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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland Health Benefit Exchange Board of Trustees

September 15, 2015
1:00pm – 4:00pm
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Members Present

Van Mitchell
Tony McCann
Kenneth Apfel, MPA
Thomas Saquella
Ben Steffen, MA
Michelle Gourdine, MD (by phone)

Members Absent

Al Redmer
Sam Malhotra
Linda Sue Comer

Also in attendance: Carolyn Quattrocki, Executive Director at the Maryland Health Benefit Exchange (MHBE).

Opening

Chairman Mitchell welcomed everyone to the Board meeting.

Approval of Meeting Minutes

The Board reviewed the minutes for the August 18 and August 21, 2015 meetings; no amendments were made. Mr. Apfel motioned to approve the minutes; Mr. Steffen seconded the motion. The Board voted unanimously to approve the August 18 and August 21, 2015 minutes.

Broker Pilot Update

Michele Eberle, MHBE Chief Operating Officer, and Chris Yeiser, MHBE Manager of Producer Operations, provided an update on the Broker Assistance Transfer (BATPhone) pilot. Mr. Yeiser reported that the goals of the BATPhone program include gathering call metrics, broker feedback, and consumer feedback; refining the procedures for identifying qualifying producers; and establishing performance milestones to fine-tune the program for future expansion. In selecting the brokers to participate in the pilot program, the MHBE requires that the broker be located in Maryland, experienced with qualified health plan (QHP) enrollment, and supportive of the program's goals. The MHBE will also consider the broker's history of commitment to the MHBE and Affordable Care Act (ACA) and the amount of time the broker can commit to the program.

- Mr. McCann asked whether the MHBE expects to meet their goal of 25 participating brokers in the pilot program and whether they expect to have more. Mr. Yeiser responded that the MHBE expects to have 25 brokers and will expand the program in the future if it is effective. The MHBE will compare statistics for enrollments with and without brokers to assess the program's effectiveness.
- Mr. McCann asked whether the MHBE will pay the licensing fees for the participating brokers. Ms. Eberle responded that the MHBE will pay the licensing fees for the first three months of the program. Ms. Quattrocki added that the MHBE is working with Maximus and will pay the licensing

cost for the first three months to reduce Maximus's cost. The MHBE will consider how to handle costs in the future.

- Mr. Apfel asked about performance metrics. Mr. Yeiser responded that the performance metrics are divided into three categories: Call Center metrics, broker feedback through surveys and interviews, and consumer feedback.
    - Mr. Apfel noted that he hopes that metrics can be incorporated into the pilot program so the MHBE can assess its success.
- Chairman Mitchell asked if a brokers' office will be considered one applicant, or if the program will only include individual brokers. Mr. Yeiser responded that the software licensing must be done on the individual level, which prevented the involvement of brokers' offices. As a result, he noted that it is very important that brokers be able to provide a large time commitment to the pilot program.
    - Chairman Mitchell suggested that the MHBE use enterprise licensing so that a brokers' office could participate, which would result in more stable staffing. Mr. Yeiser agreed that this is a good idea. Ms. Quattrocki added that although the MHBE would prefer to use enterprise licenses, it may not be possible due to the Maximus contract. The MHBE will examine this option thoroughly.
- Mr. McCann commented that the MHBE needs to have options available if the Maximus system is not effective.
- Mr. Steffen commented that if the MHBE used enterprise licensing, then the evaluation metrics would need to be changed.

Mr. Saquella motioned to approve the BATPhone pilot program, which was seconded by Mr. Apfel. The Board voted unanimously to approve the pilot program.

Failure to Reconcile Update

Michelle Wojcicki, the MHBE Director of Policy, provided an update on how the MHBE is handling consumers' failure to file taxes or reconcile their advanced premium tax credits (APTCs). Under federal regulations, Ms. Wojcicki explained that in order for an individual to be eligible for APTCs, the individual must have filed taxes for the previous benefit year and reconciled any APTC received. This is the first year where the requirement to file and reconcile taxes for the previous benefit year is in effect. As part of the federal income check, the Internal Revenue Service (IRS) will identify tax filers who failed to file tax returns and/or reconcile any APTCs received.

Ms. Wojcicki reported that the MHBE will begin sending renewal notices in mid-October. The notices will include a message reminding consumers to file their taxes or reconcile their APTCs if they have not done so already. The 2016 renewal process will be performed without consideration of whether individuals reconciled their APTCs because the IRS information will not be available in time. In 2016, the MHBE will receive the most current tax information from the IRS and will run a reconciliation protocol to identify Maryland QHP enrollees who have been flagged for a failure to file taxes or reconcile APTCs. If an enrollee did not meet the filing or reconciliation requirements, then the enrollee will lose the APTC. The consumer will receive notice of the eligibility determination without APTC and the effective date; carriers will also be notified of the change. Ms. Wojcicki noted that many states, including California, are using a similar approach. New 2016 applicants will only be affected if they enrolled in a QHP sometime during 2014 and received APTC but were not enrolled in coverage at the end of 2015. The same notification and redetermination process will be used for this group.

- Mr. McCann asked about the ACA requirements regarding this process. Ms. Wojcicki responded that the ACA does not set out any parameters regarding the timing of the reconciliation process. There is only an eligibility requirement that consumers file taxes and reconcile APTCs. She noted that given the timing of the IRS information and a lack of early federal guidance, this process was developed to reduce multiple notices and consumer confusion.
- Mr. McCann expressed concern about the reconciliation process, and that the MHBE will be unable to check an enrollee's tax status until 2017. Ms. Wojcicki clarified that the MHBE will begin checking the tax status of enrollees who renew in 2016, and the MHBE's goal is to have a more timely and seamless process in place for the 2017 open enrollment.

- Mr. McCann expressed concern that Maryland could be accused of losing millions of dollars if the reconciliation process does not properly identify and recover money from enrollees who did not reconcile their APTCs. Mr. Kromm responded that Maryland would not lose money because in 2016 a consumer who does not reconcile their APTC will lose their APTC and will be required to pay back any APTC received when filing 2015 taxes. The federal government will be able to recover any improperly awarded APTCs. An important factor is that the timing of the IRS information could place carriers out of alignment with state law; the federal regulations are unclear regarding the timeframe while the state regulations are more specific. The MHBE will have to work closely with the Maryland Insurance Administration (MIA) and the Centers for Medicare & Medicaid Services (CMS) to determine the appropriate approach for 2017.
- Chairman Mitchell asked about the process other states are using, particularly California and New York. He asked if the federally-facilitated exchange will be able to address enrollees' failure to file taxes or reconcile APTCs in 2015, while states will not be able to do this until 2016. Ms. Wojcicki responded that states vary in their approaches. Some states are using a similar process as Maryland. Other states will allow consumers to attest that they are in compliance with the tax requirement to override the IRS flag, and then later in 2016 will confirm the enrollees' tax status. The federally-facilitated exchange will follow the attestation model and will send multiple notices as it receives the tax information from the IRS.
- Mr. Steffen asked what happens if the consumer files a corrective action after losing APTC, and if the consumer will be able to have APTC reinstated. Ms. Wojcicki responded that no federal guidance has been released regarding this issue; she will look into it.
- Mr. McCann expressed concern that many QHP enrollees who are receiving APTCs have low-income and would not be able to absorb the cost of a full premium if they lose their APTC. Further, the MHBE does not know how many QHP enrollees will be affected by this. He commented that he did not know a solution for this problem.
- Chairman Mitchell asked if there are any estimates regarding the number of consumers who will be affected. Mr. Kromm responded that the IRS does not typically provide state-specific data and will not send out the list of consumers who fail to file taxes or reconcile APTC until mid-October. He noted that theoretically Maryland should have fewer problems because it expanded Medicaid.
- Mr. Steffen commented that it would be helpful to inform consumers regarding the corrective action they can take to requalify for APTC and to identify the most vulnerable populations to target outreach. Ms. Wojcicki responded that this is a good suggestion and commented that the renewal notices and outreach will encourage enrollees to file their taxes if they have not done so already. Mr. Kromm added that the MHBE will perform targeted outreach after receiving the IRS information.
    - Ms. Quattrocki added that the MHBE staff can provide an update at the next Board meeting, when more information should be available.
- Chairman Mitchell commented that he assumes that other states are in a similar situation and asked if it would be possible for the states to band together to request more guidance from the IRS and CMS. Mr. Kromm responded that CMS is working with the IRS to develop more guidance. Ms. Quattrocki added that CMS recently met with the directors of state-based exchanges, and that most states are struggling with similar problems.
    - Chairman Mitchell commented that it would be helpful for the state-based exchanges to join together regionally to request guidance.

Network Adequacy Report

Mr. Apfel introduced Robbyn Elliott and Mark Haraway, the co-chairs of the Network Adequacy and Essential Community Providers Workgroup, who presented a summary of the report prepared by the Workgroup examining policy options to improve network adequacy. Mr. Apfel commented that it is important for the Board to receive stakeholder input on issues such as network adequacy. He explained that the Standing Advisory Committee (SAC) and the Workgroup were asked to identify areas of consensus, which can serves as a starting point for the Board to consider policy options. The report does not include a fiscal analysis; the MHBE will need to consider the fiscal impact of policy options and evaluate funding sources.

Ms. Elliott explained the Workgroup process. The Workgroup had a diverse and robust membership, which included stakeholders representing carriers, consumers, and providers. The Workgroup met seven times between May and August 2015. The Workgroup reviewed federal and state law related to network adequacy, as well as federal and state data sources, and standards being developed in other states. The Workgroup then used a consensus model to identify policy options for the MHBE's consideration, providing advantages, disadvantages, and other considerations for each. She thanked The Hilltop Institute, Medicaid staff, the Maryland Health Care Commission, and the MIA for their assistance with the report.

Mr. Haraway provided an overview of the policy options, which were divided into five categories: data collection and reporting, provider directories, essential community providers (ECPs), quantitative standards, and consumer information. In analyzing the policy options, the Workgroup considered the impact on the overall commercial health insurance market, the timing of the report with the revised National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act, and the feasibility for the MHBE. The Workgroup reached consensus on seven policy options, which were also endorsed by the SAC. The policy options were not prioritized. The Workgroup was unable to reach consensus on nine options.

Ms. Elliott provided an overview of the four policy options regarding data collection and reporting, three of which had consensus. The Workgroup agreed that the MHBE should work with MHCC to help analyze network adequacy using claims and encounter data, which could help identify patterns and systemic problems. The Workgroup agreed that the MHBE should work with the licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection to identify active providers and other data, such as provider specialty. The Workgroup also agreed that the MHBE should work with Medicaid and other divisions of DHMH to assess the number, capacity, and types of providers in the state in order to identify potential provider shortages and identify willing providers. Medicaid may have the most robust data, capturing information at both the program and provider level. Ms. Elliott noted that this information may be useful to carriers venturing into a new area by giving them a list of providers they can start contacting. The Workgroup did not reach consensus on a policy option that the MHBE should work with MHCC, providers, payers, carriers, and consumer groups to expand consumer satisfaction data collection and make it available in a more transparent format, such as a report card. Ms. Elliott noted that some Workgroup members were very interested in creating report cards for QHPs, but others were concerned that the data available do not fully capture network adequacy issues.

Mr. Haraway reported that two of the policy options regarding provider directories had consensus while two did not. The Workgroup agreed that the MHBE should work with the MIA, carriers, providers, and consumer groups to improve the accuracy of provider directories because more accurate and transparent information is critical to ensure that consumers have timely access to providers. The Workgroup did not reach consensus on a policy option that the MHBE should expand the types of providers that are included in provider directories because some members were concerned that it would require carriers and the Chesapeake Regional Information System for Our Patients (CRISP) to change their systems. Mr. Haraway noted that behavioral health programs were a consistent topic throughout discussion of the policy options.

- Chairman Mitchell asked whether behavioral health was a consistent topic of discussion in relation to just the provider directory policy options, or whether it was discussed in relation to the other policy options. Mr. Haraway responded that it was a consistent topic throughout all discussion. Ms. Elliott added that the lack of consensus regarding the expansion of provider types was due to concerns about implementation issues.

Mr. Haraway noted that the Workgroup agreed that the MHBE should consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories. Members commented that consumers may have the most up-to-date information, and it could reduce the burden on carriers to identify inaccurate information. There were concerns that this approach could cause inconsistencies with directories on the carriers' websites. The Workgroup did not agree that the MHBE should assess the feasibility of developing a standard taxonomy for provider types. This option would improve consistency across directories, but would be resource-intensive. Ms.

Elliott added that the concern was focused on the implementation of this option; there was no disagreement regarding the usefulness of a standard taxonomy.

Ms. Elliott reported that the Workgroup reached consensus on one of three ECP policy options. The Workgroup agreed that the MHBE should work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate because the current CMS list is inaccurate. The Workgroup did not reach consensus on a policy option that the MHBE should expand the ECP definition beyond the federal standard to include local health departments, mental health and substance use disorder programs, and school-based health centers because of concerns about these providers' ability to enter the commercial market. The Workgroup also did not reach consensus that the MHBE should use the federally-facilitated marketplace threshold for ECP participation because there were concerns about increasing contract pressure on carriers.

Mr. Haraway reported that the Workgroup had a lot of discussion regarding quantitative standards but was unable to reach consensus on any of the four policy options. The Workgroup did not reach consensus that the MHBE should collect data regarding network adequacy and consider developing quantitative standards in the future (either after the NAIC Model Act is published or the MHBE should set a specific deadline in the future). The Workgroup did not reach consensus that the MHBE should work with the MIA, consumer groups, and carriers to define the current unreasonable delay standards to give consumers better guidance on when they can seek care out of network. Ms. Elliott noted that the MIA has regulatory authority over the unreasonable delay definition. Mr. Haraway reported that the Workgroup also did not reach consensus that the MHBE should work with the MIA to make the quantitative standards used and reported by carriers in their availability and access plans public because of proprietary data in the plans. The Workgroup did not reach consensus that the MHBE should work with the MIA to standardize the format for reporting quantitative standards in availability plans. While a uniform format will make it to easier to assess the data, some members expressed concern that it would be an administrative burden for some carriers. Ms. Elliott added that availability plans differ in format, making it difficult to compare carriers.

Regarding the consumer information policy option, Ms. Elliott reported that with the Workgroup agreed that the MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the Health Education and Advocacy Unit to develop messaging and a reasonable process to inform consumers on how to obtain relief when they cannot find a provider. She noted that the Workgroup envisioned a step-by-step consumer-friendly manual, but did not have time to delve into the details of such a manual or how to integrate it. The Workgroup discussed one possible example, that a carrier directory or the CRISP provider directory could include a message with information about finding a provider.

Mr. Haraway reported that the Workgroup's report was posted on the MHBE website from August 27 through September 4 for public comment. Seventeen sets of public comments were submitted by a variety of stakeholders and are included in the report's appendix.

Ms. Elliott stated that the Workgroup built time into their work plan for the Board to consider the policy options before developing QHP certification standards. She noted that some of the policy options, such as providing consumers more information, do not have to be incorporated into certification standards. Some policy options may require further stakeholder input or additional workgroups to be fully developed.

- Ms. Quattrocki thanked the Co-Chairs, the Workgroup, and the SAC co-chairs for all of their hard work.
- Mr. Apfel commented that network adequacy is not just a buzz word and will require a lot of work by both Maryland and across the nation. The report serves as an outline of the policies and procedures that could be put in place. Other Board members agreed with this.
- Chairman Mitchell asked the Board to read the report and consider the options.

Open Enrollment 3 and HBX Enhancement Overview

Subramanian Muniasamy, the Chief Information Officer at the MHBE, noted that the readiness plan for the third open enrollment consists of four major areas, information technology (IT), consumer assistance,

carrier management, and marketing and communications. Mr. Muniasamy provided an update on the IT preparations for the next open enrollment. He noted that in October, the IT team will develop side-by-side comparisons of stand-alone dental plans for consumers during open enrollment, load the 2016 dental plans into the HBX (IT system), and send 834 transactions to dental carriers. As of September 8, 541,159 people enrolled in Medicaid, 84,603 enrolled in QHPs with APTC, and 36,663 enrolled in QHPs without APTC. Currently, an average of 3,000 people enroll in Medicaid or QHPs every day.

Starting on August 28, 2015, Mr. Muniasamy reported that a Medicaid applicant whose information is not verified will have pending Medicaid for 30 days instead of 90 days. In August, the IT team also made operational improvements to the HBX, such as adding filters to the plan shopping page. In October, the IT team will make further operational improvements, including adding brokers to the worker portal to reduce the number of calls from brokers to the Call Center and allowing consumers to reassess APTC during open enrollment or shop for plans that were applied during auto renewal. Applications will default to paperless so that notices will be sent to consumers electronically, unless the consumer opts out.

Mr. Muniasamy provided an overview of a timeline showing IT readiness for 2016 open enrollment. In September, the IT team ran the Medicaid renewals monthly process, and 2016 Medicaid plans were loaded into the HBX. The IT team started running QHP eligibility batches yesterday with 50 cases, which went well. The IT team will be running 15,000 to 20,000 members every day for initial QHP auto-renewals over the next week. The actual QHP auto-renewal process will be run in October. He also provided an overview of a chart illustrating the IT command center during open enrollment.

- Chairman Mitchell asked whether the MHBE will proactively send out information about the next open enrollment. Andrew Ratner, Director of Marketing and Strategic Initiatives at the MHBE, responded that the MHBE is informing consumers proactively.
- Chairman Mitchell asked if the command center is established and if it will run through January. Mr. Muniasamy confirmed that the command center has been established and will run from November 1 through January 31.
- Chairman Mitchell asked when HBX enhancements will end. Ms. Quattrocki responded that the HBX enhancements will stop from October 9 through January 31.

Mr. Muniasamy reported that 98 percent of QHP enrollment for 2016 is estimated to be through auto renewals. Fifty-five percent of Medicaid enrollments performed last week were auto renewals. A table illustrating weekly enrollment status by application for August 29 through September 4 shows that 80 percent of applicants during that week successfully enrolled in Medicaid. Twenty percent of applicants had to contact the Call Center or the local departments of social services to finish their applications because of failure to validate income or identity.

- Chairman Mitchell asked if these statistics are consistent with other weeks. Mr. Muniasamy confirmed that it is consistent; typically 75 to 80 percent of Medicaid applicants successfully enroll.

Mr. Muniasamy reported that the MHBE is considering modifying their contract with Xerox to increase the not-to-exceed amount by $150,000 to implement new software. The software will result in savings of $40,000 during the first year, and then savings of $160,000 for subsequent years.

- Chairman Mitchell asked whether the MHBE bid or renegotiated the contract with Xerox. Mr. Muniasamy responded that the MHBE renegotiated the contract with Xerox.
    - Chairman Mitchell asked if this was in compliance with the procurement policy. Sarah Rice, assistant attorney general with the MHBE, confirmed that this approach is appropriate because it is a contract modification.
- Mr. McCann asked if the budget increase and savings estimates are the final numbers. Mr. Muniasamy responded that the proposal numbers will be fine-tuned before the contract is put before the Board for a vote.
- Mr. Steffen asked if actual auto enrollment for QHPs will be less than 98 percent because consumers will be able to switch plans at a later date. Mr. Muniasamy confirmed this.

Ms. Eberle provided an overview of operations readiness for open enrollment. The MIA approved carriers' premium rates on August 30, and the MHBE completed reauthorization of carriers on September 4. The MHBE is on track to load carriers' plans and final premium rates into the HBX on September 18 and the plans will be tested and verified by the carriers. The plans are on track for final certification on September 25. Ms. Eberle provided an overview of a chart showing the breakdown of plans being offered through Maryland Health Connection (MHC) for 2016 by carrier.

- Mr. McCann asked about the percentage of the non-Medicaid population enrolled in a CareFirst plan. Ms. Quattrocki responded that roughly 78 percent of the QHP population is enrolled in a CareFirst plan.
- Mr. McCann asked whether there will be an increase in tax credits to offset the increase in premium rates. Ms. Eberle responded that she will address this issue later when discussing benchmark plans.

Ms. Eberle provided an overview of a table showing the percent change for each carrier's premium rates from 2015 to 2016. She noted that some plans increased their rates, while others decreased their rates.

- Mr. Saquella asked whether Evergreen's premiums increased or decreased. Ms. Quattrocki responded that Evergreen's premiums increased.

Ms. Eberle then provided an overview of three tables showing the premium rates of six silver level plans for 2014, 2015, and 2016 for a 30 year-old enrollee. She noted that the tables show that there has been movement in costs and across carriers over the years.

- Mr. Apfel asked about CareFirst's premiums for 2016. Ms. Eberle responded that the CareFirst plan is more than $229; she can get back to the Board with the specific rate.
- Mr. McCann asked for a ranking of the silver-level plans by population size rather than just premium rate. Ms. Eberle responded that she will get this information for the Board.

Ms. Eberle explained that a state's benchmark plan is defined as the second lowest cost silver plan within a given rating area. The benchmark plan's rates are used to determine the amount of a consumer's APTC. She provided an overview of a table showing the benchmark plans for the four rating areas. She noted that there is a greater variation of carriers with benchmark plans for 2016.

- Mr. McCann asked when the benchmark plan premiums will be available. Ms. Eberle responded that the rates are currently available.
- Mr. McCann asked about the increases in premiums and out-of-pocket expenditures for the plans with the largest enrollee population for region one. Ms. Eberle responded that she will get back to the Board with this information.
    - Mr. Apfel commented that it would be interesting to see the shifting of carriers' market share for 2016.
    - Chairman Mitchell asked for similar information for Small Business Health Options Program (SHOP) plans. Ms. Eberle responded that she will give the Board this information.

Ms. Eberle provided an overview of two charts showing the timeline for QHP renewals and renewal notices. She noted that the MHBE conducted regular renewal meetings over the summer to develop consistent messaging and uniformity in notices. The goal was to improve from last year, when consumers received multiple notices, which could be confusing. She also provided an overview of a timeline of the Medicaid renewal process. The timing and method of communications for Medicaid renewals has been designed to make notices as short as possible and encourage enrollees to switch to electronic notices to save money.

Ms. Eberle provided an overview of a chart showing the timeline for the Call Center's preparation for the next open enrollment. The Call Center is working to improve consumers' experience and expand Call Center representatives' access to the Medicaid system so they can check a caller's Medicaid status. The CISCO upgrade to a new integrated voiced response call distribution is on track. The MHBE continues to review the staffing and funding needed to meet desired services levels. Ms. Eberle then provided an overview of a chart showing the timeline for Connector Entities' preparation for the next open enrollment.

The MHBE conducted leadership training on September 1 and will be conducting additional trainings for Connector Entity staff and certifying new navigators in time for open enrollment. For 2016, Connector Entities are required to address health and insurance literacy in communities, employ quality assurance techniques, and appoint designated staff for handling escalated cases and appeals. Connector Entities will also be collaborating and sharing expertise with local insurance producers and application counselor sponsoring entities, addressing service needs in communities that cross over regional lines, and improving services and referrals for the senior population. Connector Entities have already scheduled enrollment fairs for the next open enrollment.

Ms. Eberle reported that the MHBE received 23 applications from new application counselor sponsoring entities, which will be reviewed and then approved on September 18. As of August 14, there were 35 active application counselor sponsoring entities with 200 certified application counselors across the state. Ms. Eberle noted that certified application counselors are paid by the sponsoring entity, not the MHBE. In August, the reauthorization of insurance producers was completed, and the policy training was loaded to the hub. As of August, there were 1,097 producers, and from January to July 2015, 26,174 consumers were enrolled into QHPs by producers, with half of all enrollments by the top 60 producers.

- Mr. McCann asked if the terms producer and broker are interchangeable. Ms. Eberle confirmed that these terms are interchangeable.
- Mr. Steffen asked how many 2016 QHPs have narrow networks. Ms. Eberle responded that she believes there are four QHPs with narrow networks but will double-check.
    - Mr. Steffen commented that the Board should monitor plans with narrow networks, which could conflict with the goal of improving network adequacy.
- Mr. Steffen asked for an update on SHOP. Ms. Eberle responded that the MHBE recently performed outreach at the Hispanic chamber of commerce. The MHBE is working on educating the producer community on the value of the SHOP to small employers. The MHBE is also examining the current contract with third-party administrators, which ends next June, to determine how to restructure the SHOP to encourage enrollment.
- Mr. McCann commented that national data regarding the disenrollment of QHP participants who did not pay their premiums has been in the media and asked about the disenrollment rate in Maryland. Ms. Eberle responded that the MHBE knows who has lost QHP coverage due to failure to pay and can look into it to better determine who is losing coverage due to non-payment.
    - Mr. McCann commented that he would like to know the categories of people who do not pay their premiums and how Maryland's data compares with national data. Ms. Quattrocki responded that the MHBE can get those statistics. She noted that last year. 70 to 75 percent of QHP enrollees nationally effectuated coverage by paying their premiums, and Maryland had a similar percentage.

Mr. Ratner provided an update on the marketing and outreach plan for 2016. The MHBE is focused on increasing outreach efforts to areas that have been identified as hard to reach, young adults, and minority populations. The MHBE is also focused on creating and continuing relationships with community and faith-based organizations and evaluating health insurance literacy materials to educate consumers and encourage utilization of coverage. The MHBE conducted a webinar for faith leaders to educate them about QHPs and performed other outreach events. The MHBE will promote the enrollment events scheduled for the next open enrollment, but will also direct people to Connector Entity satellite offices that are open throughout the week, as this information was not widely know during the second open enrollment. The MHBE will use cost-effective media, such as radio, cable TV, text messages, digital advertising, and social media to reach consumers. The MHBE is working to increase the visibility of the SHOP among eligible small business and make greater use of LinkedIn to promote the SHOP. The MHBE is also building partnerships with state agencies and local business groups. The MHBE is improving the consumer website to be more mobile friendly. Mr. Ratner noted that the website is an important tool; there have been 4.3 million visits to the website since November 2014.

Mr. Ratner then provided an overview of statistics regarding the remaining uninsured in Maryland, developed by State Health Access Data Assistance Center (SHADAC) at the University of Minnesota. SHADAC estimated that 308,000 non-elderly adults remained uninsured as of August 2015. This 308,000

estimate is 58 percent less than a 2011 estimate of 730,000 uninsured adults. Mr. Ratner provided an overview of maps showing enrollment and the remaining uninsured adults by region. A chart identified the areas with the most remaining uninsured who are QHP eligible. A side-by-side comparison of estimated uninsured by region in 2012 to 2015 enrollments shows that the estimates and actual enrollment are similar. SHADAC also created a map showing the number of people receiving APTC by zip code.

- Mr. Saquella asked if the MHBE has been able to encourage people to look at the premiums of all of the QHPs rather than just select CareFirst. Mr. Ratner responded that CareFirst's market share dropped from 90 percent to 80 percent. He noted that it can be difficult to strike the right balance between informing consumers that they can passively renew and encouraging them to actively select a plan to get the best price.

Closed Session

Chairman Mitchell announced that the Board would be moving into closed session. The purpose for moving into closed session was to consult with counsel regarding potential litigation and to discuss previously approved contracts and potential contracts.[1] Mr. Apfel motioned to move into closed session, which was seconded by Mr. McCann. The Board voted unanimously to move into closed session.

For topics discussed and actions taken, please see the Statement for Closing a Meeting dated September 15, 2015.[2]

Adjournment

Mr. Apfel motioned to adjourn the meeting, which was seconded by Dr. Gourdine. Chairman Mitchell adjourned the meeting.

[1] General Provisions Article § 3-305(b)(7) allows a closed session to consult with counsel to obtain legal advice. Article § 3-305(b)(14) allows a closed session to discuss, before a contract is awarded or bids are opened, 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.

[2] Statement for Closing a Meeting. Available at http://www.marylandhbe.com/wp-content/uploads/2015/10/ClosedSessionStatement.09152015.pdf