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MARYLAND HEALTH BENEFIT EXCHANGE

Maryland Health Benefit Exchange Board of Trustees

April 16, 2018
2:00 p.m. – 4:00 p.m.
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Members Present

Robert R. Neall, Chair	K. Singh Taneja
S. Anthony (Tony) McCann, Vice Chair	Ben Steffen, MA
Linda S. (Susie) Comer (by phone)	Dana Weckesser
Alfred W. Redmer, Jr.	Sastry Dhara (by phone)

Also in Attendance
Lourdes Padilla, Secretary, Maryland Department of Human Services
Michele Eberle, Executive Director, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
John-Pierre Cardenas, Director, Policy & Plan Management, MHBE
Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration, MHBE
Michelle Compton, Manager, Procurement, MHBE
Sharon Stanley Street, Assistant Attorney General, OAG

Welcome & Introductions
Secretary Neall welcomed everyone to the Board meeting.

Approval of Meeting Minutes
The Board reviewed the minutes for the February 20, 2018 open meeting. Mr. McCann moved to approve the minutes; Commissioner Redmer seconded the motion. The Board voted unanimously to approve the February 20, 2018.

Executive Update
Michele Eberle, Executive Director, MHBE

Ms. Eberle welcomed Secretary Neall to the meeting. She then thanked Secretary Neall, Webster Ye, the Maryland Insurance Administration (MIA), Commissioner Redmer, Cathy Grason, Joe Fitzpatrick, Todd Switzer, the Governor's office, Matt Clark, the Office of Legislative Affairs, Vicki Gruber, David Romans, Simon Powell, Senator Middleton's office, Delegate Pendergrass' office, Delegate Pena-Melnyk's office, the internal MHBE team, John-Pierre Cardenas, and Kris Vallecillo for their work during the legislative session and highlighted their hard work and collaboration. Three items came out of session that were important to the MHBE: authorization for MHBE to conduct background checks on contract employees, 1332 waiver application approval for the reinsurance program, and a funding mechanism bill that will determine the funding source for the reinsurance program. There were also two other items in the funding bill, Senate Bill 387. The first was in reference to ensuring that association health plans conform to other state standards that already exist, and the other item was in reference to maintaining

short-term health plans at 30 days with them not being renewable. Ms. Eberle acknowledged CareFirst and Kaiser Permanente for their help on the bills.

Ms. Eberle provided an overview of the annual conference for state-based marketplaces in Denver, Colorado attended by the MHBE. Betsy Plunkett presented on retention and outreach efforts. John-Pierre Cardenas had the opportunity to speak on the innovative work that Maryland has done with the standard benefit design workgroup. Venkat Koshanam spoke on IT innovation, such as the mobile application, password re-set, and managed care organization (MCO) shopping. Ms. Eberle also presented on the legislative efforts in Maryland and highlighted that other states expressed admiration for the work that the MHBE has been able to complete. Ms. Eberle highlighted that Maryland continues to be at the forefront in terms of the work done for the marketplace.

Ms. Eberle provided an overview of the national open enrollment numbers that were released. The MHBE has reviewed them thoroughly, and Maryland had the 2nd highest percentage of new enrollees aged 26-34. Washington, D.C. had the highest percentage, which can be attributed to legislative staffers having to enroll through the D.C. Marketplace. Maryland had the 5th lowest percentage of new enrollees aged 55-64. Maryland also exceeded HealthCare.gov states, with the 6th highest percentage overall of enrollees aged of 18-34 and was also ahead of the other state-based marketplaces. Ms. Eberle highlighted that new enrollments made up 29.7 percent of total enrollments, which is the 10th highest in the United States. She also explained that Maryland ranked 28th highest in average monthly insurance premium and ranked 15th highest when tax credits were factored in.

Ms. Eberle provided an overview of IT and operations. There was a big release at the end of March that included five Medicaid-specific enhancements, two system wide enhancements, and overall system improvement. The next major release is scheduled for May 25 and will include MCO auto-assignment, federal verification processing, and reconciliation through carriers. Ms. Eberle emphasized the great work with Kaiser Permanente and CareFirst and stated that the MHBE hopes to move over to policy-based payments with the Centers for Medicare & Medicaid Services (CMS) this summer.

Ms. Eberle provided an overview of escalated case management. There are 864 open cases, and 60 percent of those cases are less than 7 days old. The MHBE continues to work on resolving issues quickly related to Medicaid enrollment and verification, Exchange enrollment, and 1095 A forms. The Office of Legislative Audits just finished their operational audit of the MHBE and are finalizing their technology audit. The MHBE is also undergoing an independent state financial audit and programmatic audit. CMS released the final 2019 payment notice. The MHBE will be returning to the Board with more information on this notice.

1332 Waiver Application, Reinsurance Parameters and Board Resolution
John-Pierre Cardenas, Director, Policy & Plan Management, MHBE

Mr. Cardenas provided an overview of the legislation for the establishment of a reinsurance program. There are three different parameters for the proposed program, which include an attachment point, coinsurance rate, and a cap. Mr. Cardenas discussed the legislation for the funding of the reinsurance program and explained that the federal tax on health insurance carriers was waived for 2019 in the Tax Cuts and Jobs Act of 2017. Mr. Cardenas also explained the necessity for a 1332 waiver in order to obtain federal pass-through funding. In order to access pass-through funding, the MHBE is required to decide on parameters for the program and what money the state is allocating.

Mr. Cardenas discussed the progress on the application and thanked Commissioner Redmer and the MIA. He explained that Wakely Consulting has worked most closely on 1332 waivers for other states and worked on the MHBE's 1332 waiver. Mr. Cardenas explained that the MHBE has worked closely with the MIA and Wakely Consulting on the parameters that the MHBE is recommending to the Board. Mr. Cardenas added that the MHBE is recommending that the attachment point be set at a later date because it should reflect the stakeholder feedback and the most accurate and current data. Wakely Consulting has outstanding calls on data with an issuer. The information from that call is needed before an attachment point is determined. Mr. Cardenas emphasized that other states have taken this approach of waiting to set an attachment point.

Mr. Cardenas stated that the MHBE is prepared to recommend an 80 percent coinsurance rate and a $250,000 cap. Mr. Cardenas added that the MHBE believes that it is prudent that the issuer manages claims above the cap of $250,000. Mr. Cardenas stated that the resolution meets all of the needs required under HB 1795, and he added that the reinsurance program sends the message that the MHBE is addressing high premium rates in the individual marketplace.

Commissioner Redmer thanked Mr. Cardenas for the thorough summary and asked about the collaboration with the federal government throughout the process. Mr. Cardenas answered that, from the very beginning, CMS offered their expertise and support in anticipation of a Maryland 1332 waiver. He added that CMS recommended planning for waiver implementation beginning in 2019. The MHBE has worked closely with CMS staff to assure that the approach to the waiver application is consistent with their expectations. CMS will already know what is in the application when it is submitted.

Ms. Eberle added that she was able to speak directly with Deputy Director Jeff Wu, and she was reassured that there should be no issue getting the waiver application approved if it follows another state that has already been approved.

Mr. Taneja asked if the assessment fee is for all carriers and all products, and he expressed concern that the fee will be passed onto consumers through commercial carriers and products. Ms. Eberle answered that the MHBE looked at the effect of the federal health insurance fee and explained that if they want to apply the fee to MCOs, it has to be a broad-based flat tax. Commissioner Redmer added that the health insurance fee is going to be paid in 2018 by carriers, and the expense of that is already built into the rates that consumers pay. As part of the new federal tax plan, the fee was not going to be required to be paid in 2019, but will be paid in 2020. Commissioner Redmer explained that the original objective was, to the extent possible, have the same fee that would have been paid to the federal government in 2018 paid in 2019 to the state government because it is already built into the rates. It would be a revenue neutral transaction as far as the consumer is concerned. The money could be used to offset the increase of costs in the individual market.

Mr. Steffen asked about feedback obtained from other states, mainly Oregon, on why holding off on determining an attachment point is wise. Mr. Cardenas answered that Oregon did not include an attachment point in the application, but they did include a date by which the attachment point would be set. Oregon waited until they were able to assess what the total funds would be and until after rates were finalized. Oregon is still determining their attachment point. Mr. Cardenas emphasized that Oregon is just an example of a state in which an application was approved without an attachment point determined, and Ms. Eberle added that Oregon had a referendum for funding their program that delayed their process. Mr. Cardenas stated that stakeholder engagement and feedback is crucial to the MHBE establishing an attachment point. Secretary Neall added that waiting for actuarial information is also important before determining an attachment point.

Issuer Incentive to Manage Healthcare Costs and Utilization under a Reinsurance Program
Chet Burrell, President and Chief Executive Officer, CareFirst
Kim Horn, Regional President, Kaiser Permanente
Sheila Schroer Executive Director and Regional Chief, Kaiser Permanente
Scott Leitz, Senior Fellow, NORC at the University of Chicago

Mr. Burrell stated that CareFirst shares the principle concern of steep premium increases making coverage unaffordable for everyone without action. Mr. Burrell highlighted a few points. He stated that there are two key concepts at play. One is reinsurance, and the other is risk adjustment. Reinsurance deals with high cost claimants, and risk adjustment looks at differences between whole populations. Mr. Burrell stated that Kaiser Permanente tends to draw healthier risks because of the restricted access to hospitals, primary care physicians, and specialists in their model. He also explained that Kaiser Permanente does not offer coverage in Western Maryland or on the Eastern Shore. CareFirst offers coverage in the whole state with both a preferred provider organization (PPO) product and a health maintenance organization (HMO) product. Mr. Burrell emphasized that there are differences between Kaiser Permanente and CareFirst, and he is just drawing out distinctions that may cause the risk pools to differ. He also stated that if a person is sick, they are more likely to choose a PPO that allows them to seek care where they need it. Mr. Burrell added that 89 percent of CareFirst individual market enrollees are in an HMO plan, and 11 percent are in

a PPO plan. Mr. Burrell explained that the average claims cost for HMO enrollees is in the $495 range, and the average claims cost for PPO enrollees is in the $970 range. He added that 19 percent of the most expensive people in the PPO plan are equal to 73 percent of the payout, and 13 percent of the most expensive people in the HMO plan are equal to about 65 percent of the payout.

Mr. Burrell spoke to the issue of whether or not the PPO population is managed. He explained that 80 percent of all people in an HMO and PPO have primary care physicians, and a vast majority of those primary care physicians are in the Patient-Centered Medical Home (PCMH) network with incentives to manage those people. Additionally, Mr. Burrell explained that CareFirst identifies people who are seriously ill with high utilization and seeks to place them in care plans, which consist of a nurse working directly with a primary care physician chosen by the member. In any given year, there are approximately 30,000 to 40,000 people in care plans. The care plans coordinate care across multiple providers and seek to avoid readmissions, emergency department admissions, and expensive causes of care, including confusion, depression, and non-compliance. There are over 5,000 nurses in the field working on these plans.

Mr. Burrell explained that the average duration of coverage for an enrollee in the individual market is approximately 17 months, and the sickest of these people remained in for 24 months, even when in a care plan. Mr. Burrell emphasized that the concern about controlling costs in the population is not due to fees set by CareFirst, but instead, the level of service use is much higher in this population. Mr. Burrell stated that since the beginning of 2014, CareFirst is expected to lose approximately $500 million on this population, and if anyone had an incentive to try and control costs, these losses would incentivize that. Mr. Burrell emphasized that CareFirst is motivated to control costs and is very attentive through the PCMH program.

Mr. Burrell suggested that the attachment point be set to offset the premium increases, but to the extent that one tries to offset reinsurance and risk adjustment, which he highlights is a complicated problem that no one has solved and that the federal program did not do, Mr. Burrell stated that doing this would lessen the amount and value of claims that would be subject to reinsurance protection. If a carrier cannot get the protection through risk adjustment, then the carrier has to get it through a higher premium. Mr. Burrell expressed concern that if that premium is not checked, then few will be able to afford to pay the premium. Mr. Burrell recommended doing what the federal government did with the federal reinsurance program, which is to not offset reinsurance and risk adjustment. He also added that the filing deadline is May 1, and CareFirst would like to avoid double filing. Mr. Burrell stated that the funding being provided through the health insurance fee and the waiver could provide protection stretched over a few years and could hold rates down as much as possible. He added that if rates have to rise higher, then the state is in danger of losing its statewide PPO option, and it will be left with two HMOs.

Commissioner Redmer asked Mr. Burrell what CareFirst would prefer in terms of filing rates. Mr. Burrell replied that if everything cannot be done by May 1, then CareFirst would prefer to file without the assumption of the reinsurance program and then file again when the parameters are set. Commissioner Redmer asked if the 89 percent of individual market enrollees in an HMO has increased over the years. Mr. Burrell responded in the affirmative. Commissioner Redmer asked if it is good or bad in the CareFirst perspective if decisions are made that result in people moving from the HMO product to the PPO product. Mr. Burrell responded that it would depend on the details of the reinsurance program. Mr. Burrell added that it would not be a bad thing, but it would depend on how much protection is in the reinsurance program. Mr. Burrell explained that the pressure of cost is greatest in the PPO program, so there would have to be substantial protection from reinsurance to hold the PPO rates down. He added that the HMO program is also feeling upward pressure but not to the same extent as the PPO program. Commissioner Redmer asked if the PPO premium would react sooner than an HMO premium if a reinsurance program is created. Assuming that the rules for the reinsurance program are the same for HMOs and PPOs, Mr. Burrell stated that it is more likely that rates would stay moderate for the HMO than it is for rates to stay moderate for the PPO. If rates for the PPO were to rise rapidly, even with the protection of the same rules, then it would become unaffordable for people to obtain the coverage.

Commissioner Redmer stated that multiple attachment point options have been considered, and the state does not want to take away the incentive of managing care and controlling costs. Commissioner Redmer asked if CareFirst would have the same incentive to manage cost if the attachment point decreases. Mr. Burrell responded that the

coinsurance rate is a powerful motivation and that there are many claimants above the $250,000 cap. Mr. Burrell added that the large amount of money lost on this population means that there is money being lost and is spread across the entire spectrum of claimants, and the losses alone are a powerful motivation to control costs. Mr. Burrell stated that CareFirst has tried to keep people stable in the community and not have them readmitted to the hospital whether they are in the PPO or HMO program, but these are people with advanced cancers, heart disease, and stroke.

Mr. Steffen asked if CareFirst contracts with all Maryland hospitals in the HMO product. Mr. Burrell responded yes. Mr. Steffen asked if CareFirst has the capability to offer an exclusive provider organization (EPO) product. Mr. Burrell responded that CareFirst's experience with the EPO product has shown problems with access and service, particularly for individuals who need the access the most. Mr. Burrell added that CareFirst has stayed away from narrow networks because of these access and service problems and because people often do not understand how narrow the network is until they try to use it. Mr. Steffen asked what share of the former Maryland Health Insurance Program (MHIP) population is enrolled in CareFirst. Mr. Burrell replied that CareFirst has a very high share of the MHIP population, and the MHIP population turned out to be materially sicker than the population that was medically underwritten. Mr. Burrell added that in 2013 before the Affordable Care Act (ACA), the average premium in the individual market that CareFirst quoted was $200 or less, but the average MHIP cost was $1,500. The people in MHIP were approximately four to five times more expensive than the people who were medical underwritten before the ACA when the risk pools were segregated. Mr. Burrell thanked the MHBE Board.

Ms. Horn expressed her support of stabilizing the Maryland marketplace and stated that she believes it is critically important to do. The issue is very significant to Kaiser Permanente, the people Kaiser serves, and Kaiser's business clients. Ms. Horn stated that the 2.75 fee is an additional tax to Kaiser Permanente that is about three times more than it was under the federal fee. Kaiser is advocating for a few parameters in the reinsurance program. Ms. Horn stated that Kaiser's individual marketplace enrollees increased by 50 percent going into 2018. Kaiser has lost approximately $120 million through 2017, and has lost about twice as much per capita than CareFirst. In addition to the health insurance fee, Kaiser paid $80 million in risk adjustment payments, and Kaiser estimates they will pay upwards of $120 million this year. Ms. Horn emphasized that Kaiser pays more in risk adjustment as the cost of the premium base in the marketplace increases, so it is important to carefully construct the reinsurance program in the context that there is risk adjustment. Ms. Horn stated that constructing the program without the context of risk adjustment could produce winners and losers and further destabilize the market.

Ms. Horn added that the reinsurance program by design should not disproportionately benefit higher cost of care. Ms. Horn stated that enrollees with a high cost of care in Kaiser Permanente are managed and kept in a very narrow network, which includes managing where the enrollees should and should not be going. Ms. Horn added that the waiver is an opportunity to encourage cost containment and innovation and provide incentives that could persuade more people to come into the market. Ms. Horn expressed the importance of all Marylanders sharing in the program's benefits. Ms. Horn provided the example that Kaiser pays approximately 30 cents on the dollar for risk adjustment, meaning that those people are potentially disproportionately funding the program. Ms. Horn stated that Kaiser believes that there should be rewards for quality and cost effectiveness. Kaiser is very focused on quality outcomes, HEDIS measures, prevention, and management of chronic diseases. Ms. Horn expressed the need for the reinsurance program to coordinate with risk adjustment and highlighted the impact that the risk adjustment program has on the market with just two carriers. Ms. Horn requested that the proposed state reinsurance program not "double dip" with the risk adjustment program. Ms. Horn acknowledged the complexity of the coordination between the risk adjustment and the reinsurance programs, and she recognized that the federal reinsurance program did not take into account both programs. Ms. Horn also stated that there is guidance coming from CMS that explains that they are now understanding how the different programs interact within the marketplace.

Mr. Leitz provided an overview of his background, which includes his current position at NORC and previous roles as CEO of MNsure and Assistant Commissioner at the Minnesota Department of Human Services. Mr. Leitz stated that in designing programs to mitigate risk, there is a potential for duplication and the possibility of paying for the same risk twice. Mr. Leitz highlighted groups, such as the American Academy of Actuaries, who have raised concerns about the need to mitigate against market distortions and coordinate the programs. Mr. McCann asked if the proposed reinsurance program falls under the category of an invisible high risk pool. Ms. Eberle responded yes.

Mr. Leitz referenced Milliman who noted this past summer that the current federal risk adjustment methodology does not account for payments from state-based reinsurance programs and can result in double compensation for high risk members both from the reinsurance program and risk adjustment, which could lead to pricing inefficiencies and distortions that negatively impact the market. Mr. Leitz added that the Milliman conclusion is that states should coordinate the risk adjustment program with the reinsurance program to ensure that the state is achieving the right outcome and is not unintentionally distorting the market. Mr. Leitz stated that, due to the nature of the reinsurance program, it favors plans that would more often surpass the attachment point. He emphasized that PPO members have higher medical costs than HMO members and suggested that in designing the reinsurance program, incentives for effective and efficient care be included and recognized. Mr. Leitz suggested that Maryland's reinsurance program address the disparities so that premiums are not reduced disproportionately due to high cost delivery system design even after risk profiles are addressed. Mr. Leitz added that absent that incentive, the state could see disproportionate premium effects between the two carriers in the market.

Ms. Horn highlighted several mechanisms that may be used to provide the right incentives in the market, such as higher quality ratings or lower cost structures receiving a higher multiplier in the reinsurance program, eliminating double dipping by requiring a carrier to exhaust its risk adjustment payment before it goes into the reinsurance payment, and rewarding or providing incentives to carriers, such as MCOs who are serving both Medicaid and the individual market. Commissioner Redmer asked for Ms. Horn for clarification. Ms. Horn stated that providing incentives through the reinsurance program could further stabilize the market, such as different multipliers for MCOs, higher quality ratings, or lower cost structure programs. She added that she believes that CMS would welcome incentives to maximize the dollar and the return of the reinsurance program. Commissioner Redmer asked if the point of the reinsurance program is to offset the high cost of patients, every dollar used to provide an incentive is a dollar lost to offset the cost of someone else. Ms. Horn clarified that it would create the right incentives so that carriers are thinking carefully about individuals who are high risk and potentially high cost and getting them into cost effective delivery systems and benefit designs. Ms. Horn stated that the sickest people in the Kaiser plans are lower cost than those in other plans. Commissioner Redmer asked if losing the money due to high cost patients is enough of an incentive already to lower costs and increase quality. Ms. Horn responded that is not necessarily the case if the carrier is getting the money back in risk adjustment coupled potentially now with a reinsurance program to cover the cost. Commissioner Redmer challenged the statement that all carriers were getting their losses back in risk adjustment.

Secretary Neall emphasized that he would not want to do anything to discourage issuers from joining the market and asked Ms. Horn what would objectively discourage a carrier from joining the market. Ms. Horn responded that risk adjustment dissuades carriers from joining because the payments are unpredictable and as other carriers' PPO plan rates increase, other carriers pay more in risk adjustment. Ms. Horn added that, in Maryland and Virginia, risk adjustment has been the biggest destabilizer for Kaiser Permanente.

Mr. Steffen asked how many hospitals Kaiser contracts with. Ms. Horn responded that Kaiser contracts with many, but concentrates patients within six hospitals, which means that Kaiser staffs those hospitals. Ms. Horn added that it is not just about the hospital but about the hospital having their delivery system and managing that care. Mr. Steffen asked which hospitals have Kaiser Permanente staff. Ms. Horn named Holy Cross, Anne Arundel, St. Agnes, Baltimore Washington, and Doctors Hospital, with a couple of physicians and care coordinators at Prince George's County Hospital and one other hospital. Mr. Steffen asked about access to other hospitals, such as Johns Hopkins, for necessary treatments. Ms. Horn answered that, on any given day, there are 25 patients at Hopkins or somewhere else where they can get the best care. Mr. Steffen asked about the protocol for patients getting access to these other hospitals. Ms. Horn answered that the patient would go through the typical process for a specialist so the patient can go to the place where they can get the best treatment. Ms. Horn added that there is a misconception that there are not patients outside the core of Kaiser. Commissioner Redmer asked what percentage of premiums goes toward risk adjustment. Ms. Horn answered that 24 percent of premiums go towards risk adjustment.

Secretary Neall thanked both CareFirst and Kaiser Permanente for their input. Secretary Neall then asked Mr. Burrell, if he was not with CareFirst, what would encourage or discourage a carrier from entering the market in Maryland. Mr. Burrell answered that he would want to know what the effect of the reinsurance and risk adjuster was and the duration of the programs. He added that he would also want to know if the rates can be stabilized at an affordable level. Mr. Burrell stated that it is hard to attract other carriers without a track record of stabilization.

Secretary Neall asked if there was any further discussion. Ms. Eberle clarified that the resolution is to move forward with the next step in the application. The MHBE will be returning to the Board after the next steps. Mr. Steffen further clarified that the vote today does not confirm agreement with either carrier position.

Secretary Neall recited the MHBE Board of Trustees Resolution on the 2019 State Reinsurance Program and Submission of a 1332-Waiver Application. Ms. Weckesser moved to approve the MHBE Board of Trustees Resolution on the 2019 State Reinsurance Program and Submission of a 1332-Waiver Application. Mr. Taneja seconded the motion.

Mr. McCann asked if the regulations for the reinsurance program will come back to the Board for final approval. Ms. Eberle responded yes and clarified that the regulatory process is separate from the application process. Mr. McCann expressed concern that the language in the resolution suggests approval. Secretary Neall clarified that the resolution includes the minimum requirements to proceed with the application. Secretary Neall stated that the reinsurance program has already been created through law, and the MHBE was instructed to apply for a 1332 waiver. Secretary Neall also clarified that this resolution is the instrument that moves the 1332 waiver application forward. Mr. Cardenas added that the parameters of the reinsurance program can still be adjusted.

The resolution was approved unanimously.

Small Group Health Options Program (SHOP) Interim Process Proposal
John-Pierre Cardenas, Director, Policy & Plan Management, MHBE

Mr. Cardenas provided a follow-up to the SHOP presentation in February. The MHBE presented on the direct to issuers model to the plan management stakeholder committee and received one comment from CareFirst. Mr. Cardenas gave an overview of the interim option for direct to issuers model and highlighted that it is very similar to the direct enrollment process previously used by the MHBE. Mr. Cardenas showed a graphic representation of the interim option of the direct to issuers model. He explained how the processes can happen in parallel because the small employer can go to either the SHOP participating issuer or the SHOP account manager, and they can happen in parallel. Mr. Cardenas explained that the small employer would be matched with an authorized producer, who would work on behalf of the small employer to help enroll them into these plans. Mr. Cardenas highlighted that this process is similar to the off-Exchange marketplace today, except that the small employer would have to go through the Exchange for an eligibility determination to ensure that the small group is eligible for SHOP. Mr. Cardenas explained that due to recent federal regulation, the eligibility and enrollment processes can happen in parallel. Mr. Cardenas stated that the issuer would be responsible for the administration for the group, similar to how the SHOP currently operates, and the authorized producer would continue to operate in the same manner as in the off-Exchange marketplace.

Mr. Cardenas emphasized that there are benefits and impacts to this model, and the MHBE staff recommends that this would be an interim solution. Mr. Cardenas stated that the benefit of the eligibility determination being centralized at the MHBE is that the MHBE can be certain that the prospective SHOP employer is given a correct eligibility determination. Mr. Cardenas provided an example of the impact of the model on employee choice, which could increase administrative burden on the employer. Mr. Cardenas provided an example of the impact of the model on employer choice and explained that auxiliary benefits could not be consolidated as they are now. Mr. Cardenas stated that additional resources within the MHBE will not be needed to implement the interim solution.

Mr. Cardenas summarized the direct enrollment process, as well as permanent SHOP solutions. He explained that permanent solutions will be presented to the Board before September 30, 2018. Mr. Cardenas also stated that there are many states that pursue different options, and the MHBE could leverage the Massachusetts approach of coordinating with Washington, DC. He also stated that the Washington, DC approach is the gold standard, and the MHBE could leverage their code. Mr. Cardenas also explained that the MHBE has the option of building its own SHOP in-house, and the MHBE is currently assessing the cost of building it in-house. Mr. Cardenas stated that early projections are estimating that it is more cost effective for the MHBE to build it in-house. Mr. Cardenas explained that the last option would be to propose removing the SHOP requirement from the responsibilities of the Exchange

in the statute. Mr. Cardenas stated that the MHBE believes there needs to be an interim solution, but also explained that the MHBE believes it is important to have a permanent solution in place sooner rather than later.

Secretary Neall asked when the interim solution would be in place and when the interim solution would be replaced with a permanent solution. Mr. Cardenas stated that the interim solution would begin in July 2018, and the permanent solution would be in place depending on determination by the Board and which solution is chosen. Ms. Eberle estimated that the MHBE could have a permanent solution in place by July 2019.

Commissioner Redmer moved to reject the recommendation of the interim SHOP direct enrollment process. Commissioner Redmer expressed concern about the timing of this change. He stated concerns about the upcoming challenges and uncertainties, which included: preparing to apply for a 1332 waiver, hopefully rolling out a reinsurance program, the potential for an additional carrier, the uncertainty in Washington, DC, and preparation for the 2019 legislative session. Commissioner Redmer emphasized the timing and does not believe this is the right time to expand the MHBE's scope.

Secretary Neall seconded the motion to reject.

Ms. Weckesser discussed the issues that the MHBE faces with the current contractor and the problem with rewarding very bad behavior. Ms. Weckesser also expressed concern about the process being manual, but she does not want to reward a contractor who is not doing what they are supposed to be doing. Commissioner Redmer agreed and asked if the contractor has stopped receiving the monthly stipend. Mr. Cardenas responded that yes, the MHBE has stopped paying the monthly stipend. Ms. Weckesser asked if there is a possibility for a new contractor. Ms. Eberle explained that ending the current contract would result in a new request for proposal, but also emphasized the difficulty in obtaining administrators. Commissioner Redmer also asked what communications have occurred with the contractors since the February 13, 2018 letter. Mr. Cardenas responded that a robust level of communication has occurred, and the MHBE SHOP has done everything they can, including a site visit and a thorough review of their technical specifications and capabilities. Mr. Cardenas emphasized that the MHBE has had extensive contact with the administrator.

Ms. Eberle added that continuing this contract with a month's notice to end is a possibility. She stated that the manual way is a low risk way to continue the program, and it allows the MHBE to continue the program until a future solution is decided on. Mr. McCann stated that if the opinion on the current contractor is accurate, continuing with the contractor is not a viable solution. Mr. Steffen asked how many covered lives come through SHOP. Mr. Cardenas answered that 899 covered lives currently come through SHOP. Mr. Steffen asked about the operational cost of the program, and Mr. Cardenas explained that the MHBE has ceased payment of the $30,000 a month but pays about $15,000 a month on costs that scale with enrollment. Mr. Steffen emphasized that allowing a contractor to continue like this sets a very poor standard.

Secretary Neall stated that he is at a loss with a solution, but wants the MHBE to be focused on the larger issues. Mr. Cardenas reassured the Board that the resources for the SHOP program would not impact other functional areas. Ms. Eberle reiterated that direct enrollment is happening off-Exchange, but small groups have had to come through the Exchange for the tax credit in the employee choice model. Ms. Eberle stated that 2 of 110 groups have selected the employee choice model. Mr. Cardenas added that the current employee choice model is administratively burdensome. Mr. Taneja asked if the MHBE can manage the interim solution without an impact on other areas. Commissioner Redmer asked how enrollment has changed over the last 12 months, and Mr. Cardenas answered that enrollment has been flat.

Commissioner Redmer and Susie Comer voted in favor of the motion to reject the recommendation. All other Board members abstained. The motion failed.

Mr. Taneja moved to approve the staff recommendation to implement a direct enrollment process to administer the Maryland SHOP until a permanent solution is recommended by staff and approved by the Board. Mr. Steffen seconded the motion. Commissioner Redmer voted against the motion, and the rest of the Board voted in favor of the motion. The motion passed.

Indefinite Delivery Indefinite Quantity (IDIQ) RFP Award
Venkat Koshanam, Chief Information Officer, MHBE
Michelle Compton, Manager, Procurement, MHBE

Ms. Compton explained the benefits of the IDIQ procurement structure for the agency and estimated that about half of the awarded contracts have been awarded to minority business enterprise (MBE) firms. Ms. Weckesser asked why there was a zero percent requirement for participation rate. Ms. Compton answered that, due to the structure of the IDIQ, there is no assurance that a master contractor will be awarded any money throughout the process. Ms. Compton reiterated that at least half of the current task order holders are MBE firms.

Mr. Koshanam provided an overview of the services in the ten different functional areas. Mr. Koshanam emphasized that the prior IDIQ has been very successful in reducing costs of services and meeting policy demands rapidly. The functional areas cover most of the IT regular operations. Mr. Koshanam provided examples of positions within the functional areas, and he stated that these functional categories would satisfy hiring to meet current and upcoming demands. Mr. Steffen asked about the nature of the review process because of the vast qualifications of the vendors. Mr. Koshanam responded that 57 out of 106 vendors have been awarded to apply for all services. The MHBE took careful consideration of vendors' proposals to determine which were approved to apply for the different functional areas. Mr. Koshanam added that, in previous IDIQs, only about 50 percent have obtained a task order from the MHBE. Mr. Koshanam also explained that, in the past, the MHBE did not receive a large variety of resumes, so this time, they wanted to keep the pool for resumes larger and become more selective during the request for resume process.

Ms. Compton added that the request for resumes only goes to contractors who were awarded under the designated functional area. Ms. Compton explained how master contractors are evaluated and awarded and stated that the process is similar to a pass/fail process. Mr. McCann asked about the issue of duplicate resumes. Ms. Compton answered that they do not allow duplicate resumes. Mr. McCann voiced concerns over inappropriate incentives in the process. Ms. Compton reassured the Board that while the process is informal, it is also robust because only technical proposals are viewed and accepted and only the best of the best are interviewed, determined by an evaluation panel of state employees. Mr. McCann asked about average number of responses for a request for resumes. Ms. Compton responded that it depends on the number of positions that are open, as well as the maximum number of resumes that master contractors are allowed to submit. Mr. McCann asked for clarification that the MHBE is buying resumes for people who will then come do work for the MHBE. Ms. Compton responded that yes, the MHBE is buying resources. Mr. McCann asked if it was an alternative personnel system, and Ms. Compton responded that it is similar in some ways to an alternative personnel system. Ms. Eberle added that it is a mechanism to get the best of the best resources out there quickly, and she added that the number of resumes that the MHBE receives is highly dependent on the skillset that the MHBE is seeking. Ms. Eberle stated that the MHBE has had problems in the area of technical training, and this process provides the MHBE with a bigger pool with which to draw the best resources. Mr. McCann noted that the process seems very unstructured and recommended that the MHBE reexamine the process. Secretary Neall added that the process is similar to the university process of having a roster available to fill positions and service needs.

Mr. McCann moved to approve staff recommendation to award Master Contracts to all proposed Master Contract awardees listed in the Procurement Officer's report and to appropriate a not-to-exceed amount of $18,200,000.00 for the IT Consulting and Technical Support Services IDIQ Contract for FY 2019. Secretary Neall seconded the motion.

Secretary Padilla voiced concerns about using the word appropriate. Secretary Neall amended the word appropriate in the motion to be authorized.

The motion was approved unanimously.

Quarterly Consumer Assistance Update
Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration, MHBE

Ms. Forsyth provided an overview of different consumer assistance groups and explained the different ways that people can access assistance. She also described the ways in which consumers can get assistance by phone or in person. Ms. Forsyth stated that, although there are over 500 authorized producers, about 20 percent of the authorized producers write about 80 percent of the cases. She reiterated that many are authorized, but most of them only engage with a case or two a year.

Mr. McCann asked if there was a fixed number of allowed authorized producers. Ms. Forsyth answered no. Ms. Forsyth then gave an overview of the appeals and constituent services teams, as well as the escalated cases team. She gave a description of the process for escalated cases and explained that those cases were resolved through a coordinated approach within the MHBE. Ms. Forsyth presented a graphic that showed the call center metrics and highlighted that, as call volume increased, the speed and time with which calls are answered decreases. Ms. Forsyth explained why the call center is experiencing those peaks and valleys. She stated that the contractor has sophisticated modeling to predict calls and uses that model to staff the call center. Ms. Forsyth stated that drivers behind the increase in calls were the implementation of MCO shopping and only 30 percent of consumers accepted their passive enrollment. Ms. Forsyth explained that it takes about three months to onboard, train, and nest a new call center representative, and she added that the contractor was able to utilize new staff in the tech services portion of the call center. Ms. Forsyth provided an overview of the special projects team and their role in the call center. She also summarized call handling time.

Ms. Forsyth provided an overview of producer operations. She noted that the BATphone was in place again this year during open enrollment. Ms. Forsyth noted that the authorized producer enrollments include passive renewals. Ms. Forsyth explained that there is a special support team for producers due to feedback, and the MHBE will be releasing the annual producer stakeholder survey shortly. Ms. Forsyth added that they are planning an annual producer meeting. Ms. Forsyth stated that they will be preparing the BATphone for the next open enrollment due to the popularity of the program.

Ms. Forsyth gave a summary of the Application Counselor Sponsoring Entity Program and the navigators in the state. She explained that there are 140 navigators throughout the state. She highlighted the earlier information that 26 percent of new enrollments were between the ages of 26 and 34 years. She emphasized that this group is more likely to need health literacy generally, and this age group tends to seek assistance.

Other Discussion

Secretary Neall then opened the floor for any other Board members who wished to speak.

Adjournment

Mr. McCann moved to adjourn the meeting. Commissioner Redmer seconded the motion. The Board voted unanimously to adjourn the meeting.