MARYLAND HEALTH BENEFIT EXCHANGE

Joint Chairmen's Report:

Reinsurance Program Costs and Forecast

Maryland Health Benefit Exchange

September 30, 2024 (updated October 29, 2024)

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I. Introduction

The 2024 Joint Chairmen's Report on the Fiscal 2025 State Operating Budget (SB 360) and the State Capital Budget (SB 361) 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

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[1] Available at https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2024rs-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/

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 ("the Departments"), 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 June 28, 2023, the Departments approved MHBE's application to extend the 1332 State Innovation Waiver authorizing the SRP for an additional five-year period, through December 31, 2028.

On July 15, 2024, the MHBE Board of Trustees finalized the 2025 SRP parameters of an attachment point of $21,000, 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

During the 2024 Session, the Maryland General Assembly passed the Access to Care Act (SB705/HB728), directing MHBE to apply for a waiver amendment to allow all otherwise-qualified residents to enroll on-Exchange, regardless of immigration status (a waiver of section 1312(f)(3) of the Affordable Care Act. On July 15, 2024, MHBE applied to the Departments to amend Maryland's 1332 Waiver.[4] The Departments determined the application complete on August 22, 2024[5] and must issue a decision on the request by February 25, 2025, although MHBE has requested a decision by the end of 2024.

III. Impact of the State Reinsurance Program

The SRP continues to stabilize the individual market: premiums are down, enrollment is up, and three carriers have entered the individual market since the program launched: Aetna Health Inc. announced its entrance in 2023 for plan year 2024, and Wellpoint Maryland, Inc. has announced it will offer plans on-Exchange beginning in plan year 2025. 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. After four years of single-digit increases, average premiums are still more than 17% below 2018 levels.[6]

Plan Year	Average Individual Market Premium Change
2014	n/a
2015	10%
2016	18%
2017	21%
2018	28%
2019	**-13%**
2020	-10%
2021	-12%
2022	2.1%
2023	6.6%
2024	4.7%
2025	6.2%

Prior to implementation of the SRP, on-exchange enrollment had 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 July 2024, on-exchange enrollment is up 58.5% compared to July 2019.[7] Looking more broadly at both on and off exchange individual market enrollment, we also see substantial gains, with total individual market enrollment up nearly 18% in the last year alone, between July 2023 and July 2024.[8] Although multiple factors have contributed to on-exchange enrollment increases, including the Tax Time Easy Enrollment Program beginning in 2020, the COVID-19 special

[4] Maryland's 1332 Waiver Amendment Application can be accessed at https://www.marylandhbe.com/wp-content/uploads/2024/08/MD-1332-Waiver-Amendment-Request-FINAL-w-updated-exhibits.pdf.
[5] The Departments' August 22, 2024 Determination of Completeness Letter to Maryland can be accessed at https://www.cms.gov/files/document/1332-md-amendment-completeness-letterfinal.pdf.
[6] "Maryland Insurance Administration Approves 2025 Affordable Care Act Premium Rates: Marylanders have more health insurance options as Wellpoint enters individual market," *Maryland Insurance Administration,* September 5, 2024, https://insurance.maryland.gov/Documents/newscenter/newsreleases/2025_ACA_Press-Release-952024.pdf.
[7] Maryland Health Connection Data Reports, July 31, 2019, and July 31, 2024. Enrollment increased from 136,397 to 216,116. Data available at https://www.marylandhbe.com/wp-content/uploads/2024/08/Executive-Report-as-of-07.31.24.pdf and https://www.marylandhbe.com/wp-content/uploads/2019/09/Executive-Report_07_31_2019.pdf.
[8] Enrollment increased from 229,774 to 270,897.
https://insurance.maryland.gov/Documents/newscenter/newsreleases/2025_ACA_Press-Release-952024.pdf

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, the Unemployment Easy Enrollment Program that launched in 2022, and the unwinding of the Medicaid continuous coverage requirement in 2023-2024, 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 30 to 35 percent higher.[9]

In addition, Wellpoint Maryland, Inc. will be joining the individual market for plan year 2025. Wellpoint will be offering plans statewide, giving individual market enrollees in all counties four carriers from which to choose. This follows Aetna Health, Inc's entrance to the market for plan year 2024, and UnitedHealthcare's reentry to the individual market in 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. These additions indicate that carrier confidence in the Maryland individual market has grown as a result of the SRP.

Table 8: MHBE On-Exchange Summary Data, 2014-2025

Benefit Year	Participating carriers (#)	Enrollment[10]	Subsidized/ Unsubsidized (%)[11]	Average Premium Change (%)
014	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	180,958	76/24	6.6%
2024	4	214,892	77/23	4.7%
2025	5	TBD	TBD	6.2%

[9] *Maryland Insurance Administration*, September 5, 2024.
[10] Enrollment reported as of the end of open enrollment preceding the applicable plan year.
[11] 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 and beyond.

IV. Program Costs for Plan Year 2023

A. 2023 Program Spending and Funding

In July 2023, Lewis & Ellis projected total program costs for 2023 of approximately $544.2 million.[12] Actual program costs for 2023, finalized in July 2024, consisted of approximately $567.8 million in payments to carriers (approximately 4.3% higher than projected in 2023) and $83,375 in program administration.[13] The main driver of this deviation from the projection was an under-projection of Medicaid redetermination members entering the market after being disenrolled.

On April 28, 2023, HHS notified the MHBE that the Department of the Treasury's final administrative determination for pass through funding would be $473,027,855 for calendar year 2023.[14] The 2023 health insurance provider assessment of 1% collected $136,947,734 for the state reinsurance fund. Spending and funding numbers for 2023 are presented below in Table 2 and additional detail on spending is provided in Table 3.

[12] 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.
[13] Federal pass-through funding may be used to cover program administration costs.
[14] Maryland 2023 Pass-Through Funding Letter. April 28, 2023. https://www.cms.gov/files/document/1332-md-2023-ptf-letters.pdf.

Table 9: 2023 SRP Payments to Carriers, Federal Funding, Individual Market Enrollment, and Average Premium

Total Payments to Carriers	Total Federal Funding	Total Individual Market Enrollment[15]	Average Individual Market Premium PMPM[16]
$567,836,479.35	$473,027,855	235,982	$459

Table 10: 2023 SRP Cost and Funding Breakdown

Spending	Value	Comments
Total spent on individual claims payment to issuers	$567,836,479.35	
CareFirst BlueChoice, Inc.	$336,940,146.20	
CareFirst of Maryland, Inc.	$60,280,951.88	
GHMSI	$48,061,628.59	
Kaiser Foundation Health Plan, Mid-Atlantic, Inc.	$85,287,091.45	
Optimum Choice, Inc.	$37,266,661.23	
Amount of funding spent on operation of the reinsurance program	$83,375	CMS EDGE server fee: $8,000 Actuarial fees: $75,375 Costs are paid quarterly as incurred
Total Spending	$567,919,854.35	Claims payment to issuers plus operational cost
2023 Federal Funding	$473,027,855	
Federal Funding Carried Over from Previous Years Spent on 2023 Claims	$0.00	
Amount from the state reinsurance fund needed to fully fund the program for the reporting year	$94,891,999.35	
Amount of any unspent balance of Federal pass-through funding for the reporting year	$0.00	

[15] 2023 total individual market enrollment calculated by MHBE as the 2023 individual market member-months reported in the 2023 Reinsurance Summary Report provided by CMS to MHBE, divided by 12.
[16] 2023 average individual market premium PMPM was calculated by MHBE using the 2023 total individual market premium and 2023 individual market member-months reported in the 2023 Reinsurance Summary Report provided by CMS to MHBE.

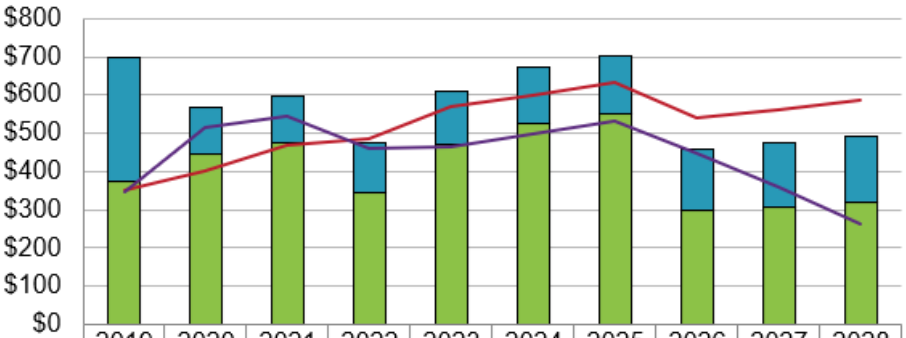
V. Program Forecast through 2028

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. The fund balance projected to remain at the end of 2028 is about $260 million— enough to ensure program solvency through the end of the second waiver period in 2028.

Pass-through funding is projected to reduce significantly in 2026 and beyond, assuming the ARPA-enhanced tax credits expire. Extension of the federal subsidies past 2025 would 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 (in millions)**



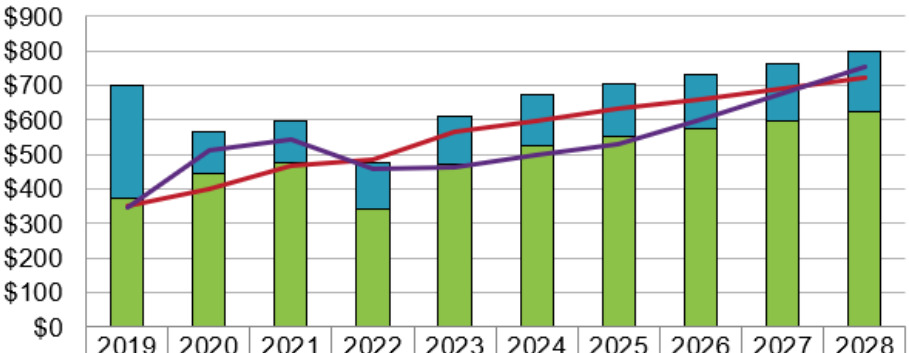
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$137	$146	$153	$160	$167	$174
Federal Funding	$373	$447	$475	$344	$473	$527	$551	$298	$307	$318
Reinsurance Cost	$353	$400	$468	$485	$568	$598	$632	$539	$563	$588
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$500	$530	$448	$359	$263

*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. As expected, the combination of state and federal funding exceeded the costs of the program in 2023. Projections that account for an attachment point of $20,000 in 2024 and assume an attachment point of $21,000 in 2025 that increases by $1,000 each year thereafter anticipate that the combination of state and federal funding will again exceed the costs of the program in 2024, but that 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 as it did for the first time in 2022.

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 through the end of the current waiver period in 2028 (see Table 5).

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



	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
State Funding	$327	$119	$124	$131	$137	$146	$153	$160	$167	$174
Federal Funding	$373	$447	$475	$344	$473	$527	$551	$574	$597	$623
Reinsurance Cost	$353	$400	$468	$485	$568	$598	$632	$660	$690	$721
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$500	$530	$603	$678	$754

*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). Costs are projected to continue to rise in 2024, despite a return to a $20,000 attachment point. 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 23 was $13.2M), $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 $247.9M through FY 24.

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 should increase federal pass-through funding in 2023-2025 relative to a scenario in which the enhanced subsidies had not been extended. From 2021 to 2022, we saw a 27% reduction in federal funding, 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, and in 2024, federal funding increased to about $527M (an increase of 11.4% from 2023 and 11.1% higher than projected last year), due to the impact of ARPA. However, we expect to see federal funding decline in 2026, followed by an even steeper 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 $137 million in 2023, close to the projected amount, and is estimated to collect approximately $146 million in 2024. 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.

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	$568	$598	$632	$539	$563	$588
MA Budget Transfer			$100	$50						
Young Adult Subsidy				$15	$13.5	$24.5	$26			
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	$527	$551	$298	$307	$318
State Funding	$327	$118	$124	$131	$137	$146	$153	$160	$167	$174
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	$465	$500	$530	$448	$359	$263

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.[17] The third year of data under this requirement was collected in 2023, for plan year 2022. A report summarizing key findings, as well as the carriers' data submissions, are available on the MHBE website.[18] Background and highlights from plan year 2022 are summarized below. MHBE is in the process of collecting the fifth year of reports, for plan year 2023.

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.[19]

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

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

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, behavioral health, heart disease, and pregnancy. Diabetes, one of the state's public health priorities, was the most frequent HCC among SRP enrollees in all 3 years. HIV/AIDS and Ongoing Pregnancy without Delivery with No/Minor Complications were among the most frequent HCCs in 2 of the 3 years. Septicemia, sepsis, and systemic inflammatory response syndrome/shock were also among the top five most costly HCCs in all years. Heart Failure was in the top 5 most costly HCCs in 2 out of 3 years. Additionally, various cancers were among the top three most frequent and most costly HCCs in all three years.

*Table 14: Top Hierarchical Condition Categories by Count and Cost, PY 2020-2022 SRP**

	Most Frequent			Highest Cost		
	2020	2021	2022	2020	2021	2022
1	Diabetes with and without Complications	Diabetes with and without Complications	Diabetes with and without Complications	Cancers	Cancers	Cancers
2	HIV/AIDS	HIV/AIDS	Ongoing Pregnancy without Delivery with No or Minor Complications	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
3	Cancers	Cancers	Major Depressive Disorder, Severe, and Bipolar Disorders	Respiratory Arrest, Failure and Shock	Hemophilia	Ongoing Pregnancy without Delivery with No or Minor Complications
4	Heart Failure	Ongoing Pregnancy without Delivery with No or Minor Complications	Varicella Encephalitis and Encephalomyelitis	Diabetes with and without Complications	End Stage Renal Disease	Hemophilia
5	Asthma and Chronic Obstructive Pulmonary Disease	Heart Failure	Cancers	Heart Failure	Inflammatory Bowel Disease	Heart Failure

**Blue highlighted cells indicate conditions of state population health interest.*

In 2022, Kaiser Permanente and CareFirst both had care management initiatives targeting diabetes and behavioral health, and Kaiser Permanente had an initiative targeting heart disease:

- CareFirst:
    - Diabetes Care Management (PYs 2019-2022)
    - Diabetes Virtual Care Program (PYs 2020-2022)
    - Behavioral Health and Substance Use Disorder Care Management Programs (PYs 2019-2022)
    - Behavioral Health Digital Solution (PY 2022)
    - High-Cost Claimant Unit (PY 2022)
- Kaiser Permanente
    - Hypertension Messaging Program (PY 2022)
    - Diabetes Glucometer Program (PYs 2020-2022)
    - Diabetes Messaging Program (PYs 2021-2022)
    - Diabetes Educational Video (PY 2019)
    - Diabetes Care Management Program (PYs 2019-2020)
    - Depression Care Management Program (PYs 2020-2022)

UnitedHealthcare was new to the market in 2021 and had limited enrollment in 2022, 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—the Retrospective Drug Utilization Review Program—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 2023-2033)