Maryland Health Benefit Exchange Board Meeting Minutes

December 12, 2011
1:00 p.m. - 4:00 p.m.
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

The materials presented in the meeting are listed on the Maryland Health Benefit Exchange webpage: http://dhmh.maryland.gov/healthreform/exchange/materials/dec12materials.html

Members Present

Joshua M. Sharfstein, M.D.	Kenneth Apfel, M.P.A[1]
Georges Benjamin, M.D.[1]	Therese Goldsmith, J.D., M.S.
Jennifer Goldberg, J.D., LL.M.	Darrell Gaskin, Ph.D.
Enrique Martinez-Vidal, M.P.P.	Rebecca Pearce, M.B.A
Ben Steffen, M.A.	Thomas Saquella, M.A.

Members Absent
None

Opening and General Updates
Secretary Sharfstein welcomed the Board members and participants. Executive Director Rebecca Pearce provided a few staffing updates and noted that minutes from the November 19th and December 12th meetings will go to the Board for review prior to the December 20th meeting.

Policy Discussions
SHOP
The first discussion point was whether or not to merge the small group and individual markets in 2014. The key pieces of information to consider about the individual market are that it is an underwritten market, Maryland Health Insurance Plan (MHIP) covers about 200,000 high-risk individuals, and there is an over 300% loss ratio on MHIP members. A question was raised about how the Basic Health Plan (BHP) would impact the merger of the markets and the analysis. It was stated that the BHP has not yet been incorporated into this analysis but if it were to be seriously considered, another assessment of the issue would need to occur. One suggestion was to revisit consideration of this topic in 2016. The Board agreed that the two markets should not be merged in 2014.

Regarding the question of whether to expand the definition of the small group market from a cap of 50 to 100 employees in 2014 versus 2016 when it becomes mandated, the Board agreed with the recommendation to wait until 2016. It was noted that, currently, the 51 to 100 employee

[1] Participated in the meeting through teleconference.

group market is very different than the 2 to 50 employee group market. A board member pointed out that this topic gives the Exchange an opportunity to weigh in on federal stop loss guidelines. It was suggested that the Exchange take that opportunity if it becomes available.

The topic of what level of employee choice to offer in 2014 stimulated some clarification questions around what level of choice is currently available and what the ACA mandates. The recommendation that was made and agreed to by the Board was to allow employers to offer the ACA-required level of choice in 2014, which allows an employer to offer one metal level across all qualified health plans (QHP) regardless of carrier within the Exchange. However, the employer is not required to offer plans in that manner and could still offer as they do today with one carrier and a variety of plans from the carrier. It was also agreed that the topic should be clearly explained and described in the report because it can be confusing.

The final main area of discussion was reviewing the interest and capacity for developing the SHOP Exchange. An in-depth analysis is underway, internal to the Exchange, about the technical infrastructure and capacity to support the SHOP Exchange. It may include issuing a Request for Information, but significant input has already been sought and is currently under review. The newly hired IT Director will be focusing on this topic.

Dental
The Board agreed with the recommendation that there is value in offering dental plans in the Exchange beyond the ACA requirements and the option to offer both bundled and stand-alone plans. It was noted that this option adds a benefit for consumers to purchase in the Exchange as opposed to altering what would be included in the essential health benefits. A suggestion was made to coordinate oversight requirements for qualified dental pans with the Maryland Insurance Administration (MIA) similar to the coordination with QHPs.

Continuity
The Board agreed that continuity is an essential component for the success and sustainability of the Exchange; however, the Exchange has limited areas for impact. The main area of focus for the Exchange would be in the area of care continuity. There needs to be a focus on creating a smooth process for the variety of transitions that can occur. Further study needs to take place to better understand the current guidelines that exist in regards to care continuity for certain conditions and whether guidance is predominately provided through statute or regulation. Flexibility will be paramount as standards of care change, and a process will need to be developed to coordinate transitions with the input of Medicaid and MIA.

Financing
It was stated that all Marylanders benefit from the Exchange; however, the health industry (defined as insurers, providers, brokers, etc.) benefits the greatest. Therefore, the costs to finance the Exchange ought to be spread widely, and a combination approach of assessments is recommended. The Board agreed with this recommendation. Nevertheless, there was much debate over how the potential financing options ought to be considered and how the framework should apply to thinking about building a sustainable budget for the Exchange. One viewpoint is to consider a broad-based set of assessments to fund the Exchange infrastructure with transactional costs being applied to fund marginal costs, such as those necessary for navigators

who assist in enrollment. It was suggested that first foundational funding be determined and then service fees be applied to make up the costs of the Exchange. A board member expressed the concern that if the assessment is applied largely at the plan level, self-insured groups (about 50% of the Maryland market) would be able to avoid the assessment. The Board agreed in principle to a broad-based assessment but asked for a restructuring of the topic with additional options presented at the next meeting on December 20.

Next Steps

Logistics and the timeline for review of the draft report to the General Assembly were discussed. The Board will discuss the following at the December 20th meeting: Navigator licensure; financing options; the process for decision making on EHBs; carrier participation thresholds; multi-state/regional contracting; the plan for detecting waste, fraud, and abuse; and continuity of care. A teleconference was scheduled for December 22, 2011, at 10:00 a.m. to review any final comments on the report before its December 23 submission.