750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
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MHBE Plan Management Stakeholder Committee
May 3, 2018
Meeting Minutes
Maryland Health Benefit Exchange
750 East Pratt Street, 6th Floor, Baltimore, MD 21202
Call-in: 877-431-1883
ID: 6876841631

In Attendance

John-Pierre Cardenas
Michelle Eberle
Kimberly Edwards
Amanda Ballard (Phone)
Bill Wehrle
John Fleig (Phone)
Shaunteria Scott (Phone)
Natasha Murphy
Jackie Cahill
Stephanie Clapper
Tasha Woodberry
Sheebani Patel (Phone)
Talaya Ray-Fagan (Phone)
Carol Ball (Phone)
Hemalatha Tumuluri (Phone)
Dave Brock (Phone)
Cindy Hipwell (Phone
Marion Hilton (Phone)
Kathy Clayton (Phone)
Mark Haraway (Phone)
Ines Mayorga (Phone)
Linda Deitsch
Marylou Fox (Phone)
Jon Evans
Nabila Rahman (Phone)
Rebecca Smith
Sandy Walters (Phone)
Melissa Cole (Phone)

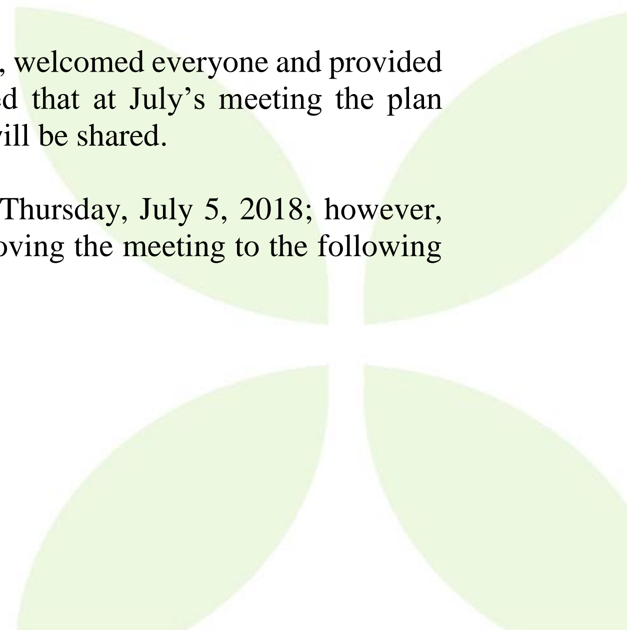
<u>Welcome and Introductions</u>

There were opening introductions by all present.

March 1, 2018 meeting minutes were approved.

John Pierre Cardenas, Director of Policy and Plan Management, welcomed everyone and provided an overview of meeting agenda. John Pierre also announced that at July's meeting the plan certification process along with an in-depth renewal timeline will be shared.

John Pierre confirmed that the next meeting will be held on Thursday, July 5, 2018; however, attendance will be taken and consideration will be given to moving the meeting to the following Thursday.



Proposed Regulation Timeline

John Pierre announced the need for stakeholders to provide insight into the proposed regulations. The goal for the month is to send all four chapters to stakeholders no later than May 15th which is at the end of the 1332 waiver public comment period. The following timeframes were provided:

May 15th – June 15th Public comment period.

August 2018 - Public comments from the stakeholders will be received as a result of the formal public comment process.

September 2018 – MHBE staff will review the comments and respond or work with stakeholders to address comments.

November 2018 – Request approval of final regulations from the Board of Trustees.

Summary of Chapters Submitted for Proposed Regulation
Chapter 7 - Rules that govern eligibility standards for enrollment in a Qualified Health Plan and a qualified health plan with Cost Share Reductions.

Chapter 14 - Rules that govern termination, cancellation or rescission of coverage in a qualified health plan.

Chapter 15 - Rules that issuers have to follow in order to participate in Maryland Health Connection.

Chapter 16 - Rules that determines the individual plans that issuers offer in the Marketplace.

Legislative Session Impact and 1332 Waiver

John Pierre gave a brief description of the 2018 Legislative session. There were 3127 Bills introduced, 890 passed and 2237 did not move forward. There were four Bills that impacted MHBE. The first is the department Bill to allow MHBE to perform criminal background checks on contractors who access federal tax information. This Bill allows MHBE to meet IRS standards for allowing access to federal tax information.

Second, HB152 allows automatic voter registration of consumers when enrolling in health coverage. The Bill requires MHBE to inform consumers that they will be registered to vote unless they decline. The process does give the option to opt out. MHBE amended the Bill to remove the requirement to share information when consumers have opted out of voter registration.

Third, HB1795 is the establishment of a reinsurance program. It directs MHBE to file an application with the Department of Health and Human Services and Treasury to implement the Reinsurance program. It also alters the purpose of the MHBE Exchange fund to receive federal pass through funding and state funding to relieve carriers of financial burdens. This Bill directs

Board of Trustees to establish parameters of what the program will be. Further, it requires the Exchange to promulgate regulations to administer the program no later than 1/1/2019.

Finally, SB387 affects the individual market place more broadly, it places an assessment on issuers to recoup the aggregate amount of the health insurance provider fee. Previously the assessment was instituted across all issuers with a rate that varied depending on the kind of issuer. Now, the 2.75% assessment is a single broad assessment across all issuers. The Bill provides an estimated $365 million to the state for the state reinsurance program. This Bill matched former regulation where short term limited duration plans were no longer than three months and are non-renewable. It amends the definitions to association health plans to better protect the small group market place. This Bill adds studies to Maryland health insurance coverage protections commission charge. The Bill codifies the current federal definition instead of the proposed change of the definition.

John Pierre reminded members that the 1332 Waiver went out on April 20, 2018 for public comment. John Pierre announced that there was a public hearing today right after the PMSC meeting at MHBE's office and welcomed all to attend.

Plan Management Updates

John Pierre discussed the proposed Plan Management updates to be implemented prior to the open enrollment period.

First is the enrollment payment URL timeline, release 23 slated for July 27, 2018. This functionality will allow for members to pay for coverage at the point of enrollment. The Exchange will not handle payment the applicant will be redirected to the issuer for payment. The pluses are that this function increases the rate of effectuation in enrollment. A meeting will be established with participating issuers by mid-May, 2018.

Second, SEP verification for the loss of minimum essential overage. Comments are taken until May 15th. John Pierre provided visual aids of what the process proposal will look like.

> SEP Verification Background: The initiative brought on by the market stabilization rule released by the administration in 2017. The Exchange reached out to issuers to determine what their insights were on the market stabilization rule and how to get maximum return on the initiative. The Board of Trustees voted to allow MHBE to include verification for loss of minimal essential coverage in the special enrollment period. Consumers must provide verifying documentation before continuing to select coverage. John Pierre noted the difference between this process and how it's done on the federal level, the consumer's enrollment is pended until verification documents are provided. Maryland is taking a different approach by allowing consumers to enroll during the special enrollment period. Applicants will have 60 days from the loss of minimal essential coverage to supply verification documentation to access plan shopping.

A committee member asked what retroactivity from the consumer perspective is. The answer

provided was as follows: If a consumer pays for coverage in the next month they have a period of time before the first of the month. If they have to pay for coverage that begins in the current month they will have to pay two premiums in the same month.

Verification Document Requirements

Applicants must supply documents that demonstrate that individuals on the application will lose minimal essential coverage within 60 days after they apply, or they have lost coverage within 60 days. Documents have to identify who lost coverage and when they lost coverage. If a consumer only submits one part of the required documents the application is not complete. The consumer must submit both parts for processing.

Proposed Notification Pathway

After verification documentation is submitted the consumer will receive a confirmation notice of receipt, and the go ahead to enroll. MHBE would like to follow the Federal practice of sending reminder notices to take action 10 days before the end of period. If applicants takes no action an expiration notice is sent out. If documents are supplied that MHBE has determined are insufficient, then a termination notice will go out.

Documentation Review

MHBE proposed to review submitted verification documents each month utilizing a random sampling method. If there are 1000 enrollees in March, MHBE will take a random sample from those enrollees that is statistically significant and representative. MHBE's proposal is to terminate coverage at the end of the month when documentation is not sufficient. For example, an application review done on March 25th will terminate March 31st if documentation is insufficient.

The question was asked, when will an issuer receive notice of the termination from MHBE. The response was as follows: Issuers will receive notices before the end of the month. For example, if a consumer request termination on August 25th the issuer will receive a termination date of August 31th. Notices to the issuers will continue to follow current protocol.

Another committee member asked, are issuers terminating retroactively. The response was, no, consumers will have coverage through the end of the month.

IT and EDI Updates-Jon Evans

834 Process

Jon Evans presented on the 834 responses for Automated Renewals. He provided updates on corrective action taken regarding the discrepancies with sending effectuation notices. He discussed the projected output goal, which is to eliminate issuers having to resend 41 codes. Carriers would not have to implement new practices, the work will be done on the Exchange's side.

Jon Evans discussed the push back regarding change transactions. He said the Exchange decided there was a need to make it easier for carriers. He announced that carriers would not have to make a change all of the work will be done on the Exchange's side.

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Jon Evans announced key dates

- Design analysis began April 1st and is ongoing
- Leadership sign off began May 1st
- Carrier sign off on the approach due May 11th
- Internal testing for three weeks to begin June 1st – 15th
- Carrier testing will be conducted for four weeks from June 25th – July 20th followed by another three weeks of contingency testing through August 17th
- Projected implementation date is August 27th

Contingency Planning
If something goes wrong during the testing no changes will be made to the existing process. The design allows switching back and forth without interruption to the process.

Jon provided a development and testing timeline as follows:

- 834 development is underway and will go into June 1st
- Internal and renewals testing will happen between the renewals testing and contingency testing and will be implemented
- Automated renewals should begin in late September rolling over into open enrollment

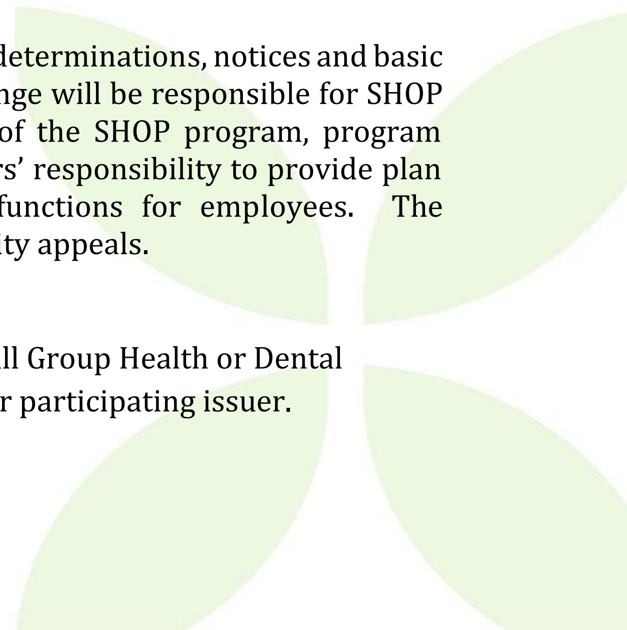
2019 SHOP Process - Rebecca Smith

Rebecca Smith began with providing updates about the direct enrollment process for SHOP plans. She informed members that the Exchange is exploring options about how the SHOP Program should be best operated. She announced that on April 16, 2018, the Board of Trustees voted to approve the direct enrollment process for the Maryland SHOP program. The direct enrollment process will begin on July 1, 2018, with new groups with effective dates of August 1, 2018, being the first groups to move direct. BenefitMall's contract as SHOP administrator will not be renewed. The direct enrollment policy was attached as a visual aid for stakeholders viewing. She requested that issuers review and comment on the process.

Process Flow Direct Enrollment
Rebecca Smith discussed responsibilities such as eligibility determinations, notices and basic administration of SHOP eligibility. Additionally, the Exchange will be responsible for SHOP eligibility appeals by employers and the administration of the SHOP program, program management, research and outreach. She explained issuers' responsibility to provide plan quotes, benefit information and enrollment eligibility functions for employees. The Exchange will be responsible for SHOP-specific SEP eligibility appeals.

High Level Steps

- Employer requests information on MD SHOP or Small Group Health or Dental Insurance from an authorized producer, MD SHOP or participating issuer.



- MD SHOP will direct employers to authorized producer for assistance and plan shopping and implementation.
- For Employer Choice Groups, MD SHOP or participating issuer advises an employer that they can enroll directly with the aid of the participating issuer or an authorized producer, for assistance, plan shopping and implementation.
- For Employee Choice Groups, MD SHOP or participating issuer advises an employer that they need to enroll with the assistance of an authorized producer for plan shopping & implementation. Employers will be provided a link to a list of authorized SHOP producers. The authorized producer will coordinate with MD SHOP for plan implementation.
- Employer (and/or producer) completes an online MD SHOP Employer Eligibility Application. The completed online form is submitted and transmitted to MD SHOP to determine group eligibility (can happen simultaneously with steps E to G below). The contacts provided on the form will be emailed a confirmation to include a submission number.
- For group implementation, the employer would use a Universal Employer/ Carrier Application and its employees would use the universal Employee Election Form.
- The employer selects a SHOP plan or plans to offer to employees, and informs employees about their options. Employees and dependents enroll in the plan of their choice through the issuer(s) directly.
- Group implementation information and employee enrollments are sent to the issuer for processing.
- The employer makes their initial payment to the issuer and coverage begins.
- Issuers submit to MD SHOP a monthly enrollment file of those employees and dependents who enrolled in their SHOP-certified plans.
- The Exchange will provide notices to employers with active SHOP plans. Issuers should also provide notice to active employers. The SHOP Administrator and BenefitMall will also provide a notice to groups. Copies of these draft notices were provided as part of the visual aids for review and comment.
- All comments are due by May 17th and then final version of the Employer and Employee forms will be released to issuers.

The Exchange's intention is to send eligibility decisions to the employer only. There should be no impact on issuers to determine eligibility for plans. Issuers only need to review to make sure they are meeting requirements.

A question was asked, "Does this online Employer Eligibility Form from Maryland have the potential to cause confusion among the employer group that this will get them coverage without other steps. How will this be communicated?" John Pierre Cardenas answered, the Exchange feels it is wise to include in the SHOP eligibility form that there is a second step and what items are required.

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The question was asked, "How will the Exchange document 75 percent participation when employer has multiple carriers? How will broker roles change?" Rebecca Smith answered, "that task will be taken on by the Exchange in coordination with brokers that are working with employee choice groups. Brokers will copy the Exchange on group submissions to issuers so we can review the participation level across issuers and send notification to the issuers, brokers and groups. If TPAs are allowed by issuers to work with SHOP groups, this process may change as the TPA will be able to assist with this confirmation."

A discussion occurred to see how participation across issuers were handled in the past. It was confirmed that a copy of the Wage and Tax was submitted to the carrier. MHBE confirmed that this is the information we expect to be submitted to the issuers to provide proof of meeting participating levels.

Minimum Participation
Rebecca Smith announced that the minimum participation rate set by the Exchange for SHOP groups. Employers must have a minimum employee participation rate of at least 75 percent. The window for no participation requirement minimum is November 15th – December 15th; and the waiver period for Maryland SHOP program. Issuers will be able to set their own participation rate so long as it does not fall below the 75 percent minimum. The Exchange will provide additional requirements in training to authorized producers on how to work with Employee Choice groups to prove minimum participation. MHBE is seeking information from the issuers on how they would like MHBE to provide information to each issuer.

Further clarification was given by John Pierre Cardenas on the 75 percent minimum ceiling. That is the only way to ensure equity across the process that it is set at the highest level that issuers allow rather than the lowest. It was further explained that the 75 percent is the ceiling of a minimum; the highest amount that a carrier can allow for a minimum participation rate. He explained that issuers can go less than 75% for their direct group but not more than 75 percent because they could crowd out certain employers.

Change Direct Enrollment
Rebecca Smith informed all present that the change for direct enrollment is expected to begin July 1, 2018 (effective dates of new groups will be August 1st due to implementation deadlines) with some transitional duties.

If BenefitMall receives premium payments for any direct groups during the transition period, BenefitMall will submit them to the issuers.

The Exchange is asking issuers to communicate with active groups regarding the upcoming transitions, expectations of how the groups will complete enrollment activity and how premium payments should be handled. New SHOP business will be direct and the Exchange is requesting details on what methods a direct group can use with each participating issuer to request quotes and group plan implementation. For renewing groups, additional details

are need to understand how brokers and groups will perform enrollment activities and renewal functions.

Third Party Administrators (TPA)
Rebecca Smith informed that the Exchange SHOP is requesting the issuers to consider allowing the use of TPA's to assist employers with SHOP groups. The use of TPA would have to be compensated out of any current or new TPA agreements to be put in place. The arrangements already exist in the small group health marketplace in Maryland. Therefore, there is history that TPAs can function with small groups. Allowing TPAs to assist will take some of the burden off of issuers. TPAs would have the same roles that they currently have with small group businesses. Feedback and comments are welcomed regarding what role third party administrators can take.

The Exchange is requesting issuers to:

- Comment and submit change requests for universal employer/employee application forms
- Share the current minimum participation rate, and what rate is expected to be maintained in the future?
- Provide what information may be needed for MHBE to accurately account the participation rate to issuers on employee choice groups?
- Share how each issuer might envision getting SHOP groups and brokers access to plan quoting and rates?
- Provide how current SHOP groups can be transitioned to a direct enrollment model for enrollment activity, premium billing and renewal functions. Issuers need to provide process information, including contact information to be issued in notices.
- Provide comments on their intention to use TPAs for SHOP business.

Renewals Policy Review

John Pierre Cardenas announced that the Exchange will release a document called Enrollment Instructions for Re-enrollment in Maryland Health Connection for 2019 Renewals. The document will be released in early June after stakeholder engagement. The Exchange has one-on-one sessions with issuer partners for renewals specifically. The form will be added as an addendum to the carrier reference manual to serve as a single source for all information for issuers. Further it will serve as a resource to answer policy and enrollment based questions about renewals. Stakeholders are encouraged to provide questions and feedback regarding the document no later than May 15, 2018.

Plan Certification Update

John Pierre Cardenas shared that the Carrier Business Agreement (CBA) is in final stages of updating for the 2019 plan year. Updates are necessary because much has changed since the agreements were initially signed. First, the inclusion of the state reinsurance program has been added. Changes in Maryland statutes has been added on network adequacy and provider directories. Updates have been made to the regulatory changes on the SHOP. We expect to send to issuers for review by May 15, 2018, providing a one month review period.

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John Pierre informed issuers that fully executed copy with wet signature should be mailed to Kimberly Edwards. A digital copy should be uploaded to the SERFF binder. Issuers will receive a complete application packet for the 2019 plan certification to include the CBA.

John Pierre informed all present that the Exchange updated the Essential Community Providers (ECP) list to reduce issuer administrative burden for plan year 2019. The Exchange developed a single integrated macro enabled Template. The Template will allow the submitter to select ECPs and evaluate the network inclusion standards. The template also allows the submitter to use the adjusted denominator standard. Instruction will be given on how to make submissions. The Exchange completed an audit of the 2018 ECP list and the spreadsheet to remove providers that are no longer at reported locations. A copy of the new 2019 ECP list will be forwarded to stakeholders at a later date.

John Pierre advised stakeholders that a request will be released for stakeholder insight on 2019 notice and benefit payment parameters. The Exchange is specifically looking for feedback about the risk adjustment reduction option.

Closing Remarks

John Pierre, encourage committee members to provide comments and feedback on the issues discussed. Comments and feedback can be submitted to: mhbe.carriers@maryland.gov.

Meeting adjourned at 3:40 p.m.