9M through FY 23.

ii. Program Funding

The American Rescue Plan Act increased federal premium subsidies for 2021 and 2022, and the Inflation Reduction Act passed in August 2022 extended the enhanced federal premium subsidies through 2025. This extension will increase federal pass-through funding in 2023-2025 relative to a scenario in which the enhanced subsidies had not been extended. Despite the effect of the enhanced subsidies, we saw a 27% reduction in federal funding from 2021 to 2022, primarily due to the impact of a third carrier entering the individual market statewide, which lowers premium tax credit spending by the federal government and affects the blend of carrier assumptions regarding the impact of the SRP on rates. From 2023 through 2025, we expect to see federal funding increase from the reduced 2022 amount, with another significant decline projected in 2026 if the enhanced federal premium subsidies are not extended again.

The projected state reinsurance funding generated by the state-based health insurance provider assessment has increased slightly since last year. The assessment totaled approximately $131 million in 2022 and is estimated to collect approximately $135 million in 2023. The federal terms and conditions of the State Innovation Waiver, in the section titled “Legislation Authorizing and Appropriating Funds to the reinsurance program”, state that “the MHBE must ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in the MHBE's waiver application”. The 2019 and 2020-2028 health insurance provider assessment ensures that Maryland has consistent funding to support the SRP and allows Maryland to access the federal pass-through funding that undergirds the SRP.

Any unspent federal funds or state reinsurance funds can be rolled forward to support the SRP in future years. We project that starting with plan year 2022 (FY 2024), the cost of the program will exceed that year’s federal funding, and we will start drawing down on the state reinsurance fund to support the program.

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MARYLAND HEALTH BENEFIT EXCHANGE

Table 4. SRP Financial Overview, Plan Years 2019-2023 (millions)

	2019	2020	2021	2022	2023
SRP Cost	$353	$400	$468	$519	$582
MA Budget Transfer			$100	$50	
Young Adult Subsidy				$16	$20
Health Equity					$15
CHRC				$8	$8
SPDAP				$1.9	
Federal Funding	$374	$447	$475	$344	$439
State Funding	$327	$118	$124	$131	$135
Approx. End of Year Balance – Fed.	$20	$67	$75	$0	$0
Approx. End of Year Balance - State Reinsurance Fund	$327	$445	$469	$424	$373

End of year balances may not sum due to rounding; also, nominal administrative costs are not shown.

VI. Carrier Accountability Reporting

MHBE regulations require all carriers participating in the SRP to submit an annual report that describes carrier activities to manage the costs and utilization of the enrollees whose claims were reimbursed by the SRP, as well as efforts to contain costs so enrollees do not exceed the reinsurance threshold.[13] The second year of data under this requirement was collected in 2021, for plan year 2020. A report summarizing key findings, as well as the carriers' data submissions, are available on the MHBE website.[14] Background and highlights from plan year 2020 are summarized below. MHBE is in the process of collecting the third year of reports, for plan year 2021.

These early years of reports serves as baseline. By allowing data to be tracked year-over-year, future reports will provide more meaningful information on the effectiveness and savings of the interventions that the carriers report. Going forward, MHBE will use these reports as a basis for conversations with carriers about their care management programs and initiatives to improve outcomes and manage SRP costs. MHBE is interested in exploring how we can encourage carriers to align care management activities for individual market enrollees with state population health initiatives, as well as focus on those conditions that are driving reinsurance payments and involve potentially preventable costs.

[13] COMAR 14.35.17.03(C)
[14] https://www.marylandhbe.com/policy/reinsurance-program/

A. Reporting Overview

MHBE collected data from carriers on the following items:

- The initiatives and programs the carrier administers to manage costs and utilization of enrollees whose claims are reimbursable under the SRP;
- The total population of enrollees whose claims are reimbursable under the SRP, the allocation of these enrollees across each of the initiatives and programs described above, and the allocation of enrollees who do not participate in these initiatives and programs;
- The effectiveness of the initiatives and programs, as measured by the estimated reduction of claims and utilization, and actions the carrier will take to improve on the effectiveness;
- Estimated savings to the SRP and estimated rate impact due to these programs and initiatives, and the methodology used to make these estimates; and
- Population health initiatives and outcomes for individual market enrollment.[15]

MHBE asked carriers to report on targeted initiatives addressing diabetes, behavioral health, asthma, and pregnancy/childbirth, as well as health outcomes addressing these conditions. These conditions were chosen to align with state population health goals and because they can have preventable costs. In order to protect patient privacy, carriers were asked to report on initiatives that served 300 or more total individual market enrollees.

B. Key Findings

The table below lists the most prevalent and costly Hierarchical Condition Categories (HCCs) among the claims reimbursed by the SRP, according to data reported by the carriers. HCCs are groupings of related diagnoses that are used by the federal risk adjustment program and are a way to classify diagnosis codes into meaningful categories. Table 6 presents, in descending order, the most frequently occurring and the highest cost HCCs among SRP claims across both carriers. MHBE notes that the top HCCs reimbursed by the SRP include conditions of state population health interest—diabetes, asthma, and behavioral health. Various cancers accounted for both the highest cost HCCs in both years.

[15] Reporting instructions are available here and a corresponding reporting template is available here.

Table 5. Top Hierarchical Condition Categories by Count and Cost, PY 2019 and 2020 SRP

	Most Frequent		Highest Cost	
	2019	2020	2019	2020
1	Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Diabetes	Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others
2	HIV/AIDS	HIV/AIDS	Congestive Heart Failure	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
3	Diabetes	Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others	Diabetes	Respiratory Arrest, Failure and Shock
4	Major Depressive and Bipolar Disorders	Congestive Heart Failure	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Diabetes
5	End Stage Renal Disease	Asthma and COPD	Respiratory Arrest, Failure, and Shock	Congestive Heart Failure

In 2020, Kaiser Permanente and CareFirst both had care management initiatives targeting diabetes and behavioral health.

- CareFirst had Diabetes Care Management and Behavioral Health and Substance Use Disorder Care Management Programs in PYs 2019 and 2020 and implemented a new Diabetes Virtual Care Program in 2020
- Kaiser Permanente had a Diabetes Care Management in PYs 2019 and 2020, a Diabetes Educational Video Program in PY 2019, a new Diabetes Glucometer Program in 2020, and a new Depression Care Management Program in 2020.

Neither carrier reported care management initiatives targeting asthma or pregnancy.

I. 1332 Waiver Renewal

The federal Section 1332 waiver approved by the federal government enables Maryland to receive federal funds to support the SRP. The federal government authorizes 1332 waivers for a 5-year period. The current waiver is authorized for calendar years 2019-2023 and expires December 31, 2023. In accordance with federal submission deadlines, MHBE will submit a letter of intent to extend the waiver through 2028 by December 31, 2022, and intends to submit the extension application by March 31, 2023.

Appendix: 10-Year Projections (Plan Years 2019-2029)

State Reinsurance Fund 10-Year Projections

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029
Baseline (Turn Off)											
Total Non-Group Enrollment	179,708	197,546	207,932	244,182	257,968	244,355	245,552	214,087	215,136	216,192	217,254
APTC Enrollment	113,588	124,638	147,891	180,781	195,839	185,059	185,977	135,396	136,060	136,886	137,558
Total Non-Group Premium PMPM	$ 799	$ 749	$ 633	$ 618	$ 687	$ 723	$ 764	$ 794	$ 839	$ 886	$ 935
Gross Premium PMPM for APTC Mbrs	$ 863	$ 815	$ 709	$ 699	$ 771	$ 814	$ 859	$ 915	$ 967	$ 1,021	$ 1,077
Net Premium PMPM for APTC Mbrs	$ 115	$ 80	$ 112	$ 180	$ 213	$ 216	$ 230	$ 227	$ 242	$ 260	$ 278
APTC PMPM	$ 749	$ 743	$ 599	$ 509	$ 547	$ 597	$ 629	$ 689	$ 724	$ 761	$ 799
Total Premiums	$ 1,722,994,592	$ 1,775,435,632	$ 1,580,310,698	$ 1,809,415,387	$ 2,127,856,855	$ 2,121,004,326	$ 2,251,179,075	$ 2,040,353,110	$ 2,165,388,683	$ 2,298,323,511	$ 2,438,212,343
Total APTCs	$ 1,020,470,372	$ 1,111,674,904	$ 1,062,775,639	$ 1,103,168,462	$ 1,285,587,016	$ 1,326,401,092	$ 1,404,025,842	$ 1,118,821,729	$ 1,182,361,723	$ 1,249,417,583	$ 1,319,323,975
After Reinsurance											
Attachment Point	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 18,500	$ 19,000	$ 19,500	$ 20,000	$ 20,500	$ 21,000	$ 21,500
Reinsurance Cost	$ 352,840,511	$ 400,166,658	$ 467,658,488	$ 519,238,420	$ 581,972,216	$ 622,958,130	$ 654,827,842	$ 649,626,552	$ 682,762,510	$ 717,225,570	$ 753,062,274
State Reinsurance Fee	2.75%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
State Reinsurance Fee Funding	$ 326,606,485	$ 118,517,416	$ 124,158,202	$ 130,897,529	$ 135,478,942	$ 140,220,705	$ 145,128,430	$ 150,207,925	$ 155,465,202	$ 160,906,484	$ 166,538,211
Change in SLCSP Premium	50%	57%	47%	43%	48%	49%	49%	50%	50%	50%	49%
Total Non- Group Premium PMPM	$ 529	$ 472	$ 426	$ 426	$ 456	$ 477	$ 504	$ 523	$ 552	$ 584	$ 616
APTC PMPM	$ 462	$ 434	$ 404	$ 356	$ 352	$ 392	$ 413	$ 428	$ 452	$ 473	$ 498
Change in Total Non-Group Enrollment	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%	6.4%
Total Non-Group Enrollment	191,178	210,155	221,204	259,769	274,434	259,952	261,226	227,752	228,869	229,992	231,122
APTC Enrollment	113,296	122,984	137,951	168,908	189,160	175,086	175,957	132,338	132,987	134,776	135,438
Total Premiums	$ 1,213,524,479	$ 1,189,580,622	$ 1,130,554,973	$ 1,328,462,859	$ 1,500,965,888	$ 1,488,747,763	$ 1,580,435,034	$ 1,429,264,859	$ 1,517,178,291	$ 1,610,451,564	$ 1,709,409,109
Total APTCs	$ 627,665,728	$ 640,913,580	$ 669,536,444	$ 721,210,493	$ 798,451,389	$ 822,911,692	$ 871,510,731	$ 680,414,473	$ 721,285,551	$ 764,508,258	$ 810,060,267
Savings											
Estimated APTC Savings	$ 392,779,706	$ 465,769,486	$ 393,239,195	$ 362,860,070	$ 462,778,846	$ 478,314,930	$ 505,889,356	$ 416,486,893	$ 438,022,364	$ 460,663,859	$ 483,800,523
Estimated Federal Pass Through	$ 373,395,635	$ 447,277,359	$ 474,542,755	$ 344,149,951	$ 438,916,624	$ 453,651,623	$ 479,804,231	$ 395,011,619	$ 415,436,658	$ 436,910,692	$ 458,854,362
Estimated Pass Through % of Reinsurance Costs	106%	112%	101%	66%	75%	73%	73%	61%	61%	61%	61%
Funding Available											
Federal funding remaining EOY (carried forward)	$ 20,555,124	$ 67,665,825	$ 74,550,093	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
State funding remaining EOY (carried forward)	$ 326,606,485	$ 445,123,901	$ 469,282,103	$ 423,741,255	$ 373,164,605	$ 329,078,803	$ 284,183,622	$ 179,776,615	$ 67,915,965	$ (51,492,429)	$ (179,162,129)

Year	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**
Inflow											
State Funding	326,606,485	118,517,416	124,158,202	130,897,529	135,478,942	140,220,705	145,128,430	150,207,925	155,465,202	160,906,484	166,538,211
Federal pass through	373,395,635	447,277,359	474,542,755	344,149,951	438,916,624	453,651,623	479,804,231	395,011,619	415,436,658	436,910,692	458,854,362
Outflow											
Reinsurance Payment	352,840,511	400,166,658	467,658,488	519,238,420	581,972,216	622,958,130	654,827,842	649,626,552	682,762,510	717,225,570	753,062,274
State adjustment (sum of below)		-	100,000,000	75,900,000	43,000,000	15,000,000	15,000,000				
Medicaid[1]			100,000,000	50,000,000							
Young Adult Subsidy[2]				16,000,000	20,000,000						
Health Equity Grants[3]					15,000,000	15,000,000	15,000,000				
Community Health Resources Commission[4]				8,000,000	8,000,000						
Senior Prescription Drug Affordability Program[5]				1,900,000							
Net Funding EOY	347,161,609	512,789,726	543,832,195	423,741,255	373,164,605	329,078,803	284,183,622	179,776,615	67,915,965	(51,492,429)	(179,162,129)

[1] Md. INSURANCE Code Ann. § 6-102.1(d)(1)(i) In each of fiscal years 2021 and 2022, $ 100,000,000 of the funds collected from the assessment required under this section shall be transferred in accordance with subparagraphs (ii) and (iii) of this paragraph to Medical Care

[2] Md. INSURANCE Code Ann. § 31-122(e) Subject to available funds, in each of fiscal years 2022 through 2024, the Exchange may designate funds from the Fund to be used for the Pilot Program so that not more than $ 20,000,000 in annual subsidies may be provided to young adults who meet the subsidy eligibility and payment parameters established under subsection (d) of this section in calendar years 2022 and 2023

[3] SB172 of 2021/Md. INSURANCE Code Ann. § 31-107(f)(2) In each of fiscal years 2023 through 2025, the Governor shall: (i) transfer $ 15,000,000 to the Health Equity Resource Community Reserve Fund

[4] Md. INSURANCE Code Ann. § 6-102.1(d)(2) At the beginning of each of fiscal years 2023 and 2024, the Governor shall transfer the first $ 8,000,000 of the funds collected from the assessment required under this section to the Community Health Resources Commission.

[5] 2021 BRFA (pg 18) https://mgaleg.maryland.gov/2021RS/fnotes/bil_0009/hb0589.pdf

Projections reflect $18,500 attachment point in 2023 and assume attachment point increases by $500 each year thereafter. Projections reflect enhanced federal premium subsidies in 2021 through the end of 2025. Actual and projected figures do not include MHBE's modest administrative costs.