Maryland Health Benefit Exchange Board of Trustees

January 25, 2016
1:00pm – 3:00pm
MEETING HELD BY CONFERENCE CALL
(inclement weather)

Members Present

Van Mitchell
Kenneth Apfel, MPA
Michelle Gourdine, MD
Linda Sue Comer
Tony McCann
Al Redmer
Thomas Saquella
Benjamin Steffen, MA

Members Absent

Sam Malhotra

Also in Attendance

Carolyn Quattrocki, Executive Director of the Maryland Health Benefit Exchange (MHBE); Carolyn Ellison, Chief Financial Officer of MHBE; Michele Eberle, Chief Operating Officer of MHBE; Subramanian Muniasamy, Chief Information Officer of MHBE; Andrew Ratner, Director of Marketing & Strategic Initiatives of MHBE; Michelle Wojcicki, Director of Policy of MHBE; Trevor Coe, Assistant Attorney General.

Opening

Chairman Mitchell welcomed everyone to the MHBE Board of Trustees (Board) meeting.

Approval of Meeting Minutes

The Board reviewed the minutes of the November 23, 2015 MHBE Board meeting. No amendments to the minutes were made. Mr. Apfel motioned to approve the minutes and Dr. Gourdine seconded the motion. The Board voted unanimously to approve the minutes of the November 2015 meeting.

Voting Session

Budget Update

Carolyn Ellison, Chief Financial Officer of MHBE, advised the Board regarding the FY 2016 and FY 2017 budget as released in the Governor's Allowance.

FY16 - Three deficiencies in Operations Program:

1. $1.6 million in General funds to be used for FY 2015 expenses that MHBE could not pay for out of FY 2015 appropriations;
2. $12.1 million in a mix General and Federal funds – $5.7 million General, $6.4 million Federal, all for call center, small portion of general funds needed to bring to $24 million call center, the rest to expand services at call center for redeterminations; and
3. $868,436 in General funds to pay for legal services ongoing throughout the fiscal year

FY17 - Budget by Program:

1. Operations - $51 million;
2. IT - $32 million; and

3. Reinsurance payments (New program transferred from Maryland Health Insurance Program (MHIP)) - $40 million.

Mr. McCann noted that it seemed as if our budget was being reduced for FY17 and wants to ensure MHBE does not struggle with the budget in FY 2017. Ms. Ellison responded that the FY 2017 budget is as requested by MHBE. Mr. McCann expressed an interest in following up with Ms Quattrocki and discussing the budget further at the Board Meeting in February.

Update on RFP for Small Business Health Options (SHOP) Program

Michele Eberle, MHBE Chief Operating Officer

Ms. Michelle Eberle, Chief Operating Officer of MHBE, advised that the current contracts with Third Party Administrators (TPAs) will expire on June 30, 2016. A new Request For Proposals (RFP) is being prepared. The new RFP changes the payment structure with the SHOP administrators. Ms. Eberle and her staff would appreciate comments and recommendations as the RFP is prepared. In particular, Ms. Eberle seeks input on the optimal number of TPAs - currently there are three.

Commissioner Redmer asked when the RFP will be complete. Ms. Eberle advised that the goal is to have the RFP out in March 2016. Commissioner Redmer asked about what IT requirements are to be included in the RFP and if there would be enough time for the system to be built and effective before July 1, 2016. Ms. Eberle explained that the upcoming RFP requires a bidding organization to have the infrastructure and interface already in place to support SHOP functions, specifically the Employee Choice model. Ms. Eberle explained that the first RFP was meant to build the system, while the upcoming RFP will focus on the administration of the program, thus the expectation is that whichever organizations win bids already have systems in place to support SHOP functions. Commissioner Redmer asked if any organization would qualify beside the current TPA vendors. Ms. Eberle replied in the affirmative, stating that other organizations may qualify for the RFP if they have already prepared their system for Employee Choice.

Mr. Saquella inquired if the current TPAs were aware of the change in compensation structure that would be included in the upcoming RFP. Ms. Eberle replied yes, this change had been discussed openly for the past year. Mr. Saquella noted his concern that the current "per employee per month" payment structure encourages growth in enrollment, while the block payment system proposed in the RFP will not, and asked whether TPAs will still want to participate. Ms. Eberle responded yes, the expectation is that the current TPAs will still want to participate.

Mr. Steffen remarked that Ms. Eberle's report was very useful and asked if MHBE had collected any data on the performance of the TPAs. Ms. Eberle advised that of the three current TPAs, two have had significant enrollment, and one had fewer than hoped (but more enrollments are anticipated).

Maximus Call Center Contract Modification

Michele Eberle, MHBE Chief Operating Officer

Ms. Eberle requested the MHBE Board's approval of certain modifications to MHBE's contract with Maximus for operation of MHBE's call center. A brief PowerPoint presentation was shown.

The first slide contained data regarding the efficiency of the call center in relation to the number of employees staffed there at various times. Among the data noted were the increase in staffing, average speed and handle time of Customer Service Representatives (CSRs), the inception of the first Medicaid redetermination notices, and the corresponding spike in call volume. Ms. Eberle noted that her team has been working closely with the call center to decrease call handle time through training, the use of subject matter experts to resolve certain types of cases, and the use of dedicated CSRs for QHP and Medicaid calls. These efforts have led to an overall increase in number of calls answered and resolved.

The second slide showed a proposed modification from the current "Not to Exceed" (NTE) amount. The call center is requesting the Board to approve an NTE of approximately $15.2 million. If approved, the increase would consist of two components:

(A) $4 million already budgeted for fulfillment services through end of June 2016 not included in the prior NTE; and

(B) $11.2 million (approximately $9 million increase from prior year) for expansion of Medicaid enrollment. The funds would come from a combination of Federal Funds and state General Funds, and would allow the call center to add 10-120 customer service representatives based on projected call volume; 5 special project staff (at least some dedicated to resolving outstanding verification issues); 2 social media rapid response members; and a supervisor and team lead to support customer service representatives.

The third slide showed projected staffing levels with additional proposed funding. Ms. Eberle summarized that, up for the Board's vote, is an increase in the NTE for approximately $15 million for the time period of 1/1/16 through 6/30/16. Finally, Ms. Eberle asked if the Board members had any questions.

Mr. McCann noted that a previous dashboard sent to the Board on 1/6/16 states that the average wait time was 0 minutes and asked for clarification about how average answer speed and wait time were calculated. Ms. Eberle responded that she would look into the dashboard issue and explained that the answer speed was the average of all calls received, while wait time reflected the maximum on any given day.

Mr. McCann then inquired whether it is normal practice for a state agency to approve funds prior to approval from legislature. Secretary Mitchell responded that the NTE was already reflected in the budget and that it is the legislature's project, thus he saw no reason why the legislature would not approve it. Secretary Mitchell also responded that this is not normal practice, but that this is an abnormal situation.

Secretary Mitchell asked Ms. Eberle to elaborate upon the continued improvement in average handle time in January and February. Ms. Eberle replied that the improvements were due to small steps taken, such as speeding up password reset functions, the implementation of better staff training, the hiring of new staff, and enhanced access given to for CSRs to resolve issues firsthand rather than by supervisors.

Dr. Gourdine then asked if the funding geared toward expanding personnel specifically to support Medicaid enrollment would be maximally helpful in light of the top issues creating problems for individuals trying to navigate the redetermination process. Ms. Eberle responded that the top issue (an inability to get through to a CSR) would be mitigated by providing more representatives to answer calls. The second biggest issue is calls about the status of application, and the third biggest issue is processing of verifications. The additional funding will support special project team members and additional representatives to assist with these issues. MHBE is also working closely with DHR and DHMH to improve processes for verifications and terminations. MHBE is also focusing on issues with enrollees switching between QHPs and Medicaid as part of a larger effort. Finally, special project staff may be used to contact consumers who have not come back through the system (such as verifications, information updates, etc.) and need to be contacted.
MHBE is looking into whether the new staff could possibly make outbound calls to these individuals.

Lastly, Mr. Steffen inquired about call center call abandonment rate – the difference between calls handled to calls offered. Ms. Eberle advised that we do not post that information publicly anymore because it is not an accurate reflection of the call center's success. Many callers abandon calls then call back - there is no way to differentiate those calls. Thus, MHBE looks at handle time and maximum wait time instead. Mr. Steffen asked

for clarification whether the maximum capacity of the call center is 80,000 calls. Ms. Eberle responded that MHBE estimates one CSR could handle 24 calls per day.

Mr. Apfel motioned to approve the increase of the Maximus contract's NTE amount. Mr. Saquella seconded the motion. The Board voted unanimously to approve the motion.

Appointment of New Standing Advisory Committee (SAC) Members
*Mr. Kenneth Apfel and Dr. Michelle Gourdine, MHBE Board's Advisory Process Committe*e

Mr. Apfel advised that, in searching for new committee members, he and Dr. Gourdine focused on a broad range of stakeholders and had a broad range of interest in the positions. He and Dr. Gourdine presented 12 names for recommendations, with 11 going forward out of 12 because the 12th person did not respond. Mr. Apfel noted that they may come back and search for another person, but believe between the remaining 11 they have enough qualified candidates for the openings.

Commissioner Redmer asked who vetted the candidates and how thoroughly have they were vetted. Mr. Apfel responded that MHBE staff vetted the candidates, that they considered feedback from Board members and other individuals through various discussions.

Commissioner Redmer asked if MHBE determined whether clinicians and producers on the candidate list have had any adverse actions taken against them, such as suspension or repeal of their state license. Ms. Quattrocki responded that MHBE did consult with the Producer Team about candidates who are producers, specifically regarding the candidates' experience with the Exchange and Exchange consumers, but did not specifically check other candidates for license violations. Commissioner Redmer suggested that the Board hold off on voting and wait until the candidates were vetted for professional infractions. Ms. Quattrocki advised that MHBE employed a public application process, including a form and narrative. Ms. Eberle added that, in order for producers to work with MHBE, they must be actively licensed.

Ms. Quattrocki suggested that the Board approve candidates subject to additional vetting in the interest of time. Secretary Mitchell then asked for clarification regarding what additional vetting Commissioner Redmer would suggest. Commissioner Redmer suggested that, in addition to the applications received, at least a cursory look at licensure infractions and professional conduct is warranted for the purpose of ensuring candidates are qualified for appointment to the SAC. He recommended that Kim Bernardy get in touch with Ms. Quattrocki to move forward on additional vetting.

Secretary Mitchell then suggested a motion to appoint the selected candidates to the SAC (excluding candidate #5, who did not respond to the application) subject to further vetting as Commissioner Redmer proposed. Dr. Gourdine moved to appoint the selected candidates to the SAC subject to Ms. Quattrocki vetting each candidate and removing them from the SAC if any were found to found to have been subject to sanctions related to professional conduct. Mr. Apfel seconded the motion. Commissioner Redmer then noted that historically Board members serve in a rotating capacity, and clarified that candidate Kim Connolly would fall into the producer position for the SAC, although she could qualify for other positions given her experience. The Board unanimously voted to approve the motion. Secretary Mitchell brought to the Board's attention that candidate #8 provided no details of their professional experience or credentials, and thus should be vetted with additional scrutiny. Ms. Quattrocki stated that she would diligently undertake the additional vetting and report back to the Board.

2017 Draft Plan Certification Standards
Michelle Wojcicki, MHBE Policy Director

Michelle Wojcicki, MHBE Policy Director, reminded the Board that they had been presented with the Draft 2017 Letter to Issuers at the last Board meeting and advised that MHBE staff had reviewed all of the public comments on the proposed Plan Certification Standards and stakeholder responses. Ms. Wojcicki referred the Board to the document created by MHBE staff aggregating public comments and providing MHBE's responses. Ms. Wojcicki noted that, at the end of her presentation, she would ask the Board to approve the changes to the Final Proposed 2017 Letter to Issuers presented to the Board.

Ms. Wojcicki noted that, later in the spring of 2016, MHBE staff plans to propose regulations regarding plan certification standards. MHBE will allow an additional opportunity for public comment on the proposed regulations and will update the Carrier Reference Manual, which contains standards and operational guidance, accordingly.

MHBE received a number of requests for clarification on certain standards and did not receive comment on others. Staff reviewed and attempted to respond to each request for new or expanded standards and each request for clarification. Ms. Wojcicki noted that she would be presenting to the Board the major substantive issues raised in comments. Any requests for new or expanded standards that stakeholders had not previously been able to review were not incorporated in the final letter to allow further opportunity for public comment.

The first topic covered during the presentation was the addition of mental health/substance use disorder treatment cost examples and quantitative network adequacy metrics to SBC forms addition to SBC forms. Staff concluded that the information is important to collect, but the requirement to include the information in the SBC form must be removed from the final letter to issuers due to contradicting federal requirements. MHBE will work further with stakeholders to find a location and format to collect the cost example information. MHBE will also provide a network adequacy template to carriers at the end of January for the reporting of primary care/mental health provider information and standards to determine driving time and distance to providers to add to the front-facing area of the website.

The second topic dealt with the areas of network adequacy data collection. Ms. Wojcicki clarified that carriers' standards of network management - information on accreditation, including complaints received and resolved - will be collected and displayed on the front-facing part of website. Additionally, network access plans – information on carriers' self-imposed quantitative network standards - will be collected to give MHBE a full picture of carriers' approaches to network adequacy calculation, but will not be shared publicly. Network access plan information will also be submitted to MHBE through three new templates described in the letter to issuers.

On the third topic of provider directories, Ms. Wojcicki emphasized MHBE's goal of, and proposed methods for, keeping directories current, accurate and complete. Carriers will be required to submit their directories to CRISP once every 15 days, and will be required to reconcile their own directories to match the CRISP data within 15 days thereafter. In the letter to issuers, MHBE clarified that "reasonable degree of variance" means that carriers must keep their own directories updated within 15 days of the updated information provided to CRISP. Ideally information would be pushed to both CRISP and the carrier directory at the same time.

Secretary Mitchell asked Commissioner Redmer asked what the Maryland Insurance Administration (MIA) is doing on the issue as well as what is being done nationally. Commissioner Redmer advised that a bill is before the legislature this year to try and improve provider directories, but that the bill is not as robust as what's happening on the national level. Secretary Mitchell then asked if the MHBE proposed standards create a different playing field for on- and off-Exchange plans. Commissioner Redmer said no, MHBE's standards were in line with MIA's proposed standards. Ms. Wojcicki explained that she will continue to track MIA legislation and revisit the standards if legislation is enacted and creates a conflict.

Ms. Wojcicki noted that consumer advocates asked carriers to include additional information in their provider directories, such as program and community health center names. MHBE will encourage carriers to share this information and will further review it as requirement for 2018. Ms. Quattrocki asked Ms. Wojcicki to discuss the baseline accuracy standards. Ms. Wojcicki responded that, as proposed in the draft letter, MHBE will require carriers to conduct a self-assessment of directories and share this information and methodology with MHBE in order to establish a standard assessment method and baseline targets with the Board's approval for future certification years.

The fourth topic of the presentation related to an expanded essential community provider (ECP) definition. MHBE will work with the Department of Health and Mental Hygiene (DHMH) to provide a specific list of ECPs to carriers for the purpose of calculating their compliance with the proposed 30% contract standard by the end of January. Ms. Wojcicki noted that providers must be able to meet carrier credentialing standard to be considered an ECP for each carrier's calculation, and that dental carriers do not have to meet all ECP requirements but must offer a contract in good faith to at least 30% of ECPs per service area and all available Indian Health Care Providers; MHBE also encourages SADPs to contract with at least 1 Federally Qualified Health Center (FQHC) per service area and any willing local health department (LHD). Additionally, Ms. Wojcicki pointed out that MHBE will continue to allow an alternate ECP standard and write-in option, as offered at the federal level. Secretary Mitchell commented that the agency had received many positive comments about expanding the ECP definition.

Ms. Wojcicki explained that like previous years standard MHBE is exercising its authority under the Affordable Care Act (ACA) to review benefit plans for discriminatory effect. Under state law, fair marketing standards are addressed jointly by MHBE and MIA.

The fifth topic discussed was prescription drugs, a topic on which MHBE received a number of proposals and requests for clarification. MHBE will develop a timeline to evaluate the Maryland Health Progress Act's (MHPA) continuity of care policies in general, and specifically regarding prescription drugs. Under the proposed final certification standards, carriers must provide a link with drug tiering, which may include a legend to allow consumers to match tiers. For example, multiple plans may use the same formulary but cost sharing for a tier is different across plans. Regarding the drug exception process, the final standards would impose no additional requirements on top of the existing MIA/internal IRO process. Carriers already track drug exceptions. MHBE will work with carriers to discuss the usefulness of this information.

Sixth, Ms. Wojcicki covered two topics regarding dental plans: Stand Alone Dental Plan (SADP) rating caps and optional embedded pediatric dental benefits. The final plan certification standards would require SADPs to cap rating at 3 minor dependents due to MHBE operational process and IT system capabilities. Additional, the standards would make optional the embedding of pediatric dental benefits into Qualified Health Plans (QHPs). The system constraints that required all plans to offer embedded pediatric dental benefits in 2015 are no longer an impediment; however, the Board previously approved this option before system constraints led to the 2015 approach.

The seventh topic discussed was primary care above-essential health benefits (EHB). Ms. Wojcicki clarified that MHBE does not intend to supersede federal requirements, but instead is reviewing expansion of the number of primary care visits without cost per year from 2 to 3, and will work with MIA regarding any EHB related issues.

On the last topic of the presentation - the proposed prohibition on ending a plan contract when the primary insured terminates coverage - Ms. Wojcicki explained that the final standards narrowed the application of the prohibition and clarified how it would operate. Under the final standards, the prohibition would only apply when the primary is terminated for outstanding citizenship and immigration status verifications. Carriers will

be required to apply all household accumulators (deductibles, out-of-pocket maximums, etc.) for the terminated group plan to the remaining members' plan(s). MHBE will visit in the future whether this prohibition should be expanded to voluntary terminations (i.e. new Medicare eligibility).

Following the presentation, Secretary Mitchell commented that UnitedHealthcare, the League of Life Insurers of Maryland, and CareFirst sent letters directly to Board, and that the carriers were concerned about duplication of efforts under the proposed requirements. Ms. Wojcicki responded that the final standards ensure MHBE is not contradicting any other established law and standards and is trying not to alter any current processes or create duplications. If MHBE is requesting information from carriers, it is because MHBE is required to do so and/or because the agency currently does not have access to the information (i.e. network management complaints).

Mr. Apfel commented that it appeared MHBE staff put a significant amount of work into the comment responses and issuer letter, that the responses ran the gamut of stakeholders, and that the letter incorporated a number of common sense compromises. Mr. Apfel believes the letter is solid - not perfect to anyone, but strikes a good balance between positions and reflects a very good approach.

Mr. Saquella commented that it seems the process this year was much more contentious than last year, and that moving forward the Board may need to get involved at earlier stage to broker compromises between stakeholders. Mr. Saquella opined that he believed staff did a great job to try to resolve as many issues as possible, despite the fact that these issues were tough to put one's metaphorical arms around. The Board had prior briefings about these issues, but the Board should be more proactive, and thus the process may have to change. Mr. Saquella also expressed that he was very concerned about provider directory accuracy, and that he will propose in February that the State be more proactive in working with all stakeholders to improve accuracy - we owe it to consumers to do so.

Commissioner Redmer asked a question on the second presentation slide regarding regulations to be proposed in the spring whether this needs to be adopted today. In response, Ms. Quattrocki explained that due to the timing jam and the federal draft letter to issuers having come out in November, MHBE must make sure carriers meet MIA deadlines and conform to federal standards. MHBE staff must have the Board adopt the standards to meet a March 1 filing deadline, and will follow up with more formal regulations to play catch up - there is no avoiding the time lag. In prior years, there was much less to follow up with substantively, but this year there are significant substantive regulations being adopted that will be a base for progress in the future. Ms. Quattrocki concluded that MHBE and stakeholders spend the next 6 months going through the regulatory process, and can tweak more details and do more thinking during that time.

Secretary Mitchell stated that his only final concerns were making sure that MHBE is working with MIA and the federal government and making sure the agency has the leanest possible procedures in place from an operating standpoint, with no duplication or unnecessary steps. Ms. Quattrocki acknowledged that staff at MIA have been very helpful in creating the proposed certification standards.

Mr. Apfel moved to approve the revised proposed certification standards. Dr. Gourdine seconded the motion. The Board voted unanimously approved the Motion.

Open Enrollment Update: IT, Communications, and Operations
Subramanian Muniasamy, MHBE Chief Information Officer; Andrew Ratner, MHBE Director of Marketing & Strategic Initiatives; and Michele Eberle, MHBE Chief Operating Officer

IT Update

Subramanian Muniasamy, MHBE Chief Information Officer, presented an IT update containing highlights of Open Enrollment (OE) 2016, a round-up of IT activities, and a preview of upcoming releases.

Mr. Muniasamy first presented a slide showing an OE-3 enrollment breakdown, QHP breakdown, QHP with APTC breakdown, Medicaid breakdown, an OE-3 to OE-2 comparison, and call volume and website visitors graph. Of note, the majority of enrollments were Medicaid (about 65%), followed by QHP + APTC (about 25%). Approximately 28,000 enrollments into QHPs were passive renewals, while just over 11,000 were changes, 8043 were initial enrollments, and 73 actively renewed online. Of those enrolled in QHP + APTC, about 46,000 passively renewed, 45,000 changed plans, just over 11,000 were initial enrollments, and 1662 actively renewed online. Of Medicaid enrollments, just over 75,000 were initial enrollments, about 64,000 were passive renewals, and just over 128,000 were changes. OE-3 showed a significant increase in QHP, Medicaid, and Dental Plan enrollments over OE-2. About 120,000 more calls were offered through the call center to consumers, while over 60,000 more consumers visited the MHC website in OE-3 as compared to OE-2.

As his second part of the presentation, Mr. Muniasamy spoke about IT production, infrastructure and security, and project management operations (PMO) activities. The production team continues to reconcile and validate 1095-A and 1095-B tax form data, coordinate with CMS on year-end annual IRS file testing, process 8001 and 834 transaction files, support escalated cases, and handle Medicaid termination and CMS bulk services on schedule. IT is currently printing 1095's, approximately 900,000 of which are 1095-Bs, and is on target to send them out to consumers by the February 1, 2016 deadline.

The Infrastructure and Security team plans to upgrade Guardium encryption and is in the process of testing a new virtual desktop environment Desktop As A Service (Daas) at MHBE with DoIT support. During OE, Consumer Portal CPU utilization ranged from 30-40%, Worker Portal CPU utilization ranged from 50-60%, and DB2 CPU utilization ranged from from 40-50%, while the maximum volume of concurrent peak users reached approximately 1900, and the system was available between 6:00am to 12:00pm.

The PMO team is currently handling an RFP for timekeeping and one for Systems Operations. The Timekeeping RFP was issued, proposals for a timekeeping system were evaluated, and an award was made on January 14. The cost to MHBE will be approximately $300 per month. There will be a regular tracking meeting to achieve operational and cost efficiencies for the system. The Systems Operations RFP was issued on January 5, the pre-bid conference was January 15, proposals are due February 5, and an award is expected to be made by end of March. Mr. Muniasamy and Ms. Quattrocki both requested that Board members convene for a March Board meeting even though one is not scheduled, in order to provide recommendations for the System Operations RFP.

Lastly, Mr. Muniasamy presented on a number of upcoming releases during 2016. Highlighted in the 8.1 and 8.2 releases for January were uploading 1095-A forms to FileNet to make accessible via consumer and worker portals, adding MAGI/non-Magi indicator to 1095-B files, and 834 fixes. For release 9.0 in February, IT plans to implement the regulatory requirement to disenroll consumers with past due verifications, perform additional 834 and 8001 fixes, and fix the SEP retro rule. Expected for release 9.1 in April are technology upgrades, integration of ABD-LTC check, and self-password reset functions. That plan for the May 10.0 release is to provide 2 months postpartum coverage, allow children born under MA to get 1 year of MA regardless of household income changes, to continue with 834 and 8001 fixes, and to implement consumer-initiated terminations. The content of the July 11.0 release and October 12.0 release is to be determined.

Marketing Update:
Andrew Ratner, MHBE Director of Marketing & Strategic Initiatives, presented to the Board a Marketing Update highlighting plan enrollment growth, the impact of tax credits, MHBE's impact on the uninsured and

underserved, enrollments and market shifts between plans, an overview of SHOP enrollments, MHBE marketing activities and corporate partnerships, MHBE's focus on improving health literacy, and media responses.

Mr. Ratner shared that MHBE was receiving a lot of good press lately, especially regarding the Broker Assisted Transfer (BAT) phone. As of the date of the presentation, over 155,000 consumers were enrolled in QHPs, 60% more than same point a year ago. The agency is pleased with the growth, which matches growth between OE-1 and OE-2. So far 290,000 consumers are enrolled in Medicaid through MHC, up from 90,000 a year ago. 24,000 consumers are also enrolled in Stand Alone Dental Plans (SADPs). The system can now handle much more volume.

Mr. Ratner noted that more than 60,000 Maryland households received $208,000,000 in tax credits during 2015, demonstrating the impact of the credits on Maryland health care consumers. The Board-approved marketing program targeting the uninsured also showed an impact, with increases up to 175% in the top targeted ZIP codes so far in OE.

Next, the presentation showed a market shift in plan selection (CareFirst - 56%; Kaiser - 24%; Evergreen - 6%; United - 12%, Cigna - 2%, All Savers - N/A). The Top 5 OE-3 plans by enrollment so far were (1) BlueChoice HMO HSA Silver $1,350 - 14,930 enrollees; (2) KP MD Silver 2500/30/Dental/Ped Dental - 7,570; (3) BlueChoice HMO HSA Bronze $6,550 - 5,933; (4) KP MD Silver 2750/20%/HSA/Dental/Ped Dental - 5,348; and (5) United Silver Compass 4500 - 5,070.

Regarding the SHOP, Mr. Ratner shared that 114 employers are participating, with 668 employees enrolled, and a total of 981 employees and dependents enrolled. Mr. Ratner then highlighted some of the media attention garnered by the SHOP, and explained that some marketing funds had been earmarked for the SHOP program for use following the individual market OE.

MHBE engaged in a significant number of marketing activities targeting underserved consumers, including: "Super Health Sunday" in partnership with the NAACP and faith organizations; a Periscope broadcast on Twitter with Meredith Hurson entitled "The Empowered Mocha Patient"; "Meet Me Monday" networking event with small businesses and entrepreneurs; Alpha Kappa Alpha African American Community Roundtable; brochure distributions at the Sportsplex of Rockville, the Education Based Latino Outreach and the Center of Help/Centro de Ayuda, and the Sagrado Corazon de Jesus parish; a Latino Health Insurance Resource Zone Event through HCAM; "Library Enrollment Day" in partnership with the Maryland Association of Public Library Administrators and connector entities; and National Youth Enrollment Day Trivia Night. MHBE also engaged a number of corporate partners, including Arundel Mills and Queenstown Premium Outlets through Simon Property Group, CVS, and the Maryland Retailers Association, to distribute MHC marketing materials.

Mr. Ratner then noted that MHBE's social media platforms via Twitter and Facebook had doubled through free initiatives such as "Twitterstorm" (which produced over 10,000 impressions) and @MarylandConnect tags, as well as the tireless work of Alison Walker, MHBE Digital Communication Manager. Additionally, MHBE hosted a co-branded animation with Kaiser Family Foundation called "Health Insurance Explained" on the Maryland stakeholder website and YouTube, plus two additional health literacy videos produced by GMMB.

Data shows that 29% of enrollees in Maryland during the first two months of open enrollment were between 18 and 34 years old, the so called "Young Invincibles", which is up from 27% last year and is tied for the 5th highest among states. Self-reported African American enrollments through week 10 of OE-3 were up to 30,000, compared to 23,000 total for all of last year. Mr. Ratner advised that he would have final numbers,

including the number of Hispanic enrollees (which at first blush appeared to be improved), during his next presentation.

Lastly, Mr. Ratner presented some sound bites from local news outlets and websites stating in summary that the state has made great strides, the strategy seems to be working, the MHC and navigators are catching the attention of young adults and increasing in-person assistance, and that QHP selections were surpassing expectations. It is always an effort to keep up with social media, but MHBE has been diligent in responding, and people are getting back to us saying "we need this, thank you for the effort."

Pursuant to questions from Secretary Mitchell and Commissioner Redmer, Mr. Ratner offered for the next meeting to look into how MHBE's dental enrollments compare to other states, how MHBE's tax credit per household compares to other states, how many individuals are covered under the plans selected during OE, and why the market shift between carriers occurred.

Operations Update: Plan Management and Consumer Assistance Workers
Ms. Eberle offered the final presentation of the Board meeting, updating Board members on Carrier and Plan Management, Consolidated Service Center (CSC) operations, Connector Entity (CE) operations, and Producer operations.

Early analysis of OE-3 enrollment shows a shift in carrier market share, as indicated above. Ms. Eberle indicated that the call center had received many calls saying rates were too high, and that enrollees wanted to switch carriers. Analysis is still needed regarding a breakdown of first-time enrollees, and a final accounting of enrollments is expected 30 or so days following the close of OE-3. Regarding metal levels, 74% of consumers enrolled in a Silver plan, 19% in Bronze, 5% in Gold, 1% in Platinum, and 1% in Catastrophic. Regarding plan type, 79% of enrollees chose an HMO, 12% chose POS, 8% chose PPO, and 1% chose EPO. 66% of enrollees were 35 years of age or older, while 34% were under 35. Total dental enrollments so far equalled 24,797 - 12,401 with QHP, 8,045 with Medicaid, and 4,351 in SADPs.

Ms. Eberle exclaimed that the CSC is geared up and ready for the final weekend of OE! The CSC will be open additional 2 hours from 8am to 6pm on Saturday 1/30 and will be open Sunday 1/31 from 10am to 10pm, with staff available to resolve anyone in queue through 11:30pm. The Colorado call center expanded its capacity while Baltimore closed over the weekend due to snow, and received approximately 55 calls an hour this past Saturday. As mentioned above, calls offered, calls handled, QHP enrollments, and Medicaid enrollments all increased significantly between OE-2 and OE-3.

Next, Ms. Eberle highlighted CE activity through the first eight weeks of OE. With an average of 104 navigators per month assisting, 48,200 contacts were made with potential enrollees, 14,495 in-person appointments were completed, 14,360 QHP enrollments were completed, and 15,980 Medicaid enrollments were completed, meaning 30,340 were assisted in enrolling through CEs. Since the beginning of OE-3, the BAT phone pilot program is working better than we could have imagined, resulting in 2348 answered calls, 1386 enrollments, a 59% conversion rate, 5344 hours in the queue, and 739 hours talking to customers, some on the weekends.

Adjournment
Chairman Mitchell adjourned the meeting.