



**Maryland Health Benefit Exchange  
Affordability Work Group**

Friday, April 19, 2019  
10AM-1PM

100 Community Place  
Crownsville, MD 21032  
First Floor Conference Room

**Staff:** JP, Michele, Jess

**Members:** Robert Metz, Beth Sammis, Ken Brannan, Kim Rucker, Maansi Raswant, Stephanie Klapper

**Support Staff:** Joseph Fitzpatrick, Laura Spicer

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JP – Data went out, more to come; today is last day of speaker series; will start on recommendations next

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Cheryl Parcham, Families USA - Why Standardized Plans

- NPR story yesterday about deductibles deterring care in the group market
- Presented several previous studies referenced in the slides
- Examples of pre-deductible services in silver plans in other states
- Silver loading an issue in preserving the benchmark –some assure highest possible AV
- Some assured a high AV bronze plan for unsubsidized affected by silver loading
- Kim – question – preference for standardized plan due to services before deductible? R – yes
- Beth – evidence that outpatient facilities asking for up-front payment, is that happening in physician offices? R – some are
- JP – what are adverse issues that result from standardization? R – states that have it as an option have assured choices of pre-deductible services, but don't have benefit that CA has of being a totally active purchaser. Issuer concerns about ability to innovate.
- Rob – need to consider impact on maximizing tax credit
- Beth – can't you do services pre-deductible through plan certification instead of standardized plan? R – yes, but display to consumers may be a concern
- Does CareFirst have plans to offer more options per metal level? Rob – 2020 – there will be multiple offerings at one metal level

- JP – piloting value bronze plan in 2020 – will be branded as value bronze plans. Joe – commented that it will be more expensive.
- Beth – concern about communicating value plan to consumers
- Kim – important for plan shopping to communicate what is pre/post deductible
- JP – noted bill that just passed that allows MHBE to target health literacy
- Michele – think about links for each plan to show pre-deductible services. JP – or filter option
- Maansi – look at uptake of value plans, but is there a way to collect survey information about why someone selected the value plan. Concern about flexibility to meet care needs of diverse populations.
- Cheryl – will send copays for plans in these charts. Suggests a follow-up conversation with VT on behavioral health services
- Rob – cautioned to consider AV when trying to limit copayments – may have to be balanced with a floor copay on other services.
- Michele – tighten AV range
- Beth – some things we want to encourage consumers to do, e.g., form a relationship with a provider and discourage other things, like non-emergent ED. Would prefer to lower office/urgent care copays and increase ED copays
- Ken – are there stats on increased usage of health care from these states? R – no

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#### Stan Dorn, Families USA

- Huge cliff for those just over 400% FPL, but most are above 500% FPL
- Individual market coverage in MD is more expensive than group coverage for the same level of coverage
- MD does not have Medicaid-based plans in individual market like some other states do. RWJ study – states where Medicaid MCOs are offered, they are the lowest cost silver plan
- Lowest cost individual market coverage is 50% more expensive in the parts of MD with only 1 carrier
- Should focus on young adults under 300% FPL
- MD Easy enrollment program – engagement of tax preparers, automated interface
- Vary web interface to conduct randomized, controlled trials of web displays
- Reference pricing
- MA – offers a public program with only Medicaid MCO-based carriers; all carriers with 5,000 or more covered lives must offer an exchange plan; merged individual and small group markets
- Beth – question about Medicaid plans in MA – obstacle in MD, b/c CareFirst is the largest, if we were to require Medicaid MCOs to come into the individual market, CareFirst would still be left with higher risk, and MCOs would be left with high risk transfer payments. R – can't get around it – it is inherent in the risk adjustment program
- Rob – state has to create funding for things like enhanced subsidies in MA. R – yes. MA leveraged Medicaid waiver funds. Rob - Reason for the differential in those regions is the geographic rating factor and not because of lack of competition.
- Maansi – what is the source for MA having second lowest cost coverage? R – several sources – Kaiser annual estimates, CCIO public use files. Per capita – commerce department

- Maansi – studies showing that MD has second lowest spend – how does that translate to the cost of coverage?
- Michele – has MIA looked at cost of care v. cost of coverage? Joe – trend is a large piece of rate review
- Kim – will be interested to see the impact of the easy enrollment program
- Stan – advantage of enrolling streamlining – does not require the same level of state funds as increased premium subsidies

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Linda Blumberg Urban

- Low premiums, high OOP, and narrower benefits makes less affordable for sick
- Higher premiums, low OOP, and broad benefits, challenge for the healthy
- New regulations with APTC % of income caps growing faster
- Options for non-subsidized
  - Public option based on Medicare or Medicaid rates – would provide a lower priced option for consumers, particularly in less competitive insurer and provider markets
  - Capped provider payment rates – function of where you want to set the rate – basing provider payment rate in non-group market at some benchmark, such as % of Medicare – may entice more insurers to enter into new areas
  - Individual mandate
  - Reinsurance
  - Global budgets
- Subsidized options:
  - BHP (MN & NY) – concerns in those states b/c feds are no longer taking into account CSRs and pulls people out of the exchange market
  - Enhance APTCs – MA & VT
  - Enhance cost sharing assistance – MA & VT
  - Eliminate indexing of APTC caps
  - Tie APTCs to gold level coverage
- Even at generous funding levels, millions will remain uninsured, particularly the undocumented population
- Joe – survey – was it broken down by premiums? R – taken from a KFF survey of navigators, but don't think it was separated out
- Beth – zero sum game here between subsidized and unsubsidized. R – absent lowering rates, you need to spend more government money – how do you want to distribute that
- Linda – why low Medicaid MCO plans participating in marketplace – anxiety around setting payment rate, anxiety of being competitive, infrastructure for premium collection, different solvency requirements

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- JP – have finished up informational sessions
- Next meeting – determine philosophical approach
- Determine how to build off of value plans within this philosophical approach

- Develop recommendations for policy (MHBE can implement in plan certification), studies, or legislative/statutory
- Kim – MIA study on access and use? Joe – hope to get some more structured information – aiming to have results by end of coverage protection commission or general assembly next year
- Beth/discussion – focus on 2021 plan year
- Questions for HICPC
- Beth – how will affordability cap affect the 1332? R – reduce pass through
- Will coordinate an additional two meetings