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MARYLAND HEALTH BENEFIT EXCHANGE

September 30, 2023

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 39 of the Joint Chairmen's Report for the 2023 Session, the Maryland Health Benefit Exchange (MHBE) submits this report on the payments made for the reinsurance program for plan year 2022, 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

Joint Chairmen's Report:

Reinsurance Program Costs and Forecast

Maryland Health Benefit Exchange
September 30, 2023

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I. Introduction

The 2023 Joint Chairmen's Report on the Fiscal 2024 State Operating Budget (HB 200) and the State Capital Budget (HB 201) 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 significantly and provided relief for Marylanders who 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

[1] Available at https://dls.maryland.gov/pubs/prod/OperBgt/Joint-Chairmens-Report-2023-Session.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/

expected state reinsurance payments when establishing the market wide index rate, decreasing premiums and federal payments of advance premium tax credits (APTCs).

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.

On March 30, 2023, MHBE submitted an application to CMS and the Department of Treasury to extend the 1332 State Innovation Waiver authorizing the SRP for an additional five-year period, through December 31, 2028. The application was approved on June 28, 2023.

On July 17, 2023, the MHBE Board of Trustees finalized the 2024 SRP parameters of an attachment point of $20,000, coinsurance rate of 80%, cap of $250,000, and a dampening factor to be determined by the Insurance Commissioner.

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

III. Impact of the State Reinsurance Program

The SRP continues to stabilize the individual market: premiums are down, enrollment is up, and two carriers have entered the individual market since the program launched. The SRP was designed to reduce rates by 30% in three years and, thereafter, to align future rate increases with increases in claim and cost trends. The program has performed as expected or better. Individual market rates fell more than 30% from 2019-2021 and, since then, increases have been consistently below the claim trends. In 2022 through 2024, average annual rate increases were 2.1%, 6.6%, and 4.7%, respectively. After the last few years of single-digit increase, average premiums are still more than 20% below 2018 levels.[4]

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 2023, on-exchange enrollment is up 34.7% compared to June 2019.[5] Looking more broadly at both on and off exchange individual market enrollment, we also see substantial gains, with total individual market enrollment up about 20.2% between June 2019 and June 2023.[6] Although multiple factors have contributed to on-exchange enrollment increases, including the Tax Time Easy Enrollment Program that started in 2020, the COVID-19 special enrollment period in place from March 2020 through August 2021, the enhanced federal premium subsidies launched in April 2021 under the American Rescue Plan Act, and the Unemployment Easy Enrollment Program that launched in 2022, 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 52 percent higher.

In addition, Aetna Health Inc. will be joining the individual market for plan year 2024. Aetna Health will be offering plans statewide, giving individual market enrollees in all counties three carriers from which to choose. This follows UnitedHealthcare's reentry to the individual market in 2021, which was 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. These additions indicate that carrier confidence in the Maryland individual market has grown as a result of the SRP.

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[4] "Maryland Insurance Administration Approves 2024 Affordable Care Act Premium Rates: Reinsurance Program Continues Positive Impact on Individual Rates," *Maryland Insurance Administration,* September 18, 2023, https://insurance.maryland.gov/Documents/newscenter/newsreleases/MIA-Approves-2024-Affordable-Care-Act-Premium-Rates-9182023.pdf.

[5] Maryland Health Connection Data Reports, July 31, 2019, and July 31, 2023. Enrollment increased from 137,828 to 185,597. Data available at https://www.marylandhbe.com/wp-content/uploads/2023/08/Executive-Report-as-of-07.31.23.pdf and https://www.marylandhbe.com/wp-content/uploads/2019/09/Executive-Report_07_31_2019.pdf.

[6] Enrollment increased from 190,409 to 228,800. https://insurance.maryland.gov/Documents/newscenter/newsreleases/MIA-Approves-2024-Affordable-Care-Act-Premium-Rates-9182023.pdf

Table 8: MHBE On-Exchange Summary Data, 2014-2024

Benefit Year	Participating carriers (#)	Enrollment[7]	Subsidized/ Unsubsidized (%)[8]	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	181,206	79/21	2%
2023	3	182,166	76/24	6.6%
2024	4	TBD	TBD	4.7%

IV. Program Costs for Plan Year 2022

A. 2022 Program Spending and Funding

In July 2022, Lewis & Ellis projected total program costs for 2022 of approximately $519.8 million.[9] Actual program costs for 2022, finalized in July 2023, consisted of approximately $484.9 million in payments to carriers (approximately 6.7% lower than projected in 2022) and $58,681.25 in program administration.[10] The lower than anticipated 2022 program cost was primarily driven by an average reinsurance claim amount per qualifying individual that was 8.3% lower than expected, at $32,299 rather than the projected $35,213.

On May 3, 2022, HHS notified the MHBE that the Department of the Treasury's final administrative determination for pass through funding would be $344,149,951 for calendar year 2022.[11] The 2022 health insurance provider assessment of 1% collected $130,897,529 for the state reinsurance fund. Spending and funding numbers for 2022 are presented below in Table 2 and additional detail on spending is provided in Table 3.

[7] Enrollment reported as of the end of open enrollment preceding the applicable plan year.
[8] 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.
[9] 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.
[10] Federal pass-through funding may be used to cover program administration costs.
[11] Maryland 2022 Pass-Through Funding Letter. May 3, 2022. https://www.cms.gov/files/document/1332-md-2022-ptf-letters.pdf

Table 9: 2022 SRP Payments to Carriers, Federal Funding, Individual Market Enrollment, and Average Premium

Total Payments to Carriers	Total Federal Funding	Total Individual Market Enrollment[12]	Average Individual Market Premium PMPM[13]
$484,920,457	$344,149,951	231,569	$431

Table 10: 2022 SRP Cost and Funding Breakdown

Spending	Value	Comments
Total spent on individual claims payment to issuers	$484,920,456.90	
CareFirst BlueChoice, Inc.	$299,251,841.42	
CareFirst of Maryland, Inc.	$50,027,540.71	
GHMSI	$37,489,290.61	
Kaiser Foundation Health Plan, Mid-Atlantic, Inc.	$82,396,335.82	
Optimum Choice, Inc.	$15,755,448.35	
Amount of funding spent on operation of the reinsurance program	$58,681.25	CMS EDGE server fee: $8,000 Actuarial fees: $50,681.25 Costs are paid quarterly as incurred
Total Spending	$484,979,138.15	Claims payment to issuers plus operational cost
2022 Federal Funding	$344,149,951.00	
Federal Funding Carried Over from Previous Years Spent on 2022 Claims	$74,063,372.24	2022 operational costs are already deducted from this amount
Amount from the state reinsurance fund needed to fully fund the program for the reporting year	$66,707,133.67	
Amount of any unspent balance of Federal pass-through funding for the reporting year	$0.00	

[12] 2022 total individual market enrollment calculated by MHBE as the 2022 individual market member-months reported in the 2022 Reinsurance Summary Report provided by CMS to MHBE, divided by 12.
[13] 2022 average individual market premium PMPM was calculated by MHBE using the 2022 total individual market premium and 2022 individual market member-months reported in the 2022 Reinsurance Summary Report provided by CMS to MHBE.

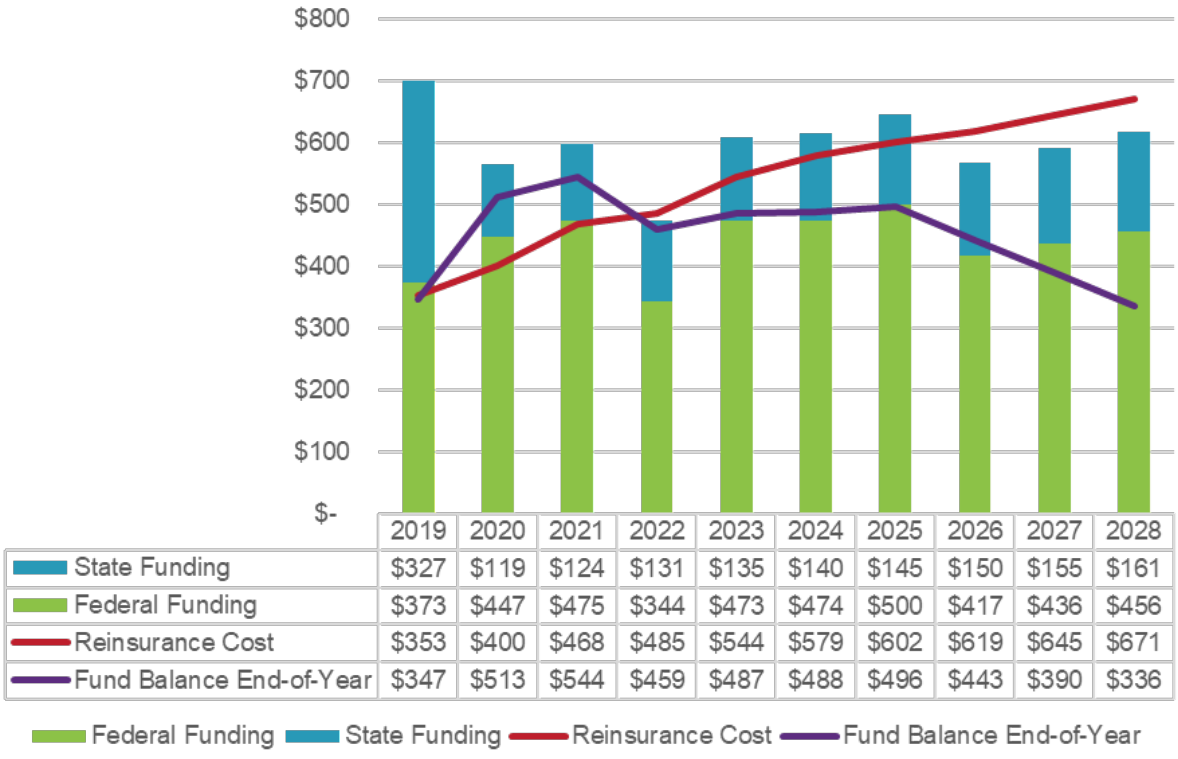
V. Program Forecast through 2028

A. Projected Program Spending and Projected Federal Funding

Table 4 below presents the most recent SRP spending and funding projections through the end of 2028, the end of the second waiver period, as modeled by Lewis & Ellis. These projections put the SRP on a stronger financial footing than we projected a year ago, thanks to both lower than expected program costs in 2022, higher than expected federal funding in 2023, and an assumption that the attachment point will increase by $1,000 per year in 2025 through 2028. With these updated projections, we anticipate the SRP will have sufficient funding to operate through 2028.

The program's fiscal outlook continues to vary significantly based on whether enhanced federal premium subsidies expire at the end of 2025 per current law, or are extended. Extension of the federal subsidies will significantly strengthen the financial outlook.

*Table 11: Projected Program Spending and Funding with Enhanced Federal Premium Subsidies Expiring at the End of 2025, 2019-2028**



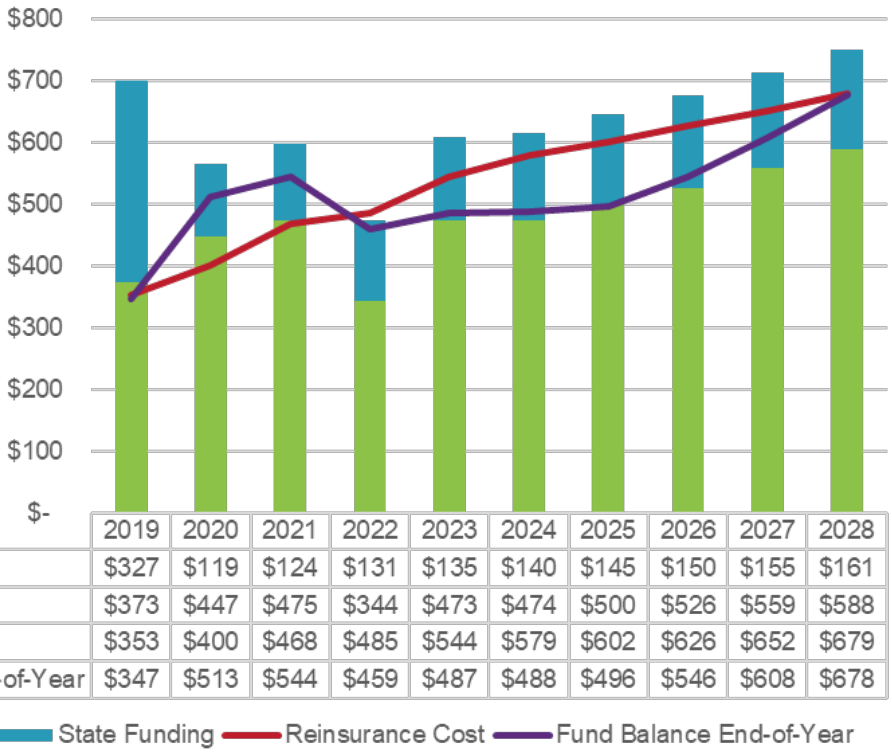
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$135	$140	$145	$150	$155	$161
Federal Funding	$373	$447	$475	$344	$473	$474	$500	$417	$436	$456
Reinsurance Cost	$353	$400	$468	$485	$544	$579	$602	$619	$645	$671
Fund Balance End-of-Year	$347	$513	$544	$459	$487	$488	$496	$443	$390	$336

*Projections assume attachment point increases by $1,000 per year starting in 2025 and that enhanced federal funding under ARPA will expire at the end of 2025.

Federal funds were sufficient to cover the costs of the SRP for the first three years of the program, allowing the MHBE to save funds from the state-based health insurance provider assessment and any remaining federal funds in the SRP fund. 2022 was the

first plan year in which the SRP expenses exceeded total federal funding for that year, requiring the use of all reserved federal funds from prior years as well as $66M in state funds. Based on projections that assume an attachment point of $20,000 in 2024 that increases by $1,000 each year, the MHBE anticipates the combination of state and federal funding will exceed the costs of the program in 2023 through 2025. In 2026 through 2028, annual costs are projected to exceed available annual funding from all sources, requiring the SRP to draw down on its reserves. The projections also assume that enhanced federal subsidies authorized under the American Rescue Plan Act and extended by the Inflation Reduction Act will end at the end of 2025; if those subsidies were extended, we project that SRP financing would be secure, with annual federal and state funding combined slightly exceeding the cost of the program in 2023 through 2028 (see Table 5).

*Table 12: Projected Program Spending and Funding with Graph with Enhanced Federal Premium Subsidies Continuing through 2028, 2019-2028**



	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$135	$140	$145	$150	$155	$161
Federal Funding	$373	$447	$475	$344	$473	$474	$500	$526	$559	$588
Reinsurance Cost	$353	$400	$468	$485	$544	$579	$602	$626	$652	$679
Fund Balance End-of-Year	$347	$513	$544	$459	$487	$488	$496	$546	$608	$678

*Projections assume attachment point increases by $1,000 per year starting in 2025 and that enhanced federal funding under ARPA will continue in 2026-2028.

i. Program Expenditures

Program costs continue to grow due to increasing enrollment in the individual market, 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 $80M across five fiscal years (four plan years) to support a state young adult premium subsidy ($10M in FY 22, $20M in FY 23, 24, 25, $10M in FY 26; actual spend for FY 22 was $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, down from approximately $475M in 2021 to $344M in 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. In 2023, federal funding increased to approximately $473M, 7.8% more than projected. We expect to see federal funding stay nearly flat in 2024 and increase slightly in 2025, followed by another significant decline 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. Plan year 2022 (FY 2024) was the first year in which the cost of the program exceeded that year’s federal funding, and we are beginning to draw down on the state reinsurance fund to support the program.

Table 13: SRP Financial Overview, Plan Years 2019-2028 (millions)

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
SRP Cost	$353	$400	$468	$485	$544	$579	$602	$619	$645	$671
MA Budget Transfer			$100	$50						
Young Adult Subsidy				$15	$13.5	$20	$20			
Health Equity Grants					$15	$15	$15			
Community Health Resources Commission				$8	$8					
Senior Prescription Drug Affordability Program				$1.9						
Federal Funding	$374	$447	$475	$344	$473	$474	$500	$417	$436	$456
State Funding	$327	$118	$124	$131	$135	$140	$145	$150	$155	$161
Approx. End of Year Balance – Fed.	$20	$67	$75	$0	$0	$0	$0	$0	$0	$0
Approx. End of Year Balance - State Reinsurance Fund	$327	$445	$469	$459	$487	$488	$496	$443	$390	$336

End of year balances may not sum due to rounding and nominal administrative costs are not shown. Additionally, the financial overview presented assumes that the enhanced APTCs established by the American Rescue Plan Act expire at the end of 2025.

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.[14] The third year of data under this requirement was collected in 2022, for plan year 2021. A report summarizing key findings, as well as the carriers' data submissions, are available on the MHBE website.[15] Background and highlights from plan year 2021 are summarized below. MHBE is in the process of collecting the fourth year of reports, for plan year 2022.

These early years of reports serve as a 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.

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.[16]

MHBE asked carriers to report on targeted initiatives addressing diabetes, behavioral health, asthma, and pregnancy/childbirth, as well as health outcomes addressing these

[14] COMAR 14.35.17.03(C)
[15] https://www.marylandhbe.com/policy/reinsurance-program/
[16] Reporting instructions are available here and a corresponding reporting template is available here.

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. Diabetes was among the three most frequent HCCs among SRP enrollees in all three years, along with HIV/AIDS. Additionally, various cancers were among the top three most frequent and most costly HCCs in all three years. Septicemia, sepsis, and systemic inflammatory response syndrome/shock were also among the top five most costly HCCs in all years.

Table 14: Top Hierarchical Condition Categories by Count and Cost, PY 2019-2021 SRP

	Most Frequent			Highest Cost		
	2019	2020	2021	2019	2020	2021
1	Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Diabetes	Diabetes with and without complications	Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others	Cancers, including breast, prostate, lung brain, colorectal, and metastatic
2	HIV/AIDS	HIV/AIDS	HIV/AIDS	Congestive Heart Failure	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
3	Diabetes	Cancers, including Colorectal, Breast, Kidney, Metastatic, and Others	Cancers, including breast, prostate, lung brain, colorectal, and metastatic	Diabetes	Respiratory Arrest, Failure and Shock	Hemophilia
4	Major Depressive and Bipolar Disorders	Congestive Heart Failure	Ongoing pregnancy without delivery with no or minor complications	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Diabetes	End Stage Renal Disease

	Most Frequent			Highest Cost		
	2019	2020	2021	2019	2020	2021
5	End Stage Renal Disease	Asthma and COPD	Heart failure	Respiratory Arrest, Failure, and Shock	Congestive Heart Failure	Inflammatory Bowel Disease

In 2021, 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 2019-2021 and a Diabetes Virtual Care Program in 2020 and 2021

- Kaiser Permanente Diabetes Glucometer Program in 2020 and 2021, a Diabetes Messaging Program in 2021, and a Depression Care Management Program in 2020 and 2021.

UnitedHealthcare was new to the market and had limited enrollment, therefore none of their care management initiatives met the threshold of 300 or more enrollees. However, UnitedHealthcare has a behavioral health program focused on opioid use disorder and a broader Case Management Program that coordinates care for high-risk patients with chronic or acute health care needs.

No carriers reported care management initiatives targeting asthma or pregnancy.

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