HEALTH CARE AFFORDABILITY IN MARYLAND: A CLOSER LOOK

HEALTHCARE VALUE HUB

INTRODUCTION

Ensuring health care affordability for residents is a challenge faced by many states. While federal policy frequently dominates the discourse surrounding health care affordability burdens, states may also use their authority to create a more effective system through various policy avenues. To explore these options, the Health Care Value Hub developed the 2022 Healthcare Affordability State Policy Scorecard (the "Scorecard"), which this report used to format the following materials. The Scorecard evaluated states on their efforts to ensure affordable health care for their residents across several key domains: curbing excess prices, reducing low-value care, expanding coverage, and reducing out-of-pocket costs.

Maryland earned 48.5 out of 80 possible points on the Scorecard, ranking 10th out of 50 states and the District of Columbia.[1] As a leader in health policy, Maryland performed well in many areas, though it still has room for improvement. This report provides an in-depth analysis of health care affordability in Maryland, examining the factors that contribute to rising health care costs and potential solutions to address it. By exploring these four domains, this report aims to provide insights and recommendations to help policymakers and stakeholders improve access to affordable health care for all Maryland residents.

CURB EXCESS PRICES

State governments have the authority to implement policies to control exorbitant prices in the health care system. In Maryland, much of the focus has been on managing the all-payer hospital rate regulation system, which has been in operation for over three decades and has received recognition for its success in reducing health care costs.[2] This section measures a state's potential for improving health care affordability based on various criteria, including the presence of a functional all-payer or multi-payer claims database, a standing health spending oversight entity, an all-payer health care spending system and quality benchmarks, and a price transparency tool.[3]

ALL-PAYER CLAIMS DATABASE (APCD)

Maryland's Medical Care Data Base (MCDB), the state's All-Payer Claims Database, collects and analyzes health care enrollment, provider, and claims data for residents enrolled in private, fully insured and self-insured non-ERISA coverage, Medicaid and Medicare.[4] Founded in 1995, the MCDB has been used to create a variety of reports, including "Request for Cost Estimate to Eliminate Cost-Sharing for Prostate Cancer Screening" and the annual "Spending Use Among Maryland's Privately Insured" reports, which help policymakers and health care providers make more informed decisions about resource allocation and care delivery.[5,6,7]

It is important to note that, due to the *Gobeille v. Liberty Mutual* ruling, the MCDB cannot require employers who provide self-insured plans to submit information to the database. As a result, the state can only allow and voluntary claims submission.[8] Due to low rates of voluntary submission result, around three-quarters of self-insured enrollees are not accounted for in the MCDB data.[9] However, even with these exclusions, the MCDB contains data on more than 3.6 million privately insured residents and Medicaid claims for approximately 900,000 managed care organization (MCO) enrollees.[10]

Comprehensive data related to private fully insured and self-insured insurance is available by request at a cost through the Maryland Health Care Commission (MHCC) website; however, pricing data for some common procedures is accessible to consumers through the state's price transparency tool, *Wear the Cost* (see "Price Transparency" section).[11,12,13]

Overall, the Maryland APCD serves as an important tool for policymakers, researchers, and the public to better understand the state's health care landscape and make informed decisions about health care policy and practice. However, the state may benefit from improving access to the data and encouraging voluntary submission from self-insured plans. With access to more comprehensive and accurate data, policymakers and health care providers can make more informed decisions about resource allocation and care delivery, resulting in improved health care outcomes.

Recommendations

△ **Increase the number of voluntary self-insured ERISA health plans included in the MCDB by establishing a more efficient process for voluntary submissions.**

Maryland could potentially increase the number of self-insured enrollees included in the MCDB by creating a user-friendly, standardized reporting mechanism to reduce the burden on self-insured group health plan administrators. In a 2021 report to the Secretary of Labor, the State All Payer Claims Databases Advisory Committee recommended engaging employers and unions that sponsor self-insured ERISA-covered group health plans to identify real and perceived barriers to submission, and then using this information to create a simplified data submission portal.[14]

HEALTH SPENDING OVERSIGHT ENTITY

The Maryland Health Services Cost Review Commission (HSCRC) is a permanently convened, health spending oversight entity that supervises the state's unique all-payer system.[15] The commission is one of the oldest health care cost oversight entities in the United States and is the only entity in the country that exercises full rate-setting authority for all payers and general acute hospitals.[16] It is funded by the state legislature, receiving $19.9 million for operating expenses in 2023.[17]

The HSCRC regulates health care expenses in Maryland through rate setting and the creation of statewide global budgets for hospitals and primary care facilities. The process of setting global budgets is complex, requiring extensive data analysis and negotiations between the hospitals and the HSCRC.[18] However, once the global budget is set, the program limits growth in per-person total spending on hospital care, which incentivizes hospitals to manage their volume and costs.

To further enhance cost containment measures, the state legislature passed a bill in 2021 to fund the Maryland Prescription Drug Affordability Board, which was first established in 2019 via Maryland HB 768.[19,20] In 2019, the board gained the authority to set upper payment limits for drugs purchased by state and local governments pending approval by the General Assembly's Legislative Policy Committee, and this authority was reestablished in 2023 in MD SB 202.[21,22] Maryland SB 202 also requires that the board submit a report to the General Assembly assessing the feasibility of granting it the authority to establish upper payment limits for all purchases and payor reimbursements in the state, a move that numerous advocates support.[23,24]

To this end, Maryland should enact legislation to allow the PDAB to set upper payment limits for all purchasers in the state. Without the authority to set upper payment limits for drugs purchased by entities beyond the state and local government, the board is only able to control drug costs among a limited group of purchasers. By expanding the scope, the state can improve its ability to contain health care costs and ensure that all payers are held accountable for their spending.

Recommendations:

△ Apply upper payment limits to all purchases of and payer reimbursements for prescription drugs dispensed or administered in the state.

Expanding upper payment limits to all purchasers is an important step towards achieving cost containment goals. Currently, the Maryland Prescription Drug Affordability Board has the authority to set upper payment limits for drugs purchased by state and local governments, but not for all purchasers. By granting the board the authority to set upper payment limits for all purchasers, the state can create a more comprehensive approach to controlling drug costs, which can benefit all Maryland residents.

ALL-PAYER RATE SETTING SYSTEM

Maryland's All-Payer Rate Setting System is the last remaining all-payer hospital rate setting system in the country.[25,26] Originally established in the 1970s amidst nationwide enthusiasm for these programs, the current iteration sets fixed rates for hospital services, select doctors' visits and outpatient services (including some long-term care).[27] The current program also sets annual global budgets for hospitals and limits all-payer per capita and Medicare per capita hospital growth across the state.[28]

This unique arrangement allows the state a significant amount of control over what payers can be charged for services, resulting in cost-savings for consumers across all insurance types.[29] The all-payer rate setting system is made possible through Medicare waivers, which exempt the state from the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS).[30] The program has continued to evolve since its inception, building on these exemptions to address modern affordability concerns.

The current iteration, the Maryland Total Cost of Care Model (TCOC), builds on the success of the preceding programs in several ways, including: expanded rate setting to non-hospital providers which maintains the all-payer global budgets for all hospitals in the state; providing incentives to hospitals to reduce total cost of care; providing incentives to improve the efficiency and quality of care; introducing waivers allowing hospitals to align incentives with other providers; introducing the Maryland Primary Care Program to encourage primary care practice transformation; and offering funding for programs designed to reduce the incidence of diabetes and overdose deaths in the state.[31,32]

Maryland continues to set the prices hospitals can charge for services and the annual budgets for hospitals across the state. However, hospitals are given "rate corridors", which provide limited flexibility to adjust their prices to conform with their global budget.[33] Hospitals and consumers both benefit from this arrangement, which provides predictable, guaranteed revenue and

incentivizes the reduction of readmission and low-value care services.

A central aim of the program is to limit the growth in total Medicare fee-for-service spending (FFS). The TCOC agreement stipulates that if the state is unable to obtain $300 million in annual in savings between 2019 and 2026, CMS has the authority to revoke the waiver that allows the state to set Medicare hospital prices.[34] A recent evaluation indicates that, between 2019 and 2021, the TCOC reduced Medicare FFS spending by 2.5% compared to the last two years of the MDAPM (2017-2018) equating to a $348 per beneficiary per year (PBPY) reduction in costs.[35]

The TCOC has also reduced hospital spending by $510 PBPY and post-acute care spending by $76 PBPY. Conversely, the evaluation indicates that the program increased non-hospital spending by $162 PBPY, with the most substantial increase in 2021. This may indicate that the rise in expenditures was influenced by the on-going coronavirus pandemic.[36] However, the increases in non-hospital spending were surpassed by the savings in overall hospital spending, implying that the system is able to endure a crisis.[37]

In addition to measurable cost savings, the TCOC model may also be effective in reducing readmission rates and preventable admissions. Between 2019 and 2021, potentially preventable admissions were reduced by 7 admissions per 1,000 beneficiaries and 30-day post-discharge unplanned readmissions were reduced by 1.7%. Although these metrics reflect modest decreases, they indicate that progress is being made to achieve the quality goals.

The success of the Maryland all-payer system has attracted attention from policymakers and health care experts across the country. Pennsylvania and Vermont have begun to experiment with global budgets, and advocates argue that the system could be a model for health care reform on a national level.[38] However, replicating the system in other states would require significant political will and support, as well as a commitment to improving health care quality while controlling costs.

HEALTH CARE PRICE TRANSPARENCY TOOLS

The Maryland Health Care Commission has developed a public price transparency tool called "Wear the Cost" that allows consumers to search for negotiated rates by procedure and hospital.[39] The tool is part of Maryland's unique all-payer model, which helps populate the cost data via its all-payer claims database. Wear the Cost also displays information on hospital performance for quality measures, consumer ratings, infection data, and hospital prices by payer type for medical conditions and procedures.

While the tool offers quality indicators by hospital, providing information on the prevalence of potentially avoidable complications, it has limitations. Specifically, it only offers data on a restricted set of common procedures: bariatric surgery; colorectal resection; coronary angioplasty; cesarean section; gall bladder surgery; hip replacement; hysterectomy; knee arthroscopy; knee replacement; lumbar laminectomy; lumbar spine fusion; tonsillectomy; vaginal delivery. In addition, it does not list the chargemaster rates for procedures.

Providing negotiated and chargemaster rates on the Maryland price transparency tool, expanding the number of procedures available for cost comparison, and conducting outreach to inform residents of the tool would be a significant step toward promoting health care price transparency. The state may achieve these goals through legislation, or through strategic partnerships with the state-run APCD and advocacy groups.

Recommendations:

△ **Expand the number of procedures available for comparison on the Wear the Cost tool.**

Expanding the number of procedures available for cost comparison on the Wear the Cost tool would increase its value to consumers. By adding more procedures, consumers would have access to a broader range of medical services and costs, leading to more informed decision-making. Administrators may consider including a list of less expensive, but often used high-value procedures that improve health long-term to encourage residents to seek out care.

△ **Conduct outreach to ensure that consumers are aware of and able to appropriately utilize the Wear the Cost tool.**

Conducting outreach to inform residents of the tool would be important for making consumers aware of this valuable resource. By increasing public awareness of the tool, more people would have access to price information, leading to more informed health care choices and potentially lower costs. For example, in New Hampshire, market observers testified that, despite limited public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state's insurers and narrowed price variation over time.

REDUCE LOW-VALUE CARE

The "Reduce Low Value Care" section of the 2022 Healthcare Value Hub Healthcare Affordability State Policy Scorecard assesses a state's efforts to avoid low-value care and improve patient safety by measuring the state's efforts to use claims and electronic health records to identify low- and no-value care, mandate patient safety reporting for hospitals, and implement antibiotic stewardship programs.[40]

The Healthcare Value Hub Healthcare Affordability State Policy Scorecard reports that Maryland ranked 47th out of 50 states and the District of Columbia in providing low-value care.[41] Research indicates that 22% of Maryland residents insured through Medicare received one or more low-value care service in 2021; however, the state does not formally track the provision of low-value care, highlighting an opportunity for improvement.[42]

MEASURING LOW-VALUE CARE

The delivery of high-quality and cost-effective health care is critical for achieving better health outcomes and increasing access to care. However, a growing concern among policymakers and health care providers is the prevalence of low- and no-value care, which refers to medical tests, treatments, and procedures that do not improve patient outcomes and can lead to patient harm, increased health care costs, and waste of health care resources. One study found that twenty-three low value care services amounted to $3.7 billion in expenditures between 2009 and 2019.[43] However, the same study noted that state-level variation in spending has not been well examined outside of Colorado, Maine, Virginia, and Washington.[44] Maryland does not formally measure the provision of low-value care, reflecting an opportunity for improvement.

Maryland should consider using the state-run APCD to conduct an annual review of low-value care provision. Policy makers may look to Washington state for a blueprint for an effective strategy; the Washington Health Alliance uses the state-run APCD (WA-APCD), managed by the Washington State Health Care Authority, to develop reports exploring the provision of low-value care across the state.[45] Similarly, the Massachusetts Health Policy Commission, the Oregon Health Authority, and the Virginia Center for Health Innovation have all also released reports measuring low-value care in their state using their respective all-payer claims databases.[46,47,48] Massachusetts is required to submit a report annually on cost trends in the state, which also includes data on the provision of low-value care.[49] Maryland could benefit from a similar initiative to measure and ultimately address low and no-value care, which could be established informally or through legislation.

Recommendations:

△ **Enact a multi-stakeholder initiative to begin formally measuring low-value care in the state.**

Enacting a multi-stakeholder initiative to measure and reduce low-value care in Maryland could lead to significant benefits for patients, health care providers, and the health care system. The state should consider using the Maryland Medical Care Data Base (MCDB) to explore the provision of low and no-value care in the state and allocate funding to enable a non-profit organization or a state department to conduct an annual review and publish the results for researchers and providers, similar to initiatives in Massachusetts and Washington state.

VALIDATED PATIENT SAFETY FOR HOSPITALS

Ensuring patient safety is one of the fundamental goals of health care, as it involves providing appropriate care while preventing any harm or injury to patients. Medical errors and adverse events can result in significant consequences such as extended hospital stays, disability, or even death. Moreover, such incidents can lead to increased health care costs during the event and possibly in the future, should the victim require follow-up care or be placed on permanent disability.

Patient safety initiatives require collaboration among health care providers, policymakers, and patients themselves. By prioritizing patient safety, health care systems can provide high-quality care and improve patient outcomes. Since 2004, the Maryland Office of Health Care Quality has published an annual report on Hospital Patient Safety, which review the adverse events that occurred in Maryland hospitals in the previous year.[50] Data from the most recent report (2021) indicate that preventable medical errors resulted in the death of eighty-six patients, a nearly 87% increase from the year prior (2020).[51] These figures may have been influenced by the coronavirus pandemic, but are nonetheless important to review.

Requiring patient safety reporting for central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) is a practical option to measure patient safety metrics and potentially mitigate the prevalence of surgical site infections in a state. Most health care facilities in the United States are already required to report the rate of hospital acquired infections (HAIs) and many states currently mandate reporting CLABSI and CAUTI rates (twenty-seven and thirty-six, respectively).[52]

Maryland currently mandates that acute care hospitals report incidents of CLABSI and CAUTI, as well as other surgical site infections (SSIs) for hip and knee replacement surgeries, coronary artery bypass grafting, colon and abdominal hysterectomies.[53] However, the impact of these mandates remains unclear. Recent research indicates that the presence of state-wide CLABSI reporting requirements did not have a significant impact on CLABSI rates.[54] However, the data remains a

crucial piece of the Maryland Healthcare-Associate Infections Prevention Plan.

In addition to these efforts, the Maryland Health Care Commission also publishes data on how often patients develop a surgical site infection after surgery. However, data is not available for every hospital or procedure and data on CLABSI and CAUTI rates may be difficult to find for the average consumer. The most recent data available to the public indicates that, in 2021, Maryland had higher rates of CLABSI and CAUTI than non-Maryland hospitals.[55]

It is also essential to note that Maryland hospitals are exempt from payment reductions that come from the Centers for Medicare and Medicaid Services Hospital Acquired Condition Reduction program, which decreases reimbursements to hospitals with high rates of hospital acquired infections.[56] Instead, Maryland operates the Maryland Hospital Acquired Conditions (MHAC) and the Maryland Quality-Based Reimbursement programs, which encourage quality improvements through financial incentives.

The MHAC program is a pay-for-performance initiative that holds 2% of hospital revenue at risk for adverse events that may occur during a patients stay.[57] Similarly, the Maryland Quality-Based Reimbursement Program (QBR) assesses hospital performance and scales penalties or rewards of up to 2% of inpatient revenue depending on a hospital's total QBR score. Unlike the MHAC, the QBR uses CLABSI and CAUTI rates in their assessment.[58] Both programs release annual reports that include recommendations, indicating that the state is amenable to improvement.

Recommendations:

△ **Mandate validation of CLABSI and CAUTI in the reporting.**

While Maryland currently mandates reporting of CLABSI and CAUTI rates, expanding validation requirements may improve outcomes in the state. As part of broader efforts to improve patient safety reporting, Maryland should invest in developing the infrastructure to conduct effective validation, including data cleaning, quality checks, and capacity to contact hospitals to correct data errors. This can help identify which hospitals may need additional supports to address CLABSI and CAUTI rates.

△ **Provide expanded data on SSIs to consumers.**

Providing expanded data on SSIs, including CLABSI and CAUTI rates, would be valuable for health care providers and consumers alike. With more comprehensive data, health care providers are given the opportunity to identify areas for improvement and target interventions to prevent SSIs. Additionally, publicly reporting this data on (for example, on the Wear the Cost website) may further equip consumers to make informed decisions about their health care and select facilities with lower rates of SSIs.

ANTIBIOTIC STEWARDSHIP

Antibiotic resistance is a global public health challenge that has been largely attributed to the inappropriate use of antibiotics. This can result in health care-associated infections becoming more severe, leading to avoidable loss of life. In fact, surveillance data indicates that antimicrobial resistant infections cause nearly 50,000 deaths each year in the United States.[59] The issue extends beyond preventable mortality to health care expenditures. The Centers for Disease Control and Prevention (CDC) estimate that antimicrobial resistance costs the United States $55 billion every year.[60]

Despite significant efforts to minimize the unnecessary use of antibiotics, health care professionals distributed 211 million antibiotic prescriptions in 2021, resulting in approximately 636 antibiotic prescriptions per 1,000 people.[61] Fortunately, Maryland has a lower rate of community antibiotic prescriptions of 551 antibiotics prescribed per 1,000 individuals, likely due to strategic decisions from policymakers, providers, and public health advocates.

Hospitals and long-term care facilities are encouraged to adopt evidence-based antibiotic stewardship programs (ASPs) such as the CDC's Core Elements of Antibiotic Stewardship. This framework provides users with a set of seven key principals to guide efforts to decrease the over-prescription of antibiotics. In 2021, 99% of hospitals in Maryland implemented all seven core elements of the CDC's antibiotic stewardship program.[62]

In addition to widely implementing the CDCs ASP, the Maryland Department of Health (MDH) also conducts surveillance for antibiotic resistance across the state. Likewise, the MDH Healthcare Associated Infections program facilitates a statewide antibiotic stewardship effort.[63] Maryland is also one of only two states (the other being California) with current state legislation intentionally dedicated to combatting antibiotic resistance. In 2017, Maryland passed the *Keep Antibiotics Effective Act* (SB 422), which restricts the use of antimicrobials in livestock and mandates that farmers and veterinarians report any antimicrobial use to the state.[64]

Despite these efforts, Maryland still has some of the highest rates of antibiotic resistant infections in the country.[65] Of the twenty-nine antibiotic-resistance bacterial phenotypes tracked by the CDC in 2020, Maryland reported higher percentages of fifteen drug-resistant bacteria compared to the national average.[66] Although exposure to these bacteria can cause severe illness, it is important to note that preventative measures can be put in place to mitigate the risk of exposure.

There are many evidence-based strategies to mitigate the incidence of antimicrobial resistant infections in health care facilities, and Maryland may benefit from enacting these in more long-term care facilities across the state. In 2018, only 77% of long-term care facilities in the state reported the implementation of the seven core elements of the CDC's antibiotic stewardship program, even though residents in long-term care facilities are particularly vulnerable to the spread of antibiotic-resistant infections.[67]

Recommendations:

△ **Invest in expanded antimicrobial surveillance efforts, including staffing for state offices involved in surveillance.**

Maryland has already implemented several successful measures to reduce antibiotic overuse and promote responsible prescribing, including the adoption of the CDC's Core Elements of Antibiotic Stewardship and legislation dedicated to combatting antibiotic resistance. However, Maryland still has some of the highest rates of antibiotic resistant infections in the country. Therefore, investing in expanded surveillance efforts and staffing appropriate personnel for data reporting is necessary to better track the spread of antimicrobial resistance and identify areas for improvement.

△ **Expand the use of the CDC's antibiotic stewardship program to all long-term care facilities across the state.**

Expanding the use of the CDC's antibiotic stewardship program to all long-term care facilities across the state is a critical next step in reducing the incidence of health care-associated infections. A lack of resources and providers are common barriers to implementing antibiotic stewardship, but the state may consider allocating funding for expanded antimicrobial surveillance in long-term care facilities. In doing so, Maryland can continue to lead the way in combatting antibiotic resistance and promoting the responsible use of antibiotics. The cost savings and benefits to public health that would result from such an investment cannot be overstated.

EXTEND COVERAGE TO ALL RESIDENTS

Maryland received high policy and outcome scores for the "Extend Coverage to All Residents" section of the 2022 Healthcare Value Hub Healthcare Affordability State Policy Scorecard, which measures a state's efforts to improve access to affordable insurance options. Ranked 15th out of 50 states, plus the District of Columbia, in terms of uninsured rates, the state has been successful in many of its efforts to increase the number of people with quality health coverage.

Access to affordable and comprehensive health care coverage is a fundamental aspect of an equitable society. Despite the progress made in recent years, millions of individuals in the United States still face significant barriers to accessing care, resulting in poorer health outcomes and greater financial burdens. While Maryland has made strides in expanding coverage through Medicaid expansion, there are still challenges to be addressed, including coverage for undocumented immigrants and addressing coverage gaps in the non-group market.

Uninsured people face significant barriers to accessing health care, and the high cost of paying out-of-pocket often prevents people from getting needed preventative care and treatment for chronic conditions. This in turn generates uncompensated care costs for hospitals when uninsured residents use costly emergency services as a last resort but cannot afford to pay the resulting medical bills. In 2021, an estimated 6% of Maryland residents were uninsured, equivalent to approximately 370,000 people.[68] Curiously, more than half of Maryland's uninsured residents are eligible for Medicaid or a marketplace plan subsidy (53%).[69] This suggests that the uninsured in the state are facing additional barriers to coverage beyond eligibility, including difficulties in the process of enrolling in health coverage is contributing to the uninsured rate.

Maryland could potentially reduce its uninsured population by creating auto-enrollment programs for free or very low-cost health coverage. Maryland already has the first-in-the-nation Easy Enrollment Program to allow uninsured Marylanders to check a box on their state income tax return form to learn about their eligibility for free or low-cost coverage. The law originally required that Maryland allow eligible uninsured Marylanders to be automatically enrolled into Medicaid who check the box, and implementation could result in tens of thousands more Marylanders getting enrolled. In addition, legislation passed in 2023 to automatically enroll uninsured SNAP recipients into Medicaid. Implementation could help over 60,000 uninsured Marylanders get coverage. Maryland should continue to examine other methods to automatically enroll Marylanders into the programs for which they are already eligible.
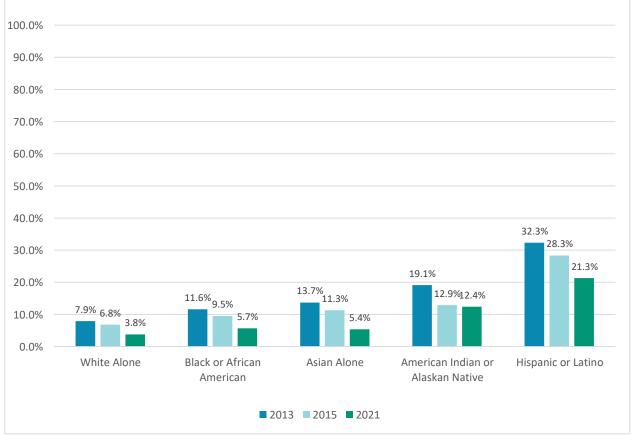
It is equally important to note that nearly a quarter (24%) of uninsured in the state are ineligible due to existing policies that disenfranchise residents due to their citizenship.[70] This contributes to persistent racial and ethnic health inequities. In 2023 legislation passed that requires the state to report on ways to expand access to affordable coverage to undocumented immigrants through private coverage, Medicaid, and CHIP in the fall of 2023. To improve health care access for

residents, Maryland must expand access to quality, affordable health coverage to all Marylanders, regardless of immigration status.

MEDICAID EXPANSION

In 2013, Maryland passed the *Maryland Health Progress Act* (HB 228), which expanded Medicaid coverage to individuals with incomes at or below 138% of the federal poverty level.[71] Following implementation in January 2014, the uninsured rate in Maryland declined from approximately 10.5% (2013) to 9% (2015).[72,73] Since then, the uninsured rate has continued to decrease and currently sits at approximately 6%, several percentage points below the national average of 8.8%.[74,75]

As of October 2022, approximately 1.6 million Marylanders are now enrolled in Medicaid.[76,77] Data on the number of uninsured indicate that all races have benefitted from expansion, although uninsurance rates remain high in Hispanic and Latino communities. While there may be various contributing factors, such as the ineligibility of undocumented immigrants for Medicaid coverage (see the "Immigrant Coverage" section), this underscores the importance of implementing additional measures to enhance coverage for these groups.[78]

Figure 1. Uninsured Rates in Maryland by Race and Ethnicity, 2012, 2015, and 2021[79,80,81]

Source: American Community Survey 5-year Estimates for Maryland, 2013, 2015 and 2021

Expansion has also reduced uncompensated care expenses for hospitals.[82] The states all-payer pricing model includes the cost of uncompensated care services in its hospital rate setting framework, and these expenses are distributed among payers throughout the state.[83] As a result, all residents who engage with the hospital system have a vested interest in expanding coverage and, in turn, reducing the amount of uncompensated care provided.

To further improve on Medicaid expansion, the state should consider adopting twelve-month continuous eligibility for adults currently enrolled in Medicaid. This initiative would align with broader national trends towards providing longer-term coverage for children enrolled in Medicaid, resulting in more efficient health spending, improved health equity, and positive economic impacts. Under the Consolidated Appropriations Act (2022), all states will be required to provide continuous eligibility to children enrolled in Medicaid and CHIP for twelve months beginning January 2024. The state could harness the momentum that will accompany this change to also offer continuous eligibility to adults.

The rationale behind providing continuous eligibility lies in its ability to improve health outcomes, promote health equity, result in more efficient health spending, and decrease administrative costs. Evidence suggests that enacting twelve-month continuous eligibility decreases the number of beneficiaries who are disenrolled and then re-enrolled ("churn"), improving continuity of care and decreasing administrative burdens.

The state may also consider allocating funds for a comprehensive evaluation of the health and economic impacts resulting from Medicaid expansion, including the recently expanded dental and postpartum Medicaid coverage. In 2022, Maryland passed the *Maryland Medical Assistance Program – Dental Coverage for Adults* bill (SB 150), which expands dental benefits (including preventive and restorative services, dentures, and orthodontics) to adults enrolled in Medicaid.[84] That same year the state also implemented a 12-month extension of postpartum Medicaid coverage, which provides new mothers with access to health care services for up to a year after giving birth.[85]

An evaluation of the effectiveness of Medicaid expansion in Maryland would offer valuable insights on all aspects of the program and may be used to inform future policy decisions. The recent *Braidwood Management Inc. v. Becerra* ruling challenging the ACA's requirement for health plans to cover preventive services without cost-sharing underscores the importance of an up-to-date, state-specific evaluation of the positive impacts of Medicaid expansion, including the mandate to cover preventive services.[86] This evaluation could prove beneficial for state advocates if the decision to waive cost-sharing for these services is left up to the states.

Finally, Maryland may also consider using state tax returns to identify and enroll uninsured residents in Medicaid. The state was the first in the country to establish the "Easy Enrollment" program in 2019, which allows residents to check a box on their tax returns to receive individualized information on free, low-cost, and subsidized coverage options based on their

income.[87] Additionally, in 2023, the state passed a bill (SB 26/HB 111) to measure and automatically enroll uninsured SNAP recipients in Medicaid coverage.[88] With the existing infrastructure in place, policy makers should commit to using tax information to automatically enroll qualifying individuals in Medicaid coverage.

Recommendations:

△ **Adopt twelve-month continuous eligibility for adults enrolled in Medicaid.**

Maryland should consider implementing twelve-month continuous coverage for adults insured through Medicaid, which can be done using a 1115 waiver. Currently, six states have approved 1115 waivers to offer continuous eligibility for adults in their state (more information on these can be found here).[89] Continuous eligibility promotes health equity by ensuring that people can access care when they need it, without fear of losing coverage due to fluctuations in their income. It can also lead to more efficient health care spending by reducing administrative costs associated with frequent eligibility redeterminations. Furthermore, continuous eligibility can help to improve health outcomes by providing consistent access to care and reducing the risk of lapses in coverage.

△ **Conduct a Medicaid enrollment and education campaign to increase coverage.**

53% of Maryland's uninsured residents are eligible for Medicaid or a marketplace plan subsidy, indicating that the uninsured in the state are facing additional barriers to coverage beyond eligibility.[90] Maryland may consider conducting a state-wide, Medicaid enrollment and education campaign to identify and address the real or perceived barriers to coverage among this group. The Kaiser Family Foundation has a resource on outreach and enrollment strategies for reaching the Medicaid eligible, but uninsured population here.[91]

△ **Appropriate state funding to conduct an independent evaluation on the impact of Medicaid expansion in Maryland.**

The expansion of Medicaid in Maryland has had a significant impact on the health and economic well-being of the state's residents. However, the state would benefit from appropriating funds to conduct an independent evaluation of the impact expansion has had in the state. The evaluation should consider various factors, including the effectiveness of the recently expanded dental and postpartum Medicaid coverage, as well as the impact on job creation and hospital viability. By conducting such an evaluation, Maryland can assess the positive impact of Medicaid expansion on access to health care, health outcomes, and economic growth. This information can be used to inform future policy decisions and to advocate for the continuation of the program.

△ **Develop policies to automatically enroll eligible residents into Medicaid based on income information gathered from state tax returns.**

Maryland should strongly consider implementing policies that leverage state tax returns to identify and enroll individuals who meet the income criteria. The state has already taken significant strides

in this direction with the establishment of the "Easy Enrollment" program, which allows residents to indicate their interest in receiving personalized information on available free, low-cost, and subsidized coverage options based on their income when filing their tax returns. Moreover, recent legislative developments facilitate the automatic enrollment of uninsured SNAP recipients in Medicaid, which demonstrate the state's commitment to using existing infrastructure to streamline enrollment processes. By tapping into state tax returns for income information, policy makers can build upon this foundation and create a more efficient and effective system that automatically enrolls qualifying individuals into Medicaid coverage.

PROVIDE HIGH-QUALITY, AFFORDABLE COVERAGE OPTIONS FOR PEOPLE WHOSE INCOMES ARE TOO HIGH TO QUALIFY FOR MEDICAID

Maryland has established several innovative programs to address the insurance coverage gap in the state, including offering a Medicaid buy-in program to working people with disabilities (the Employed Individuals with Disabilities program) and offering a state-based reinsurance program to control premium costs on the state exchange. Reinsurance programs aim to reduce the cost of health insurance premiums for consumers by contracting with reinsurance companies to cover a portion of the medical costs of enrollees who have chronic and expensive conditions that result in large claims. Without reinsurance, these high costs would be spread among the entire insurance pool, leading to higher premiums for everyone.

As of January 2023, Maryland is among the seventeen states that have adopted a State-Based Reinsurance Program (SBRP) to regulate the cost of health insurance premiums.[i,92] The existing program builds on the transitional reinsurance initiatives that were in place during the early years of the state-based marketplace. After the temporary state reinsurance programs expired, Maryland lawmakers decided to establish the current state-based reinsurance program through a Section 1332 State Innovation Waiver.[93]

The waiver establishing the SBRP was initially approved on August 22, 2018 and implemented on January 1, 2019. The Maryland Health Benefit Exchange (MHBE) administers the waiver, which is financed by a combination of state and federal sources, including the state's health insurance assessment (HIA). Maryland is one of several other states that have imposed assessments on marketplace health insurers to support state-based reinsurance programs, which necessitate that insurers contribute a small percentage of their revenue from premiums sold on the marketplace to finance reinsurance costs.[94]

The state also receives federal funding to maintain the program. In 2021, Maryland received $335.4 million in federal pass-through funding for its SBRP under the section 1332 waiver.[95] The current waiver is set to expire at the end of 2023, but the state has submitted a request to CMS for an extension that would allow Maryland to maintain the current reinsurance program until

---

[i] *Alaska, Colorado, Delaware, Georgia, Idaho, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Wisconsin*

December 31, 2028.[96] CMS has acknowledged the completeness of the application, and the state is required to conduct a 30-day federal public notice and comment process, which will run until May 25, 2023.[97]

The reinsurance program has achieved its goal of reducing premium costs by 30% since its inception in 2019.[98] In fact, Maryland had the second lowest premium cost in 2022 (following Utah).[99] According to one report, the program has resulted in an estimated 32.8% reduction in individual market premiums in 2021, leading to a 12% decrease in individual premium costs for consumers [100,101]

The SBRP has been largely successful in reducing premiums for individuals who purchase insurance through the state-based exchange. However, provisions in the American Rescue Plan Act (ARPA) and the Inflation Reduction Act increase access to subsidies for higher earners, which decreases the need for reinsurance.[102] Although Maryland offers residents with disabilities the option to "buy-in" to Medicaid if their income exceeds the traditional Medicaid limits, the state may consider expanding subsidies for individuals and families making above the threshold to qualify for affordable care through the marketplace as a way to expand coverage rates and improve affordability across the state.[103]

Recommendations:

△ **Provide additional options for individuals and families who do not qualify for subsidized care through the state health insurance marketplace.**

To ensure that all individuals and families in Maryland have access to affordable health care coverage, the state should explore and implement additional options for those who do not qualify for subsidized care through the state health insurance marketplace. While the State-Based Reinsurance Program (SBRP) has proven effective in reducing premiums for marketplace insurance buyers, recent provisions in federal legislation have expanded subsidies for higher-income earners, thereby decreasing the necessity for reinsurance. Consequently, Maryland could consider extending subsidies to individuals and families with incomes above the threshold for marketplace affordability, thereby making coverage more accessible and affordable for this segment of the population. Several states, such as Connecticut, Massachusetts, New Jersey, New Mexico, Vermont, and Washington, have already implemented successful programs that provide additional state subsidies to individuals with incomes up to 300% of the Federal Poverty Level, ensuring access to zero- or low-dollar premium plans, minimal copays, and reduced cost-sharing. By following the example set by these states, Maryland can expand coverage rates and improve affordability, promoting better health care outcomes for all its residents.

IMMIGRANT COVERAGE

An estimated 922,000 immigrants live in Maryland, making up approximately fifteen percent of the population, yet many are not able to access affordable health coverage through Medicaid or the Maryland Health Benefit Exchange.[104] At present, only lawfully residing pregnant people and children in Maryland qualify for Medicaid coverage without a five-year wait.[105,106,107] Advocates and select legislators have made several efforts to expand coverage to immigrants across Maryland, with varying degrees of success.

One significant achievement was the passage and implementation of the *Healthy Babies Equity Act* (HB 1080) in 2022. This act extends comprehensive prenatal and postpartum care for up to twelve months after birth to noncitizen pregnant immigrants who would otherwise qualify for Medicaid.[108] Likewise, in April 2023, the Maryland General Assembly passed SB 806 which directs the state Department of Health to conduct a study on expanding coverage to undocumented residents, due back to the legislature by October 31, 2023.[109] Maryland has previously considered bills (such as SB 365 and HB 588 in 2023) that aimed to grant access to the Maryland Health Benefit Exchange for undocumented individuals, but they did not pass.[110,111]

In the absence of meaningful state-level action, some local governments in Maryland have stepped in to provide health care access to undocumented immigrants. For example, Montgomery County has established a program to provide primary care services to undocumented immigrants who do not qualify for Medicaid due to their immigration status.[112] This program is available to all low-income county residents who are eighteen years or older and do not have health insurance.

Improving access to health care for undocumented immigrants is both an ethical obligation and an economic necessity. The Maryland Center on Economic Policy released a report which showed that expanding health coverage to undocumented immigrants could lower the state's expenses by decreasing uncompensated care costs and increasing insurance premiums and taxes.[113] Maryland has an estimated 125,000 undocumented immigrants and DACA recipients who lack affordable health care coverage, highlighting the urgent need for action on this issue.[114,115]

Moving forward, Maryland should leverage the growing public interest to pass legislation expanding health coverage for immigrants using strategies from other states. For example, Washington state recently became the first state in the country to obtain federal approval of a 1332 waiver that will enable undocumented immigrants to buy insurance on the state's exchange. The waiver did this by seeking a CMS exemption from the qualified individual definition, which effectively granted all residents access to coverage via the state marketplace. Maryland can draw on this approach to provide affordable and comprehensive health care options to all its residents.[116]

While some limited coverage for immigrants exists in Maryland, many others remain uninsured and without access to essential health care services. Despite efforts to expand health care access to this population, including state-level bills that have been introduced in recent years, there is still a long way to go to ensure that all Maryland residents have access to quality health care. Ultimately, the state should be working towards allowing all income-eligible residents to enroll in Medicaid regardless of citizenship status.

Recommendations:

△ **Allow all children to enroll in CHIP coverage regardless of immigration status.**

Maryland's Healthy Babies Equity Act provides coverage to lawfully residing, pregnant immigrants who would otherwise qualify for Medicaid but for their immigration status without a five year wait. Additionally, the state provides coverage to lawfully residing immigrant children under twenty-one without a five year wait under the Children's Health Insurance Program Reauthorization Act. However, the state does not offer coverage to undocumented immigrant children, reflecting an opportunity for improvement.

Maryland may consider emulating New Jersey, which expanded coverage to all children regardless of immigration status in 2023 through the *Cover All Kids* campaign. The success of the initiative has been largely attributed to legislative support and consistent efforts from state advocates. The program has taken an incremental approach to expanding coverage, beginning in 2021 when the New Jersey legislature approved the *Cover all Kids* bill (2021 NJ SB 3798).

△ **Allow all residents the option to purchase health insurance through the state-based health insurance marketplace regardless of citizenship status.**

Maryland can take inspiration from other states, such as Washington, which recently became the first state to successfully obtain federal approval for a waiver to allow undocumented immigrants to buy insurance on their state exchange. Additionally, in order to gradually reduce the states uninsured adult immigrant population, Maryland could also pursue strategies to provide state-funded coverage for undocumented adults in select age groups. For example, Illinois created a program to cover adults ages 65+ with income under 100% FPL, including an asset, regardless of citizenship status.

△ **Allow all income-eligible residents to enroll in Medicaid regardless of citizenship status.**

Maryland can take inspiration from California, which recently expanded Medicaid to all income-eligible residents regardless of citizenship. Alternatively, Maryland could draw inspiration from Washington state, which obtained a federal waiver to enable undocumented immigrants to access insurance through the state's exchange. By seeking similar exemptions from federal definitions and regulations, Maryland can ensure that all its residents, regardless of citizenship, have access to affordable and comprehensive health care options.

RATE REVIEW

Rate review refers to the process that insurance regulators use to approve or deny proposed premium rate increases for health insurance.[117] The goal of rate review is to hold insurance carriers accountable for justifying their proposed rate increases and disapprove any that are unjustified. Maryland has been an effective rate review process, classified by the Centers for Medicare & Medicaid Services (CMS), but does not incorporate affordability into its process.

Maryland's rate review process is a regulatory framework designed to ensure that health insurance rate increases proposed by insurance companies are reasonable, justified, and not excessive. The Office of the Chief Actuary at the Maryland Insurance Administration (MIA) reviews proposed rate increases and evaluates them based on criteria such as the insurer's claims experience, administrative costs, and anticipated changes in medical costs.[118,119] The MIA also considers the insurer's projected costs of medical services, as well as any changes to benefits or cost sharing that may impact the premium rate.[120]

A few states have already incorporated affordability criteria into their rate review processes, including Vermont and Rhode Island. In Rhode Island, the Office of the Health Insurance Commissioner has established a set of affordability standards that focus on equity rather than volume.[121] Under their affordability standards, insurers were required to increase their share of medical spending on primary care annually by 1% between 2010 and 2014, without increasing premium costs for consumers, in order to have their premium rates approved.[122] Maryland should consider emulating the Rhode Island rate review model to ensure that residents have access to affordable coverage and that insurance carriers are held accountable for the affordability of their products. It could also help Maryland achieve its goal of reducing the number of uninsured residents in the state.

Recommendations:

△ **Incorporate affordability criteria into the state's rate review process.**

Incorporating affordability criteria into the rate review process in Maryland is an essential step towards ensuring that consumers have access to affordable coverage. By evaluating insurance based on affordability criteria such as income levels and premium tax credits, Maryland's regulators can hold insurance companies accountable for the affordability of their products. Examples of affordability criteria may include factoring in cost of living and inflation alongside health care expenses. Stakeholders may also find it helpful to review the National Academy for State Health Policy's Rate Review Toolkit to survey examples of affordability criteria, accessible through this link.[123] This approach will ensure that the rate review process not only evaluates proposed rate increases but also considers the impact of these increases on consumers.

MAKE OUT-OF-POCKET COSTS AFFORDABLE

It is important to ensure that health care costs do not become a barrier to receiving necessary medical treatment. In Maryland, like many other states in the US, high out-of-pocket health care costs can create significant financial burdens for residents, leading to debt and financial insecurity. High out-of-pocket costs can be particularly detrimental to individuals with chronic conditions because they often require ongoing medical care, medication, and other health services.

The aggregate of the costs associated with regular visits to a provider can quickly become unaffordable, forcing individuals to make difficult choices between accessing necessary care and paying for other necessities like food and housing. Additionally, high out-of-pocket costs may discourage individuals from seeking preventive care or early interventions, which can exacerbate the progression of many different health conditions and lead to more costly treatments down the road.

Maryland received high policy and outcome scores for the "Make Out-of-Pocket Costs Affordable" section of the 2022 Healthcare Value Hub Healthcare Affordability State Policy Scorecard. Ranked 8 out of 50 states, plus the District of Columbia, in terms of affordability burdens, the state has been successful in many of its efforts protect residents from unnecessary health care costs. However, Maryland may consider enacting stronger protections against short-term, limited duration health plans and surprise medical bills.

RESTRICTING SHORT-TERM, LIMITED DURATION HEALTH PLANS

Short-term, limited duration (STLD) health plans have become increasingly popular among consumers, particularly those who are self-employed or who work for small businesses that do not offer comprehensive health insurance coverage. However, these plans often offer inadequate coverage and do not provide adequate protection against catastrophic medical expenses. Many also exclude coverage for pre-existing conditions, which may lead to surprise costs if the insurer chooses to deny claims for an adverse event related to a pre-existing condition, such as a heart attack after being diagnosed with cardiovascular disease.[124]

In response to these concerns, Maryland has taken steps to restrict the availability of STLD plans within the state. In 2018, the state legislature passed the *Maryland Health Care Access Act of 2018* (HB 1782) that limits the duration of these plans to three months, with no option for renewal.[125,126] This law was designed to prevent consumers from relying on these plans as a long-term solution to their health care needs and to encourage them to seek out more comprehensive coverage. The law also limits who can sell STLD health plans in the state, restricting the ability to admitted insurance companies who are subject to Maryland Insurance Administration (MIA) authority.[127]

Maryland is currently one of several states that limit the duration of STLD health insurance plans to three months through legislation; however, policy makers across the country have vocalized the

need to further limit their availability.[128] Maryland may benefit from emulating California, Connecticut, New Jersey, and New Mexico, which have either banned or enacted such strict regulations that these plans are not available in the state. As health care prices continue to an increase, it is possible that states will see an increase in demand for STLD plans, demonstrating an urgent need to enact increased protections against STLD plans for consumers searching for coverage.[129]

Recommendations:

△   **Completely ban short-term, limited duration health plans across the state.**

Prohibiting short-term, limited duration health plans in Maryland is a necessary step towards ensuring that consumers are not underinsured. Maryland should consider emulating California or New Jersey by banning short-term, limited duration health plans in the state. Otherwise, the state may consider joining states such as New Mexico and Connecticut, which have enacted such strict regulations that there are no available STLD plans in the state.

Examples of potential regulations that the state may consider include expanding the list of required services to align with ACA essential health benefits; requiring the state insurance commissioner to review the forms prior to the sale of the plans to ensure all plans have the mandated benefits; and prohibiting gender rating (i.e. rejecting women or charging them higher premiums) and denial for pre-existing conditions.

SURPRISE MEDICAL BILLS

Surprise medical bills (balance bills), occur when patients receive unexpected invoices from out-of-network providers when they believed they were receiving in-network care. This can occur in emergency situations, or when a patient is being treated at an in-network facility but are provided services from an out-of-network provider (such as an anesthesiologist or laboratory technician) while there. These surprise bills can create significant financial burdens for patients, leading to debt and financial insecurity. [130]

Maryland has codified patient protections against surprise medical bills by prohibiting balance billing for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[131,132] These laws hold Maryland residents enrolled in HMOs harmless for covered services received from out-of-network providers and extend those protections to residents enrolled in PPOs when they receive services from on-call physicians and hospital-based physicians who obtain assignment of benefits.[133]

The state also offers additional protections beyond those included in the No Surprises Act, such as protections against balance billing from ground ambulance services operated by local governments.[134] Although Maryland has been a leader in the effort to protect consumers from surprise medical bills, the legislation does not clarify if their protections extend to urgent care facilities. The state would benefit from explicitly noting that their protections extend to emergency services provided at urgent care facilities, and if they do not, expanding their protections.

Federal Policy Impact on State Policy Note:

The No Surprises Act is a federal law that aims to protect patients from surprise medical bills, which occur when patients receive unexpected bills from out-of-network health care providers. Under this law, patients who receive emergency care from out-of-network providers or are unknowingly treated by out-of-network providers during an in-network procedure will only be required to pay their in-network cost-sharing amounts (such as deductibles, copayments, and coinsurance), and out-of-network providers will be prohibited from billing patients for the remainder of the cost.

The No Surprises Act is intended to protect patients from unexpected financial burdens resulting from surprise medical bills, and to ensure that health care providers are fairly compensated for their services. The law went into effect on January 1, 2022, and applies to most health plans, including employer-sponsored plans, individual plans, and plans sold on the Affordable Care Act exchanges.

Recommendations:

△ **Extend protections for emergency services provided at urgent care facilities.**

Expanding protections to cover emergency services provided at urgent care facilities in Maryland is crucial to address the financial burden and insecurity that surprise medical bills can create for patients. Urgent care facilities are becoming an increasingly popular option for patients seeking medical care for non-life-threatening conditions, and without adequate protections patients can be vulnerable to receiving surprise bills from out-of-network providers. Including urgent care facilities in the state's patient protection laws would ensure that patients are not financially burdened for seeking medical care in emergency situations and promote greater financial security for patients in Maryland.

REDUCE COST-SHARING

Health care costs have been a growing concern for many Americans in recent years. While the Affordable Care Act (ACA) requires most health plans to cover preventive services without cost sharing, many Americans still struggle to afford necessary care. Maryland has taken steps to address this issue by enacting legislation to reduce cost sharing for several essential prescription drugs.

As mentioned in previous sections, Maryland became to first state to create a Prescription Drug Affordability Board in 2019.[135] Following the recommendations from the board and other stakeholders, the state passed the *Insulin Cost Reduction Act* (HB1397) in 2022, which limits monthly co-pays or coinsurance costs for insulin to no more than $30 a day for a thirty-day supply. The bill also caps copayment or coinsurance for prescription drugs that treat diabetes, HIV, or AIDS to $150 for a thirty-day supply of the drug.[136,ii]

> **Federal Policy Impact on State Policy Note:**
>
> The Inflation Reduction Act addresses prescription drug affordability through a variety of provisions. Among other provisions, the federal legislation limits monthly cost-sharing among Medicare beneficiaries for insulin to $35 a month. The bill also eliminates cost sharing for vaccines and caps out-of-pocket spending for Americans enrolled in Medicare Part D, which provides catastrophic coverage for high out-of-pocket drug costs.

Maryland could further reduce cost-sharing for prescription drugs by enacting protections against copay accumulator adjustment programs. These programs prevent consumers from applying cost-sharing assistance resources (e.g., manufacturer coupons) towards their deductible, which disproportionately affects people with rare, complex, and chronic diseases.[137] Currently, eight states and Puerto Rico require insurers to count all copayments made towards their annual deductible.[iii] Similarly, eight other states prohibit copay accumulator adjustment programs for drugs when no generic alternative is available.[iv,138]

Maryland could also explore separating medical and drug deductibles to cap monthly cost-sharing for specialty drugs. California passed legislation in 2016 to create separate deductibles and limit the cost of specialty prescription drugs to $250 a month for most insured residents, which could decrease consumer expenditures by up to 400%.[139] The Maryland Prescription Drug Affordability Board recently discussed the possibility of enacting legislation to create separate deductibles, and if the state proceeds consumers would benefit from monthly caps on prescription drugs.[140]

Beyond prescription drugs, states have the authority to prohibit cost sharing for other high value services, including behavioral health. For example, New Mexico has eliminated copays, coinsurance, and deductibles for behavioral health services for individuals insured through the state-based marketplace and select other insurers through Senate Bill 317.[141] Although Maryland already has comprehensive parity for mental health and substance abuse services and free in-

---

ii The prohibitions apply to insurers and non-profit health service plans that provide coverage for prescriptions under individual and group health insurance policies and HMOs.
iii Connecticut, Delaware, Illinois, Louisiana, New York, Oklahoma, Virginia, and West Virginia. New Jersey legislation will be enacted on January 1, 2024.
iv Arizona, Arkansas, Georgia, Kentucky, Maine, North Carolina, Tennessee, and Washington.

network screening for various behavioral health conditions, further legislation could be introduced to enhance affordability and accessibility. As opioid misuse is responsible for nine out of every ten drug overdose deaths in Maryland, and drug overdose deaths have increased considerably over the past few years, the state would benefit from incorporating innovative strategies to improve access to substance use services.[142]

Although Maryland has made strides towards reducing cost-sharing for many across the state, more could still be done to make health care more affordable across the state. Maryland could further reduce cost-sharing by enacting protections against copay accumulator adjustment programs, exploring separate deductibles for specialty drugs, and prohibiting cost-sharing for behavioral health services. Drawing inspiration from other states such as New Mexico and California, the state should consider innovative strategies to improve access to care and support individuals with complex health care needs.

Recommendations:

△ **Enact protections against copay accumulator adjustment programs.**

Accumulator adjustment programs prevent copay assistance that may be available for expensive drugs to count towards an individual's deductible. Federal bipartisan legislation prohibiting copay accumulator adjustment programs is currently pending (s.1375/H.R.830); however, Maryland could join the eight other states and Puerto Rico by enacting legislation which requires insurers to apply all copayments made towards an individual's annual deductible.

△ **Cap monthly out-of-pocket costs for an expanded number of specialty drugs.**

Capping monthly out-of-pocket costs for specialty drugs will ensure that patients with chronic and complex conditions can afford the necessary treatments without facing exorbitant costs. This is particularly important given the high cost of specialty drugs, which can exceed thousands of dollars per month. The state has already enacted legislation to reduce cost-sharing for some prescription drugs but should also consider expanding the number of eligible prescriptions to ensure greater access.

△ **Eliminate co-pays for behavioral health services.**

Maryland should eliminate co-pays for behavioral health services to improve access to care for individuals struggling with mental health and substance use disorders. The opioid crisis in Maryland has claimed many lives, and eliminating cost-sharing for behavioral health services can help address this urgent problem. Other states, such as New Mexico, have already passed legislation to eliminate cost-sharing for mental health and substance use disorders, and Maryland should draw inspiration from these policies to improve access to care for its residents. The state could begin by eliminating cost sharing for behavioral health services for people enrolled in coverage through the state-based marketplace, then expand to other insurers.

STANDARD PLAN DESIGN

Standard plan designs simplify health care coverage by providing standardized benefits across all participating insurers. To date, nine states and the District of Columbia require that Marketplace insurers offer standard plans.[143] Although Maryland has explored incorporating standard plan designs in their state-based marketplace, the Maryland Health Benefit Exchange (MHBE), the state ultimately chose to offer an alternative "Value Plan."[144] These plans limit deductibles but do not require insurers to standardize the price for each cost-sharing parameter.[145]

The Maryland Value Plans are labeled as such on the state-based exchange, allowing consumers to differentiate them from other plans offered on the Marketplace.[146] They also offer several additional protections from excess costs, including covering physician visits and generic prescriptions for enrollees. The Silver and Gold value plans also cover all diabetic supplies and may not exceed a deductible "ceiling," which is determined by the state.[147,148] Nearly half (47.5%) of all Maryland residents enrolled in MHBE coverage were enrolled in a value plan in 2021.[149]

CONCLUSION

This report provides a comprehensive analysis of health care affordability in Maryland and offers a set of recommendations to guide policymakers and stakeholders in improving access and reducing costs. The recommendations cover various aspects of health care, including data transparency, cost control, informed decision-making, health equity, coverage options, and financial burdens. By implementing these recommendations, Maryland can transform its health care system into a patient-centered model that emphasizes affordability, transparency, and quality of care.

Maryland has the capacity to build a health care system that prioritizes affordability, transparency, and quality of care. The proposed measures have the potential to improve health outcomes, reduce disparities, and create a more equitable health care system for all residents. It is essential for policymakers and stakeholders to collaborate and take decisive action to achieve these goals and ensure a brighter future for health care in Maryland.

SOURCES

[1] U.S. Bureau of Economic Analysis. (2022). Personal Consumption Expenditures by State, 2021. Retrieved from https://www.bea.gov/sites/default/files/2022-10/pce1022_0_0.pdf

[2] Haber, Susan, et al., Evaluation of the Maryland All-Payer Model, Volume I: Final Report, RTI International, Waltham, MA (November 2019). Retrieved from https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf

[3] Healthcare Value Hub. (n.d.). Healthcare Affordability Scorecard: Maryland. Retrieved May 23, 2023, from https://www.healthcarevaluehub.org/affordability-scorecard/maryland?select-state=https%3A%2F%2Fwww.healthcarevaluehub.org%2Faffordability-scorecard%2Fmaryland

[4] Maryland Health Care Commission. (n.d.) MCDB Data Release. Retrieved May 23, 2023, from https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_mcdb.aspx

[5] APCD Council. (n.d.). Maryland State Profile. Retrieved May 23, 2023, from https://www.apcdcouncil.org/state/maryland

[6] Carman, K., Dworsky, M., Heins, S., Schwam, D., Shelton, S., and Whaley, C. (2021). The History, Promise and Challenges of State All Payer Claims Databases: APCD Background Report. *RAND Health Care.* Retrieved from https://aspe.hhs.gov/sites/default/files/private/pdf/265666/apcd-background-report.pdf

[7] Pollak, A., and Ben Steffen. (2020). 2020 Annual Report. *Maryland Health Care Commission.* Retrieved from https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2020/MHCC_Annual_Rpt_FY_2020.pdf

[8] Maryland Health Care Commission. (n.d.). Maryland All-Payer Claims Database (APCD) Data Release. Retrieved May 23, 2023, from https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_mcdb.aspx

[9] Carman, K., Dworsky, M., Heins, S., Schwam, D., Shelton, S., and Whaley, C. (2021). The History, Promise and Challenges of State All Payer Claims Databases: APCD Background Report. *RAND Health Care.* Retrieved from https://aspe.hhs.gov/sites/default/files/private/pdf/265666/apcd-background-report.pdf

[10] State of Connecticut, Healthcare Cabinet. (n.d.). Analytic Framework for the Maryland All-Payer Model. Retrieved May 23, 2023, from https://business.ct.gov/-/media/OHS/Healthcare-Cabinet/Working-Groups/MARYLAND---analytic-framework-draft-2016-12-22.pdf

[11] Wear The Cost. (n.d.). Technical Details. Retrieved May 23, 2023, from https://www.wearthecost.org/jointheconversation/technical-details/

[12] Maryland Health Care Commission. (n.d.). Policy and Legislative Reports, Healthcare Expenditures. Retrieved May 23, 2023, from https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/plr_healthmd.aspx

[13] Hallum, P., Franklin, M., Anderson, L., and Mills, C. (2022). CY 2019 Milliman Benchmark and Maryland All-Payer Claims Database Cost and Utilization Exhibits. *Milliman.* Retrieved from https://www.milliman.com/-/media/milliman/pdfs/2022-articles/3-28-22-2019-benchmark-md-apcd-methodology-report.ashx

[14] State All Payer Claims Databases Advisory Committee. (2021). *State All Payer Claims Databases Advisory Committee Report with Recommendations Under Section 735 of the Employee Retirement Income Security Act of 1974.* Retrieved from https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/about-us/state-all-payer-claims-databases-advisory-committee/final-report-and-recommendations-2021.pdf

[15] Ranson, G. (n.d.) An Overview of Maryland's Unique All Payor Contract and Rate Setting. Retrieved May 9, 2023, from https://www.medchi.org/Portals/18/Files/Practice%20Services/Maryland%20Total%20Cost%20of%20Care%20slide%20presentation%202021%20.pdf?ver=2022-04-08-131445-543

[16] The Commonwealth Fund. (n.d.). Maryland: All-Payer Approach to Nonpayment. Retrieved May 10, 2023, from https://www.commonwealthfund.org/publications/newsletter-article/maryland-all-payer-approach-nonpayment

[17] Maryland Department of Health. (2023). M00R01: Health Regulatory Commissions. *Maryland General Assembly*. Retrieved from https://mgaleg.maryland.gov/pubs/budgetfiscal/2023fy-budget-docs-operating-M00R01-MDH-Health-Regulatory-Commissions.pdf.

[18] Center for Healthcare Quality and Payment Reform. (n.d.). Global Budgets. Retrieved May 10, 2023, from https://ruralhospitals.chqpr.org/Global_Budgets.html

[19] Maryland Citizens' Health Initiative. (2020). Summary of Maryland's Prescription Drug Affordability Board Act. https://www.mdmunicipal.org/DocumentCenter/View/7303/2020-Md-Prescription-Drug-Affordability-Board-Summarypdf

[20] Maryland General Assembly. (2019). House Bill 768. Retrieved from https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0768?ys=2019RS&search=True

[21] Gaskill, H. (2022, May 24). Prescription Drug Affordability Board Begins Process to Cap Costs on Certain Medications. *Maryland Matters*. Retrieved from https://www.marylandmatters.org/2022/05/24/prescription-drug-affordability-board-begins-process-to-cap-costs-on-certain-medications/

[22] Maryland General Assembly. (2023). Senate Bill 202. Retrieved from https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0202?ys=2023RS

[23] Maryland General Assembly. (2023). Senate Bill 202 Text. Retrieved from https://mgaleg.maryland.gov/2023RS/bills/sb/sb0202T.pdf

[24] Gaskill, H. (2022, May 24). Prescription Drug Affordability Board Begins Process to Cap Costs on Certain Medications. *Maryland Matters*. Retrieved from https://www.marylandmatters.org/2022/05/24/prescription-drug-affordability-board-begins-process-to-cap-costs-on-certain-medications/

[25] Murray, R., & Berenson, R. A. (2015). Hospital Rate Setting Revisited. *Urban Institute*. Retrieved from https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf

[26] West Virginia Health Care Authority. (n.d.). Rate Review - History. Retrieved May 10, 2023, from https://hca.wv.gov/ratereview/Pages/RR_History.aspx

[27] Healthcare Value Hub. (2020). Hospital Rate Setting: Successful in Maryland but Challenging to Replicate. https://www.healthcarevaluehub.org/advocate-resources/publications/hospital-rate-setting-promising-challenging-replicate

[28] Centers for Medicare & Medicaid Services. (n.d.). Maryland all-payer model. Retrieved May 5, 2023, from https://innovation.cms.gov/innovation-models/maryland-all-payer-model

[29] Rosenthal, E. (2021, October 24). A $1,775 Doctor's Visit Costs About $350 in Maryland. Here's Why. *The New York Times*. Retrieved from https://www.nytimes.com/2021/10/24/opinion/maryland-medical-bills-lower.html

[30] Centers for Medicare & Medicaid Services. (n.d.). Maryland all-payer model. Retrieved May 5, 2023, from https://innovation.cms.gov/innovation-models/maryland-all-payer-model

[31] Centers for Medicare & Medicaid Services. (2022). Maryland Total Cost of Care (MD TCOC) Model – Evaluation of the First Three Model Years (2019-2021). https://innovation.cms.gov/data-and-reports/2022/md-tcoc-qor2-aag

[32] Frist, B. (2023, February 28). A Road Map for Action on Health Care Spending and Value: Part III – Spending Growth Targets. *Forbes*. https://www.forbes.com/sites/billfrist/2023/02/28/a-road-map-for-action-on-health-care-spending-and-value-part-iii--spending-growth-targets/?sh=3b6949993e35

[33] Peterson, C., and Schumacher, D. (2020, October 5). How Maryland's Total Cost of Care Model has Helped Hospitals Manage the COVID-19 Stress Test. *Health Affairs*. Retrieved from https://www.healthaffairs.org/do/10.1377/forefront.20201005.677034/full/

[34] Rotter, J., Calkins, K., Stewart, K., Platt, I., Machta, R., Kranker, K., McCall, N., and Peterson, G. (2022). Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021). *Mathematica.* Retrieved from https://innovation.cms.gov/data-and-reports/2022/md-tcoc-qor2

[35] Ibid.

[36] Ibid.

[37] Ibid.

[38] Mathematica. (2023). Maryland Saved Medicare More than $780 Million Using New Approach to Payment. https://www.mathematica.org/news/maryland-saved-medicare-more-than-780-million-using-new-approach-to-payment

[39] Kacik, A. (2018, July 19). Maryland's Price Transparency Site Adds New Data, Petition. *Modern Healthcare*. https://www.modernhealthcare.com/article/20180719/TRANSFORMATION04/180719887/maryland-s-price-transparency-site-adds-new-data-petition

[40] Healthcare Value Hub. (2022). Healthcare Affordability Scorecard: Maryland. Retrieved from https://www.healthcarevaluehub.org/affordability-scorecard/maryland?select-state=https%3A%2F%2Fwww.healthcarevaluehub.org%2Faffordability-scorecard%2Fmaryland

[41] Ibid.

[42] Ibid.

[43] Do, L., Koethe, B., Daly, A., Chambers, J., Ollendorf, D., Wong, J., Fendrick, A. M., Neumann, P., and Kim, D. (2022). State-Level Variation in Low-Value Care for Commercially Insured and Medicare Advantage Populations. Health Affairs, 41(9), 1281-1290. https://doi.org/10.1377/hlthaff.2022.00325

[44] Budros, M., Chernew, M., and Fendrick, A. M. (2020). Utilization and Spending on Low-Value Medical Care Across Four States. *Value Based Insurance Design (VBID) Health.* https://vbidhealth.com/docs/APCD-LVC-Final.pdf

[45] Washington Health Alliance. (2019, October). *First, Do No Harm: Calculating Health Care Waste in Washington State Multi-Year and Medical Group Results.* Retrieved from https://wacommunitycheckup.org/media/47217/first-do-no-harm-oct-2019.pdf

[46] Oregon Health Authority. (2020, July). Better Health for Oregonians: Opportunities to Reduce Low-Value Care. Oregon Health Leadership Council. Retrieved from https://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/07/Oregon-Low-Value-Care-Report-Final-July-2020.pdf

[47] Virginia Health Information. (2017, February). 2016 Virginia Low Value Services Report. *Virginia Center for Health Innovation.* Retrieved from https://www.vhi.org/APCD/Virginia%20Low%20Value%20Services%20Report.pdf

[48] Massachusetts Health Policy Commission. (2019, February). *2018 Annual Health Care Cost Trends Report*. Retrieved from https://www.mass.gov/doc/2018-report-on-health-care-cost-trends/download

[49] Massachusetts Health Policy Commission. (2014, January). *2013 Cost Trends Report*. Retrieved from https://www.mass.gov/doc/2013-cost-trends-full-report/download

[50] Maryland Department of Health. (2021). Maryland Hospital Patient Safety Program Report FY21. https://health.maryland.gov/ohcq/Documents/Maryland%20Hospital%20Patient%20Safety%20Program%20Report%20FY21.pdf

[51] Ibid.

52 Agency for Healthcare Research and Quality. (2019). Health Care-Associated Infections https://psnet.ahrq.gov/primer/health-care-associated-infections

53 Maryland Health Care Commission. (n.d.). Health Data and Quality – Healthcare Associated Infections. Retrieved May 14, 2023, from https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_quality/apcd_quality_hai.aspx

54 Pakyz, A., & Edmond, M. (2013). Influence of State Laws Mandating Reporting of Healthcare-Associated Infections: The Case of Central Line–Associated Bloodstream Infections. *Infection Control & Hospital Epidemiology, 34*(8), 780-784. doi:10.1086/671280

55 Centers for Disease Control and Prevention. (n.d.). Antibiotic Resistance and Patient Safety Portal - Maryland. Retrieved May 2, 2023, from https://arpsp.cdc.gov/profile/geography/maryland?hospital-select=haiHospital109&redirect=true&state-select=currentGeography&year-select-sir=haiYear2021&hai-select-sir=haiCAUTI

56 Centers for Medicare & Medicaid Services. (n.d.). Hospital-Acquired Conditions Reduction Program. Retrieved May 14, 2023, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions

57 Maryland Health Services Cost Review Commission. (2020). Final Recommendation for the Maryland Hospital-Acquired Conditions (MHAC) Program for Rate Year 2023. Retrieved from https://hscrc.maryland.gov/Documents/Quality_Documents/MHAC/RY%202023/RY%202023%20Final%20MHAC%20recommendation%20110402020_For%20Web.pdf

58 Maryland Health Services Cost Review Commission. (2021). Final Quality-Based Reimbursement Program for Rate Year 2024: Final Approved File. https://hscrc.maryland.gov/Documents/QBR%20RY%202024%20Final%20Approved%20File.pdf

59 Centers for Disease Control and Prevention. (2022). COVID-19 U.S. Impact on Antimicrobial Resistance. Atlanta, GA: U.S. Department of Health and Human Services. https://www.cdc.gov/drugresistance/pdf/covid19-impact-report-508.pdf

60 Dadgostar P. (2019). Antimicrobial Resistance: Implications and Costs. *Infection and Drug Resistance*, *12*, 3903–3910. https://doi.org/10.2147/IDR.S234610

61 Centers for Disease Control and Prevention. (2021). Outpatient Antibiotic Prescriptions – United States, 2021. https://www.cdc.gov/antibiotic-use/data/report-2021.html

62 Centers for Disease Control and Prevention. (n.d.). Antibiotic Resistance and Patient Safety Portal - Maryland. Retrieved May 2, 2023, from https://arpsp.cdc.gov/profile/geography/maryland?hospital-select=haiHospital109&redirect=true&state-select=currentGeography&year-select-sir=haiYear2021&hai-select-sir=haiCAUTI

63 Maryland Department of Health. (2018). Maryland 2018 Statewide Acute Care Antibiogram. https://health.maryland.gov/phpa/Documents/Antibiograms%202018.pdf

64 Wallinga, D., Smit, L. A. M., Davis, M. F., Casey, J. A., & Nachman, K. E. (2022). A Review of the Effectiveness of Current US Policies on Antimicrobial Use in Meat and Poultry Production. Current environmental health reports, 9(2), 339–354. https://doi.org/10.1007/s40572-022-00351-x

65 University of Maryland School of Pharmacy. (n.d.). Antimicrobial Stewardship. Peter Lamy Center on Drug Therapy and Aging. Retrieved May 15, 2023, from https://www.pharmacy.umaryland.edu/centers/lamy/antimicrobial-stewardship/

66 Centers for Disease Control and Prevention. (n.d.). Antibiotic Resistance and Patient Safety Portal - Maryland. Retrieved May 2, 2023, from https://arpsp.cdc.gov/profile/geography/maryland?hospital-select=haiHospital109&redirect=true&state-select=currentGeography&year-select-sir=haiYear2021&hai-select-sir=haiCAUTI

67 Ibid.

68 U.S. Census Bureau. (2021). S2701 Health Insurance Coverage Status and Type by State and Age for All People: 2021 American Community Survey 1-Year Estimates. Retrieved from

https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST1Y2021.S2701

[69] Kaiser Family Foundation. (2021). Distribution of Eligibility for ACA Coverage Among the Remaining Uninsured. State Health Facts. Retrieved from https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[70] Ibid.

[71] Maryland Insurance Administration. (2013). Bulletin 13-27: Summary of 2013 Legislation Signed into Law by Governor Martin O'Malley. Retrieved from https://insurance.maryland.gov/Insurer/Documents/bulletins/bulletin13-27_2013-legislation.pdf

[72] U.S. Census Bureau. (n.d.). Table S2701: Health Insurance Coverage Status, 2013 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2013.S2701

[73] U.S. Census Bureau. (n.d.). Table S2701: Selected Characteristics of Health Insurance Coverage in the United States, 2015 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2015.S2701

[74] U.S. Census Bureau. (n.d.). Table S2701: Selected Characteristics of Health Insurance Coverage in the United States, 2021 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2021.S2701

[75] Ibid.

[76] Advisory Board. (2023). Where the states stand on Medicaid expansion. Daily Briefing. Retrieved from https://www.advisory.com/daily-briefing/resources/primers/medicaidmap

[77] Kaiser Family Foundation. (2021). Fact Sheet: Medicaid in Maryland. https://files.kff.org/attachment/fact-sheet-medicaid-state-MD

[78] Frerichs, L., Bell, R., Lich, K., Reuland, D., Warne, D. (2019). Health Insurance Coverage Among American Indians and Alaska Natives in the Context of the Affordable Care Act. *Journal of Ethnicity and Health, 27*(1), 174-189. DOI: 10.1080/13557858.2019.1625873

[79] U.S. Census Bureau. (n.d.). Table S2701: Health Insurance Coverage Status, 2013 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2013.S2701

[80] U.S. Census Bureau. (n.d.). Table S2701: Selected Characteristics of Health Insurance Coverage in the United States, 2015 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2015.S2701

[81] U.S. Census Bureau. (n.d.). Table S2701: Selected Characteristics of Health Insurance Coverage in the United States, 2021 American Community Survey 5-Year Estimates Subject Tables. Retrieved May 27, 2023, from https://data.census.gov/table?q=uninsured+rates&g=040XX00US24&tid=ACSST5Y2021.S2701

[82] Carlson, P., Chasse, J., Holthaus, L., Stahr, L. (2017). Assessing the Impact of Health Care Reform in Maryland. *Maryland Department of Legislative Services.* Retrieved from https://dls.maryland.gov/pubs/prod/HHS/Assessing-the-Impact-of-Health-Care-Reform-in-Maryland_FINAL.pdf

[83] Health Services Cost Review Commission. (2020). Rate Year 2021 Uncompensated Care Report. Retrieved from https://hscrc.maryland.gov/Documents/Hospitals/gbr-tpr-update/FY-2021/UCCReport2021.pdf

[84] LegiScan. (2022). Maryland Senate Bill 150. Retrieved from https://legiscan.com/MD/bill/SB150/2022#:~:text=Requiring%20the%20Maryland%20Medical%20Assistance,federal%20poverty%20level%3B%20and%20repealing

85 Kaiser Family Foundation. (2023) Medicaid Postpartum Coverage Extension Tracker. Retrieved May 6, 2023, from https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/#note-0-28

86 Sobel, L., Ranji, U., Pestaina, K., Dawson, L., & Cubanski, J. (2023). Explaining Litigation Challenging the ACA's Preventive Services Requirements: Braidwood Management, Inc. v. Becerra. *Kaiser Family Foundation.* Retrieved from https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/

87 Gaines, D. (2023, February 13). With tax season underway, officials hope more Marylanders will check off 'easy enrollment' box to get health insurance info. *Maryland Matters.* Retrieved from https://www.marylandmatters.org/2023/02/13/with-tax-season-underway-officials-hope-more-marylanders-will-check-off-easy-enrollment-box-to-get-health-insurance-info/

88 Maryland General Assembly. (2023). House Bill 0111 . Retrieved from https://mgaleg.maryland.gov/2023RS/bills/hb/hb0111E.pdf

89 Haldar, S, and Madeline Guth. (2023, April 24). Section 1115 Waiver Watch: Continuous Eligibility Waivers and Implications for Unwinding. Kaiser Family Foundation. Retrieved from https://www.kff.org/?p=586595

90 Kaiser Family Foundation. (2021). Distribution of Eligibility for ACA Coverage Among the Remaining Uninsured. State Health Facts. Retrieved from https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

91 Artiga, S., Rudowitz, R., and Tolbert, J. (2016, March 2). Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/outreach-and-enrollment-strategies-for-reaching-the-medicaid-eligible-but-uninsured-population/

92 State Health Access Data Assistance Center (SHADAC). (2023). State-Based Reinsurance Programs and 1332 State Innovation Waivers. Retrieved from https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers

93 Cardenas, J., & Levitis, J. (2021). The ACA in Maryland: A Case Study in Successful Bipartisan Innovation. *State Health and Value Strategies (SHVS).* Retrieved from https://www.shvs.org/wp-content/uploads/2021/01/FINAL_RWJF-SHVS-Maryland-Case-Study-Brief

94 NASHP. (2019). State Reinsurance Programs Lower Premiums and Stabilize Markets: Oregon and Maryland Show How. https://nashp.org/state-reinsurance-programs-lower-premiums-and-stabilize-markets-oregon-and-maryland-show-how/

95 State Health Access Data Assistance Center (SHADAC). (2023). State-Based Reinsurance Programs and 1332 State Innovation Waivers. Retrieved from https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers

96 Michele Eberle, Maryland Health Benefit Exchange. (December 15, 2022). [Maryland 1332 Waiver Extension Response Letter.] Retrieved from https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-md-loi-extension-response-letter.pdf

97 Ellen Montz, Centers for Medicare and Medicaid Services. (December 15, 2022). [Maryland 1332 Waiver Extension Completeness letter.] Retrieved from https://www.cms.gov/files/document/1332-md-waiver-extension-completeness-letter.pdf

98 Maryland Health Benefit Exchange. (2023). Maryland 1332 State Innovation Waiver Five-Year Extension Application 2024 – 2028. Retrieved from https://www.marylandhbe.com/wp-content/uploads/2023/02/1332-Waiver-Extension-Application-2023.pdf

99 Maryland Health Benefit Exchange. (2022). MHBE 2022 Annual Report. Retrieved from https://www.marylandhbe.com/wp-content/uploads/2022/12/MHBE-2022-Annual-Report.pdf

100 Maryland Health Benefit Exchange. (2023). Maryland 1332 State Innovation Waiver Five-Year Extension Application 2024 – 2028. Retrieved from https://www.marylandhbe.com/wp-content/uploads/2023/02/1332-Waiver-Extension-Application-2023.pdf

[101] Fabian-Marks, J. (2022, July 18). *2021 Reinsurance Results and 2023 Reinsurance Parameter Presentation* [PowerPoint Slides]. Maryland Health Benefit Exchange. https://www.marylandhbe.com/wp-content/uploads/2022/07/4b.-2021-Reinsurance-Results-and-2023-Reinsurance-Parameter-Presentation.pdf

[102] Norris, L. (2022, September 6.) What is Reinsurance and Why are States Pursuing It. Verywell Health. Retrieved from https://www.verywellhealth.com/reinsurance-4174980#toc-reinsurance-and-the-american-rescue-plan

[103] Independence Now. (n.d.) Employed Individuals with Disabilities (EID). Retrieved May 17, 2023, from https://www.innow.org/md-win/eid/

[104] Vera Institute. (2017). Profile of the Foreign-Born Population in Baltimore, Maryland. https://www.vera.org/downloads/publications/profile-foreign-born-population-baltimore.pdf https://www.vera.org/downloads/publications/profile-foreign-born-population-baltimore.pdf

[105] American Immigration Council. (2023). Map the Impact: Immigrants in Maryland [PDF]. Retrieved from https://map.americanimmigrationcouncil.org/locations/maryland/?_gl=1*1v7s9ct*_ga*MTEyODE5NTY4MS4xNjgyOTA3NTY1*_ga_W0 MSMD2GPV*MTY4MzgzNzU0NS40LjAuMTY4MzgzNzU0OC4wLjAuMA..#

[106] Hofstaedter, E. (2023, April 11). No health insurance, open marketplace for undocumented Marylanders; lawmakers want more analysis. WYPR. https://www.wypr.org/wypr-news/2023-04-11/no-health-insurance-open-marketplace-for-undocumented-marylanders-lawmakers-want-more-analysis

[107] National Immigration Law Center. (2023, March). Medical Assistance Programs for Immigrants in Various States [Table]. Retrieved from https://www.nilc.org/wp-content/uploads/2023/03/med-services-for-imms-in-states-2023-3-23.pdf

[108] Maryland General Assembly. (2022). House Bill 1080 Text. Retrieved from https://mgaleg.maryland.gov/2022RS/bills/hb/hb1080T.pdf

[109] Maryland General Assembly. (2023) Maryland Senate Bill 0806. Retrieved from https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0806

[110] Maryland General Assembly. (2022) Maryland Senate Bill 0364. Retrieved from https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0365

[111] Maryland General Assembly. (2022) Maryland House Bill 0588. Retrieved from https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0588

[112] Montgomery County Department of Health and Human Services. (n.d.). Montgomery Cares (Medical Care for Uninsured Adults). Retrieved May 6, 2023, from https://www.montgomerycountymd.gov/HHS-Program/PHS/PHSAdultMedforUninsured-p1440.html

[113] Maryland Center on Economic Policy. (2023). Supporting a Healthier Maryland through Healthcare Expansion for Immigrant Communities. http://www.mdeconomy.org/wp-content/uploads/2023/03/Economic-Benefits-of-Expanding-Immigrant-Access-to-Health-Care.pdf

[114] Michele Eberle, Maryland Health Benefit Exchange. (2021). [Submitted Joint Chairmen's Report on costs, feasibility and a review of activity in other states to serve individuals ineligible for Medicaid or Qualified Health Plans (QHPs) with Advanced Premium Tax Credits submitted by the Joint Committee on Health Care by the Maryland Health Benefit Exchange.] Retrieved May 6, 2023, from https://dlslibrary.state.md.us/publications/JCR/2021/2021_44b_2021.pdf

[115] American Immigration Council. (2023). Map the Impact: Immigrants in Maryland [PDF]. https://map.americanimmigrationcouncil.org/locations/maryland/?_gl=1*1v7s9ct*_ga*MTEyODE5NTY4MS4xNjgyOTA3NTY1*_ga_W0 MSMD2GPV*MTY4MzgzNzU0NS40LjAuMTY4MzgzNzU0OC4wLjAuMA..#

[116] Villeda, K. (2023). Washington's 1332 Waiver Presents Opportunities for Health Equity. *Community Catalyst.* https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-equity/

[117] Mendelsohn, D. (2015, June). Health Insurance Rate Review: A Powerful Tool for Addressing Consumer Health Costs. *Healthcare Value Hub.* https://healthcarevaluehub.org/advocate-resources/publications/health-insurance-rate-review/

[118] Maryland Insurance Administration. (2011). Report on Health Insurance Rate Review Process and Information Provided to Consumers. Retrieved from https://insurance.maryland.gov/Consumer/Documents/report_on_health_insurance_rate_review_process-information_provided_to_consumers.pdf

[119] Maryland Insurance Administration. (n.d.). Health Insurance Rates and the Rate Review Process: Frequently Asked Questions. Retrieved May 25, 2023, from http://www.healthrates.mdinsurance.state.md.us/RatesQA1.aspx#2046

[120] Maryland Insurance Administration. (2011). Report on Health Insurance Rate Review Process and Information Provided to Consumers. Retrieved from https://insurance.maryland.gov/Consumer/Documents/report_on_health_insurance_rate_review_process-information_provided_to_consumers.pdf

[121] Rhode Island Office of the Health Insurance Commissioner. (2020). Affordability Standards. Retrieved May 7, 2023, from https://ohic.ri.gov/policy-reform/affordability-standards

[122] Butler, J. (2021, February 1). Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience. National Academy for State Health Policy. Retrieved from
[123] https://nashp.org/toolkit-health-insurance-rate-review-authority-to-control-health-care-costs-including-model-legislation-and-regulatory-language/

[124] Lueck, S. (2020). Commentary: Growing Evidence Shows Need for Stronger Rules for Short-Term Health Plans. *Center on Budget and Policy Priorities*. https://www.cbpp.org/research/health/commentary-growing-evidence-shows-need-for-stronger-rules-for-short-term-health

[125] Norris, L. (2023, March 21). Availability of Short-Term Health Insurance in Maryland. *HealthInsurance.org.* https://www.healthinsurance.org/short-term-health-insurance/maryland/

[126] Bill Track 50. Maryland House Bill 1782: Health Insurance and Individual Market Stabilization (Maryland Health Care Access Act of 2018). Retrieved from https://www.billtrack50.com/BillDetail/962405

[127] Maryland Insurance Administration. (n.d.). Consumers: Is a Short-Term Medical Plan for You? Retrieved May 6, 2023, from https://insurance.maryland.gov/Consumer/Pages/Is-a-Short-Term-Medical-Plan-for-You.aspx

[128] Reed, J. (2023, February 23). Reed Works to Protect Americans from Skimpy Junk Health Plans. Retrieved May 5, 2023, from https://www.reed.senate.gov/news/releases/reed-works-to-protect-americans-from-skimpy-junk-health-plans

[129] Baldwin, T., Murphy, C., Merkley, J., Padilla, A., Casey, R., Kaine, T., Blumenthal, R., et al. (2023, February 22). [Letter to the United States Department of Health and Human Services from multiple senators urging them to reconsider strategies to eliminate short term limited duration health plans.] Retrieved May 5, 2023, from https://www.baldwin.senate.gov/imo/media/doc/022223lettertohhsonjunkplans.pdf

[130] Song, Z., Johnson, W., Kennedy, K., Biniek, J. F., & Wallace, J. (2020). Out-Of-Network Spending Mostly Declined In Privately Insured Populations With A Few Notable Exceptions From 2008 To 2016. Health affairs (Project Hope), 39(6), 1032–1041. https://doi.org/10.1377/hlthaff.2019.01776

[131] Maryland State Archives. (2006). Study of Balance Billing Prohibition in Maryland. Retrieved May 5, 2023, from https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/001000/001995/unrestricted/20062039e-0008.pdf

[132] Hoadly, J., Ahn, S., & Lucia, K. (2015). Balance Billing: How are States Protecting Consumers from Unexpected Charges?. *The Center on Health Insurance Reforms at Georgetown University Health Policy Institute.* Retrieved May 5, 2023, from https://www.insurance.pa.gov/Documents/Balance%20Billing/Kevin%20Lucia.pdf

[133] Lucia, K., Hoadley, J., & Williams, A. (2017). Balance Billing by Health Care Providers: Assessing Consumer Protections Across States. *The Commonwealth Fund.*

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jun_lucia_balance_billing_ib.pdf

[134] Ibid.

[135] Maryland Health Care for All. (n.d.). Reducing Prescription Drug Costs. Retrieved May 5, 2023, from https://healthcareforall.com/project/reducing-prescription-drug-costs/

[136] Legiscan. (2022). HB1397 - Health Insurance - Prescription Drug Benefits - Cost-Sharing Requirements. Retrieved from https://legiscan.com/MD/text/HB1397/2022

[137] Maryland Psychiatric Society. (2022, September 28). MPS Advocacy for Protection Against High Cost-Sharing for Prescriptions. Retrieved May 5, 2023, from https://mdpsych.org/2022/09/mps-advocacy-for-protection-against-high-cost-sharing-for-prescriptions/

[138] Treatment Access Institute. (2023). Copay Accumulator Adjustment Programs: Trends, Impacts, and Best Practices [Report]. https://aidsinstitute.net/documents/TAI-Report-Copay-Acc

[139] Shafer, P. R., Horný, M., & Dusetzina, S. B. (2022). Monthly Cost-Sharing Limits and Out-of-pocket Costs for Commercially Insured Patients in the US. JAMA network open, 5(9), e2233006. https://doi.org/10.1001/jamanetworkopen.2022.33006

[140] Maryland Health Benefit Exchange. (2022). Affordability Work Group Slides. https://www.marylandhbe.com/wp-content/uploads/2022/07/Affordability-Work-Group-Slides-07-6-22-Becca-Lane-MHBE-.pdf

[141] Troutman Pepper Hamilton Sanders LLP. (2022, June 16). New State Law Eliminates All Copays, Coinsurance, and Deductibles for Mental Health and Substance Use Disorder Services. https://www.troutman.com/insights/new-state-law-eliminates-all-copays-coinsurance-and-deductibles-for-mental-health-and-substance-use-disorder-services.html

[142] Kaiser Family Foundation. (2021). Mental Health and Substance Use State Fact Sheets - Maryland. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/maryland/

[143] The Commonwealth Fund. (2021, February 2). State Efforts to Standardize Marketplace Health Plans. https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans

[144] Maryland Health Benefit Exchange. (2017). Final 2017 Standardized Benefit Design Work Group Report. https://www.marylandhbe.com/wp-content/uploads/2017/12/FINAL-2017-Standardized-Benefit-Design-Work-Group-Report.pdf

[145] The Commonwealth Fund. (2021, February 2). State Efforts to Standardize Marketplace Health Plans. https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans

[146] Chu, R., Rudich, J., Lee, A., Peters C., De Lew, N., and Sommers, B. (2021, December 28). Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces. Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf

[147] Maryland Health Connection. (n.d.) All About Value Plans. Retrieved June 2, 2023, from https://www.marylandhealthconnection.gov/wp-content/uploads/2019/09/value-plan.pdf

[148] Ibid.

[149] Chu, R., Rudich, J., Lee, A., Peters C., De Lew, N., and Sommers, B. (2021, December 28). Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces. Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf