Maryland Health Benefit Exchange Board of Trustees Meeting Minutes

March 12, 2013
1:00 PM – 4:00 PM
Maryland Health Benefit Exchange
Sky Lobby Conference Room B
750 East Pratt Street
Baltimore, MD 21202

The materials presented in the meeting are listed on the Maryland Health Benefit Exchange (MHBE) webpage: http://marylandhbe.com/exchange-board/board-meetings/

Members Present

Joshua M. Sharfstein, M.D.
Darrell Gaskin, Ph.D.
Ben Steffen, M.A.
Enrique Martinez-Vidal, M.P.P
Therese Goldsmith, J.D., M.S. (by phone)
Kenneth Apfel, M.P.A.
Jennifer Goldberg, J.D., LL.M.
Georges Benjamin, M.D. (by phone)
Rebecca Pearce, M.B.A
Thomas Saquella, M.A.

Opening Comments and General Updates

Ms. Pearce welcomed everyone and noted that this is the first meeting of the Board of Trustees to take place in MHBE's new location. She then gave several general updates:

- MHBE has hired several new staff members; as of March 20, 2013, MHBE will have 21 staff.
- Responses are due to the request for proposals (RFP) for the Consolidated Service Center (CSC) on March 25, 2013.
- MHBE has received 12 proposals in response to the Connector Entity grant solicitation. There is at least one proposal for each region. The proposals are currently under review.

Ms. Pearce then announced that MHBE held a demonstration of the Maryland Health Connection plan selection technology for external stakeholders that morning. She said it was very well-attended. Ms. Goldberg added that the demo resulted in detailed feedback and that similar events will be held in the future to look at other parts of the system.

- Mr. Martinez-Vidal asked what the demo attendees were looking at. Ms. Goldberg replied that the demo covered plan selection and not any part of the application process.
- Mr. Apfel asked whether the event was a part of the gap analysis effort. Ms. Pearce replied that it was a continuation of the overall stakeholder involvement effort.

Ms. Pearce continued her general updates:

- Maryland and Washington are the two states that will do live testing with the federal data hub in the coming weeks. The test will consist of three out of eleven data sets.
- MHBE is performing analysis and realignment of the program management plan. Based on these efforts, and working closely with vendors, MHBE feels strongly that it will reach full functionality by October 1, 2013.
- The Center for Consumer Information and Insurance Oversight (CCIIO) released regulations on reinsurance. MHBE must respond by April 1, 2013, with details of how it will manage the state reinsurance program, as Maryland is one of only two states doing its own reinsurance. MHBE currently plans to follow the federal reinsurance model within Maryland.

- The Maryland Health Progress Act of 2013 includes legislation concerning MHBE but is broader in scope than the bills of previous years. This year, it includes:
    - Medicaid expansion
    - A dedicated funding stream for MHBE by setting out an annual appropriation for MHBE from the existing 2 percent premium tax
    - Transitioning Maryland's Health Insurance Plan (MHIP) enrollees to the broader market.
        - MHIP closes to new enrollees as of January 1, 2014
        - MHIP shuts down entirely no later than January 1, 2020
        - The Act affords the Boards of both MHBE and MHIP the flexibility to work together on MHIP funding—possibly repurposing the funds for reinsurance
    - Continuity of Care provisions to take effect in 2015
    - Rules around premium contribution in the Small Business Health Options Program (SHOP)
    - Rules concerning consumer enrollment in qualified health plans (QHPs) and Medicaid managed care organizations (MCOs) by Consolidated Service Center (CSC) staff

  Ms. Pearce noted that the efforts to craft and guide the legislation are led by Lieutenant Governor Brown and Carolyn Quattrocki from the Governor's Office on Health Care Reform.
    - Mr. Saquella asked whether the bill has been heard. Ms. Pearce replied that it had, but that it will probably undergo another round of hearings after it has been amended.

Mr. Saquella asked Ms. Pearce to comment on the recent budget hearings. Ms. Pearce replied that they went well and that the majority of the funding comes from the federal government. She noted that MHBE is asking for some state funds for Navigators, but that MHBE received no questions on that topic. The questions focused on issues of general enrollment.

Web-Based Entities Discussion

Frank Kolb, Director of Policy at MHBE, gave the Board an overview of a potential new distribution channel: web-based entities (WBEs). He began by describing WBEs as producers that offer health insurance options primarily through a web portal. He noted that several WBEs have expressed interest in selling QHPs and that having these entities involved may help to support the goal of enrolling uninsured Marylanders.

Next, Mr. Kolb described the requirements and restrictions in federal law on WBEs and laid out several considerations for the Board to keep in mind when deciding how to address the issue.

Finally, Mr. Kolb presented MHBE's recommendation: that the Board seek public comment on which to base a final recommendation for future consideration.

- Mr. Saquella asked whether WBEs would have back office integration with MHBE in order to conduct the required eligibility checks and other functions on their websites. Mr. Kolb explained that several methods are available, including an arrangement whereby a visitor would go to the WBE's site but actually be looking at Maryland Health Connection. Chairman Sharfstein added that MHBE would seek comment on the technical requirements.
- Mr. Saquella noted that the proposed WBE model is similar to the existing third-party administrator (TPA) integration program. Chairman Sharfstein agreed, saying that the programs would be similar except that WBEs address only the individual market.
- Ms. Goldberg asked how quickly MHBE must decide how to approach WBEs. Chairman Sharfstein expressed concern over whether WBEs could be integrated in the first year of operation.
- Mr. Steffen asked whether such entities might show plans from the outside market alongside plans from Maryland Health Connection.

Environmental Scan

Danielle Davis, Director of Communications, Outreach, and Marketing at MHBE, along with Chuck Fitzgibbon of Weber Shandwick and Colleen Learch of KRC Research, presented to the Board an overview of the market research plan and the results of the recently completed environmental scan.

First, Ms. Learch laid out the planned steps in the market research effort: the updated environmental scan completed in February 2013, the exploratory focus groups in the first quarter of 2013, the statewide and target audience surveys in the second quarter of 2013, in depth interviews with influencer audiences in the second quarter of 2013, and the creative testing focus groups.

- Ms. Pearce asked why no exploratory focus groups are planned to take place western Maryland. Ms. Learch replied that the team wanted a rich mix of opinions for exploratory research and that the western region would be included in the in-depth interviews and surveys.

Ms. Learch then went into some detail regarding the updated environmental scan, beginning with a high-level view of the methodology used in its development. She listed the five target demographics identified in the 2011 Landscape Analysis—Entrepreneurs, Young Immortals, Older and Unwell, Impoverished Families, and Working Families—along with some common attributes found in each. She then compared those with the demographic segments released by the Centers for Medicare and Medicaid Services (CMS) and the psychographic groups identified in the 2011 Landscape Analysis. She spent some time describing how MHBE might use the target audience studies and gave an example by extrapolating the CMS segments to Maryland's population of uninsured people.

Next, Ms. Learch described the results of the empirical scan portion of the environmental scan. She displayed the geographic distribution and concentration of population by race and ethnicity in the state, and then presented a breakdown of the race and ethnicity of the populations of each Maryland Health Connection (MHC) region (Western, Central, Capital, Southern, Upper Eastern Shore, Lower Eastern Shore). She showed the number and percentage of disabled people by race, the income bracket of the uninsured population for each MHC region, and a number of other demographic breakdowns.

Ms. Learch then spent some time on the results of the academic and public opinion research scan portion of the environmental scan. She compared Marylanders' knowledge, opinion, and support for health care reform (including MHBE) with national averages and demonstrated that educational efforts affect health care reform messaging in a strongly positive way.

- Professor Apfel asked to see national data on support for health care reform. Ms. Learch noted that such data are present in the unabridged version of the environmental scan presentation.
- Mr. Martinez-Vidal asked whether Ms. Learch plans to map the CMS population segments to the six MHC regions, noting that the numbers may be too small. Ms. Learch replied that she would try, especially in the survey process, to get that granular but that it would prove difficult.
- Mr. Steffen asked how large the samples and focus groups would be. Ms. Learch replied that the sample size is 800 completed surveys, including an oversample of the uninsured.
- Mr. Steffen asked about the response rate. Ms. Learch replied that they work toward 15 to 20 percent.
- Dr. Gaskin asked why the non-college women and the $30-$50k income groups showed such a lack of support for health care reform. Ms. Learch clarified that, rather than showing resistance, those demographics displayed a lack of knowledge, and that education is the key to gaining these segments' support.
- Ms. Goldberg asked how the research team has planned to include input from those with limited English proficiency. Ms. Learch replied that the plan allows for interviews in Spanish and includes working with multicultural experts to accommodate those populations. Ms. Goldberg asked Ms. Learch to include a language line for non-English, non-Spanish populations.

Performance Metrics Discussion

Leslie Lyles-Smith, Director of Operations at MHBE, presented an overview of the MHBE Performance Management Strategy, noting that she'd come to obtain Board approval of it. She began by providing the background of the Performance Management Strategy, including the core measurement categories approved by the Board in June 2012 and the January 2013 issuance of MHBE's proposed performance metrics.

Ms. Lyles-Smith then laid out several facts about the strategy, including its proposed timing and interval, key indicators, federal and state reporting requirements, and overall structure. She noted that performance will be measured on five axes—access, affordability, consumer satisfaction, stability, and health equity—and listed the measures for each.

Finally, Ms. Lyles-Smith presented the next steps in the development of the strategy, including the hiring of a Performance Management Coordinator and coordination with Maryland StateStat.

- Professor Apfel commented that the overall strategy is excellent and asked when would be an appropriate time to set goals for MHBE-specific indicators. He noted that it was probably too soon but asked whether MHBE intends to move that way. Ms. Lyles-Smith replied that not only does MHBE plan to implement such goals, but has already done so for the CSC RFP and the Connector Entity grant solicitation. Ms. Pearce added that the new Performance Management Coordinator will lead that effort whenever he or she is hired.
- Ms. Goldberg noted that gender does not appear as a measure under health equity. Ms. Lyles-Smith apologized for the oversight.
- Ms. Goldberg asked whether the plan includes collecting measures from channel partners. Ms. Pearce disagreed with the characterization of such numbers as performance metrics, noting that such numbers are better described as statistics and will be captured and tracked.
- Mr. Martinez-Vidal stated his opinion that several different things are being conflated in the discussion; performance metrics that measure the overall impact on Maryland and metrics specific to Maryland Health Connection, within which are metrics that are of interest to the general public and those that are of interest to MHBE for its own internal operations.
- Ms. Pearce clarified that there are certain measures that are operational for MHBE, certain measures that will be published every month, and certain measures that are required by the federal authorities.
- Chairman Sharfstein noted that not every detail will be published on the website, but that the basic performance document will be public.
- Chairman Sharfstein asked that the measures required by the U.S. Department of Health and Human Services (HHS) be distributed to the Board members. Ms. Lyles-Smith replied that HHS has not yet published its measures.
- Mr. Steffen noted that there are lessons to be learned from the reporting of hospitals.
- Professor Apfel thanked MHBE for not waiting for HHS to release its requirements before developing the Performance Management Strategy, and noted that MHBE is now further along than CCIIO on these issues.
- Chairman Sharfstein asked Ms. Lyles-Smith to supply the Board with regular updates on these issues.

A motion to adopt the Performance Management Strategy was approved unanimously.

Pediatric Dental

Tequila Terry, Director of Plan and Partner Management at MHBE, presented some new policy and operational decisions the Board must make regarding pediatric dental coverage. She began by describing how the Final Rule on Essential Health Benefits released by HHS on February 20, 2013, has complicated matters for pediatric dental plans. She noted that, under the rule, metal levels do not apply, but that two tiers of coverage have been designated and associated with an actuarial value figure: the Low Tier has 70% actuarial value and the High Tier has 85% actuarial value. Also, an actuarial value calculator does not exist for standalone dental plans. Ms. Terry then listed purchase requirements that appear in the final rule: 1) medical plans offered on exchanges may exclude pediatric dental from their benefit design, and consumers who purchase such plans are not required to purchase pediatric dental on the exchange and 2) medical plan offered outside of exchanges may not exclude pediatric dental coverage from their benefit design except when the carrier is “reasonably assured” that the individual has pediatric dental coverage through an exchange-certified standalone plan.

Ms. Terry then presented the key decision the Board must make, namely to define "reasonable" out-of-pocket maximums for pediatric dental plans that will be offered on Maryland Health Connection. She noted several timing issues necessitating the hurried pace of this decision.

Next, Ms. Terry presented a hypothetical sample pediatric dental policy one might find in the market today, with terms for deductibles and coinsurance. She explained several areas of risk that such maximums create, noting that today's dental plans do not include an out-of-pocket maximum. She added that including such maximums in the plans introduces new and unaccustomed risk to carriers in setting their premium prices. She explained that the Board faces a conundrum in that the lower the out-of-pocket maximum is set, the higher the premium will be. She added that advance premium tax credit (APTC) may be applied to standalone dental plans only after QHPs are fully paid. She noted further that federal cost-sharing assistance is not available for standalone dental plans.

Ms. Terry then presented the Board with MHBE's staff recommendation on the pediatric standalone dental out-of-pocket maximum policy. MHBE recommends that the Board require standalone pediatric dental plans to use the same out-of-pocket maximums as those required on the Federally Facilitated Exchange (FFE), set at $1,000 for one child and $2,000 for two or more children. Further, MHBE recommends that the Board order a study to identify the key dental issues, including out-of-pocket maximums, on consumer affordability, consumer uptake, and opportunities for coordination across carriers.

- Chairman Sharfstein asked whether the out-of-pocket maximum considered in the proposed policy applies only to pediatric-only plans or also to the pediatric portion of family plans. Ms. Terry replied that it could be both.
- Ms. Goldberg asked whether the maximum would apply to embedded dental plans. Ms. Terry replied that it would not.
- Mr. Saquella asked whether subsidy funds that remain unspent on medical coverage could be applied to out-of-pocket expenses on a standalone pediatric dental plan. Ms. Terry replied that it could not, since such subsidy funds are only to be applied to premium.
- Commissioner Goldsmith asked whether the proposed out-of-pocket maximum would apply to the non-exchange market as well as within Maryland Health Connection. Ms. Terry responded that there are good reasons to think about extending the policy to the outside market, but that the recommended policy covers only the Maryland Health Connection plans. Commissioner Goldsmith asked whether the Final Rule on Essential Health Benefits requires the Board to establish an out-of-pocket maximum for the broader market. Ms. Terry clarified that the Final Rule applies to Maryland Health Connection only, not the outside market.
- Mr. Martinez-Vidal asked whether his summation is correct that there are three ways to purchase pediatric dental coverage on Maryland Health Connection: by purchasing a health plan with embedded pediatric dental benefits (in which case no separate out-of-pocket maximum would apply), by purchasing a standalone full-family dental plan (in which case the out-of-pocket maximum considered in the policy would apply only to the children of the family), or by purchasing a kids-only standalone plan (in which case the maximum would apply to the entire plan). Ms. Terry replied that he was correct.

A motion to adopt the proposed policy was approved unanimously. Commissioner Goldsmith abstained.

Ms. Terry then explained that MHBE wants to provide some feedback to CCIIO on the pediatric dental aspects of the Final Rule. Mr. Kolb read a letter addressed to Director Gary Cohen of CCIIO (http://marylandhbe.com/wp-content/uploads/2012/12/Letter_to_CCIIO_Cohen_3.2013.pdf).

- Professor Apfel asked about the rationale behind the Final Rule. Mr. Kolb replied that CCIIO has repeatedly stated that the rule is based on the statute as written.
- Chairman Sharfstein said that, if carriers offer plans with embedded pediatric dental coverage on Maryland Health Connection, then this may be a non-issue, but the separate cost sharing does create a challenge. Mr. Kolb responded that, at a recent meeting, CCIIO said it did not believe

that premiums for standalone dental coverage will be very high, which will make it less of an issue.
- Chairman Sharfstein asked whether it would be reasonable to ask for an actuarial value calculator for standalone dental plans. Ms. Terry replied that there is much less understanding of standalone dental actuarial value compared with medical actuarial value.

A motion to send the letter (with one minor amendment) to Director Cohen with the signatures of the Chair and Vice-Chair of the Board of Trustees and the signature of the Executive Director of MHBE passed unanimously.

Network Adequacy and Essential Community Provider Update

Ms. Terry, along with Mark Luckner of the Maryland Community Health Resources Commission (CHRC) and Raquel Samson of the Maryland Department of Health and Mental Hygiene (DHMH) Office of Primary Care Access, presented to the Board an update on the status of the network adequacy and essential community providers policy implementation.

Ms. Terry began by reiterating the statements of policy on these linked issues that the Board of Trustees previously released. She gave an overview of the planning and oversight activities already underway and those planned for the future, going into some detail on the network consultation sessions MHBE has undertaken, with the assistance of CHRC and DHMH, to assist carriers' compliance efforts.

Next, Ms. Samson described the Maryland Health Access Assessment Tool, a survey to collect information from Maryland safety net providers on where Maryland's uninsured currently receive care. She noted that the online survey was deployed in December of 2012 and received responses from 101 organizations at 215 facilities. She listed the respondents' facility and described the types of data included in the county-level summaries created out of the survey responses.

Ms. Terry then described the Access Plan Template, a form that carriers must provide to MHBE as a condition of certification that describes in detail their plan to ensure access to care by Marylanders. She explained that MHBE has made available to carriers a number of data sources to assist with planning for access needs and capacity of safety net providers, such as the Health Resources and Services Administration (HRSA) database of 340B providers, as well as other sources.

Next, Ms. Terry explained that MHBE, DHMH, and CHRC will host several regional "Meet & Greet Sessions" to allow carriers and safety net providers to begin discussions on contracting. She added that carriers will be encouraged to attend these sessions to identify community providers in their service areas with whom they might contract.

Mr. Luckner then described the Technical Assistance Program that arose out of the survey. He said that respondents to the survey listed areas wherein they require technical assistance, such as contracting, marketing, credentialing, billing, and strategic planning. He added that other requests came in from these providers for assistance with funding and implementation for electronic medical records, training, and support, as well as assistance with linkages with local health system partners. Mr. Luckner announced that CHRC, in consultation with MHBE and DHMH, will institute a Technical Assistance Program to build capacity and promote readiness of safety net providers. He noted that a major focus of the program will be to assist providers in transitioning from a grant-based revenue model to one that involves billing third-party payers. He added that CHRC may also provide opportunities for grant-funding to support infrastructure development.

Finally, Ms. Terry laid out the oversight and monitoring structure that will be established by MHBE in this area. She announced that MHBE will form advisory committees of consumers and providers and will begin reporting on access to care to the Board of Trustees on a quarterly and annual basis in 2014.

- Dr. Gaskin asked whether the contracting assistance portion of the Technical Assistance Program will include help with determining how to set appropriate prices. Mr. Luckner replied that that is the intent, but that much depends on the resources available.

- Ms. Terry stated that a clear take-away from the survey was that the focus of the assistance should be on moving from paper to electronic systems. Mr. Luckner added that the quality of the assistance will depend on resources, and that CHRC is trying to strike a balance between customizing assistance for each provider and being able to reach all the safety net providers. He noted that they may be able to contract with a group of providers who deliver similar services.
- Dr. Gaskin noted that this assistance will need to be provided to not only clinical services, but also wraparound services. He gave the example of a social worker traditionally paid through a grant. Ms. Terry replied that, to the extent that the services provided by the social worker would be covered under the plan, that would be a reimbursable service.
- Chairman Sharfstein noted that certain providers, such as federally qualified health centers (FQHCs), have protections under the law that secure higher rates for their services, allowing them to provide more of the wraparound services. He added that payment reform, rather than establishing a new range of fees for services, is the way to give providers the flexibility to do new things.
- Mr. Martinez-Vidal noted that he works with a lot of different states and that whenever those states hear about this project, they have expressed interest in making it work in their state. He said that Maryland is on the cutting edge.

Minutes

The minutes of the February 12, 2013 meeting were approved unanimously.

Closed Session[1]

The Board approved a motion to begin a closed session. The meeting was adjourned without returning to open session.

[1] The meeting was closed pursuant to (1) State Government Article §10-508(a)(1), which provides that a session may be closed to discuss the appointment, employment, assignment, promotion, discipline, demotion, compensation, removal, resignation, or performance evaluation of appointees, employees, or officials over whom it has jurisdiction, and (2) State Government Article §10-508(a)(14), which provides a session may be closed before a contract is awarded or bids are opened, discuss a matter directly related to a negotiating strategy or the contents of a bid or proposal, if public discussion or disclosure would adversely impact the ability of the public body to participate in the competitive bidding or proposal process.