Maryland Health Benefit Exchange
Board of Trustees

January 19, 2021
2 p.m. – 4 p.m.
Meeting Held via Video Conference

Members Present:
Dennis Schrader, Chair
S. Anthony (Tony) McCann, Vice Chair
Dr. Rondall Allen
Mary Jean Herron
Ben Steffen, MA
Dana Weckesser
K. Singh Taneja
Robert D'Antonio, PhD

Members Excused:
Kathleen A. Birrane

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Andrew Ratner, Chief of Staff, MHBE
Caterina Pañgilinan, Chief Compliance Officer, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Anthony Armiger, Chief Financial Officer, MHBE
Sharon Stanley Street, Principal Counsel, Office of the Attorney General
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Raelene Glasgow, Procurement Manager, MHBE
Lourdes Padilla, Secretary, Maryland Department of Human Services (DHS)

Welcome and Introductions:
Vice Chair McCann opened the meeting and welcomed all in attendance. He acknowledged the return of Secretary Schrader in his role as Chair.

Approval of Meeting Minutes
The Board reviewed the minutes of the November 16, 2020 open meeting. The Board voted unanimously to approve the minutes of the November 16, 2020 open meeting.

Public Comment

Mr. McCann invited members of the public to offer comment. No comments were offered.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her remarks by welcoming Secretary. Schrader back to the Board.

Next, Ms. Eberle described the recently concluded open enrollment for plan year 2021. She noted that the agency has made a lot of improvements to the technology underlying the Maryland Health Connection (MHC), including the Flora chatbot. The chatbot was used more than 350,000 times during 2020, corresponding to approximately $3.1 million in costs saved had those inquiries gone through the call center.

Ms. Eberle then noted that the agency's virtual budget hearing in Annapolis is set for March 1, 2021. The MHBE's required report to the legislature on the future of funding the agency is in progress.

Next, Ms. Eberle described the upcoming legislative session, noting that all sessions will be livestreamed and that legislators have indicated priorities including broadband services, back-to-school efforts, racial equity, economic opportunity, policing, gerrymandering, and violent crime. She added that a state-level individual coverage mandate may become law during the session and that the MHBE stands ready should that come to pass.

Ms. Eberle then discussed changes at the federal level, noting that the final 2022 Notice of Benefit and Payment Parameters was released by the Centers for Medicare & Medicaid Services (CMS) and will go into effect on March 15. Changes in the Notice include a reduction to the fee for states to join the Federally Facilitated Exchange (FFE), loosening of guardrails on 1332 waivers, and allowing web-based entities more room to operate. She added that the new administration is expected to freeze implementation of the Notice and open a new comment period.

Next, Ms. Eberle alerted the Board to the availability of the monthly data report on the MHBE's website, pointing out that the report has been generated monthly for several years. Comparing 2019 to 2020 data, qualified health plan (QHP) enrollment is up five percent, Medicaid enrollment increased ten percent, and dental enrollment increased 20 percent. Regarding the provision of financial assistance, plans with assistance decreased by two percent while plans without assistance rose five percent.

Ms. Eberle then described the churn of MHBE enrollees between QHPs and Medicaid. She explained that, due to the suspension of eligibility redeterminations during the pandemic emergency, the number of enrollees moving from Medicaid to QHP coverage is down 53 percent. At the same time, the number of enrollees moving from QHP coverage to Medicaid coverage rose 12 percent. She noted that these results are unsurprising given the economic upheaval of the pandemic.

Ms. Eberle concluded her remarks by noting that the MHBE continues to work remotely and that some small contracts are posted on the website for bid.

Mr. McCann thanked the MHBE staff for their efforts.

Open Enrollment Report

Andrew Ratner, Chief of Staff, MHBE

Mr. Ratner gave the Board a report on the recently concluded open enrollment period for plan year 2021. He noted that the number of people who signed up for coverage during the period is higher than in any of the previous open enrollments. He explained that two key actions bolstered the marketplace for plan year 2021—the reinsurance program instituted in 2018 and the COVID-19 special enrollment period (SEP) launched in response to Governor Hogan's emergency declaration. Key IT development investments by the MHBE also contributed to the success of the open enrollment, including the MHC mobile app, chatbot, and responsive design overhaul of MHC. He stressed that the entirety of the enrollment growth via online channels came through the mobile app. Strong social media interaction helped as well, with growth of both followers and engagement in nearly all channels.

Next. Mr. Ratner described the efforts of consumer assistance workers. Record numbers of consumer contacts took place during open enrollment, despite largely being unable to meet face-to-face. Connector Entities experienced a 60 percent increase in the volume of consumer contacts.

Mr. Ratner then discussed the broader individual health insurance market in Maryland, explaining that enrollment in Affordable Care Act (ACA)-compliant plans off-exchange grew nearly 22 percent and that the total individual market grew nine percent, including both on- and off-exchange enrollments.

Next, Mr. Ratner shared overall trends observed during open enrollment. He demonstrated that the open enrollment had a significantly higher proportion of renewals as opposed to new enrollments than the previous year, likely due to the influx of enrollees under the COVID-19 SEP. More people enrolled without tax credits, and the choice of metal level shifted away from silver plans and toward both gold and bronze plans. The share of enrollees choosing a CareFirst plan rose with a corresponding decline in Kaiser Permanente enrollment. Enrollment in QHPs among specific target populations was mixed, with slight increases among young adult and African American populations and a slight decline in Hispanic enrollment. All target populations showed significant Medicaid enrollment growth.

Mr. Taneja asked, since QHP enrollment was essentially flat among African American and Hispanic populations, whether essentially all of the enrollment growth among those populations was in Medicaid coverage. Mr. Ratner replied in the affirmative.

Ms. Weckesser asked why enrollment declined for Kaiser Permanente. Mr. Ratner replied that, since the beginning of the State Reinsurance Program (SRP), enrollment has steadily moved more toward CareFirst. He explained that, before the SRP flattened the premium rate growth, Kaiser Permanente had been gaining market share when they offered lower rates. Now, CareFirst offers competitive rates and is gaining market share.

Secretary Schrader asked about the implications of CareFirst entering the market as a Medicaid managed care organization (MCO), noting that the company would be a dominant player in the QHP, Medicaid, and non-MHBE private insurance markets. Ms. Eberle replied that, since CareFirst is taking over an existing MCO, there is less concern about enrollment churn, with some transfers between CareFirst's QHP and Medicaid systems. She added that Kaiser Permanente operates in both markets

as well, and that the implementation is expected to be smooth due to CareFirst and the MHBE already working well together.

Mr. Steffen noted that the CareFirst plans did not become cheaper than Kaiser Permanente plans, rather the price gap between the two narrowed, showing that some people are willing to pay a little more. He asked that the MHBE investigate why people chose the plans they did.

Mr. Steffen then asked how usage of the mobile app varies between QHP and Medicaid enrollees, citing potential issues around access and affordability of technology. Mr. Ratner replied that the MHBE does have that data and it would be provided, adding that there was significant mobile app use among Medicaid enrollees.

Next, Mr. Steffen asked how the subsidy levels of 2021 enrollees compare with those of the year prior. Mr. Ratner replied that growth was flat among those eligible for assistance with QHP premium and that the growth was mostly for those without assistance. Ms. Eberle added that the agency does track the average advanced premium tax credit and will provide that to the Board.

Procurement - Salesforce

Venkat Koshanam, Chief Information Officer, MHBE
Raelene Glasgow, Procurement Manager, MHBE

Mr. Koshanam gave the Board an overview of an upcoming procurement for Salesforce licenses, noting that the Board will not be asked to act today. He explained how the MHBE uses Salesforce and how that use has expanded to cover additional functions to improve the agency's operations. He provided a breakdown of costs by license type, with fewer licenses required in 2021 than in 2020.

Ms. Glasgow then summarized the intended procurement, the history of procurements for Salesforce licenses, the status of the procurement process for this purchase.

Ms. Herron asked about the inclusion of sub-dollar figures in procurements valued at millions of dollars over several years. Ms. Glasgow explained that it is not within the MHBE's power to round off the dollar figures quoted by potential vendors.

Mr. McCann asked whether the not-to-exceed (NTE) figure budgeted for Salesforce is entirely obligated. Mr. Koshanam explained that, since the costs are for licenses, the NTE has been met exactly every year.

FY 21 Q2 Compliance Update

Caterina Pañgilinan, Chief Compliance Officer, MHBE

Ms. Pañgilinan gave the Board an update on the MHBE's compliance programs, including Constituent Services, the Compliance Hotline, and the Civil Rights Coordinator. Of the five allegations of fraud, waste, and abuse received during the quarter, three were not founded while two were referred to the Maryland Department of Health (MDH).

Next, Ms. Pañgilinan described the status of audits during the quarter, noting that no critical findings arose in the Maryland Department of Budget and Management audit, along with no findings in either

the external audits or the Internal Revenue Service (IRS) triennial audit. She explained that the MHBE is working with MDH to develop a responses to the Office of Legislative Audits.

Ms. Pañgilinan then provided an overview of the agency's internal review program monitoring for the quarter. She noted that the MHBE appeals program has a perfect record in court. She shared the status of the internal metrics used by the compliance program as well as updates to the privacy program, where new incident management tools, procedures, and policy reviews have come into effect. She demonstrated that the number of privacy incidents taking place during fiscal year (FY) 2021 fell in every category, although the rate of incidents per enrollment did increase among producers during the same time.

Next, Ms. Pañgilinan gave an update on erroneous misloads of documents, noting that the call center workers have had no loading errors during the fiscal year, and that the rate of misloads by other workers decreased by 43 percent. She explained that the MHBE incident mitigation metrics are mixed, with improved performance over the previous year in the average days to delete a misloaded document and the average days to send a breach letter, but decline in performance on the rate of misloads requiring a notice to the consumer and the rate of parties affected per 10,000 enrollments.

Evaluation & Focus of Value Plans

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks provided the Board an overview of value plans and how they fit with the MHBE's goals and mission, as requested during the November 2020 meeting. She began by providing the background of the value plan idea, explaining that standardized benefit designs (standard plans), as used in eight different states, make shopping simpler for consumers who prefer copays to coinsurance and other forms of cost sharing.

Next, Ms. Fabian-Marks summarized the history of the MHBE value plan effort, beginning in 2017 with a Standardized Benefit Plan Design Workgroup. In January 2018, the Board opted to delay consideration of standard plans. Throughout 2018, the MHBE received public comments concerned about deductibles and out-of-pocket costs. In November of that year, the agency once again proposed standard plans for the 2020 plan year. In January of 2019, the recommendation changed from standard plans to value plans, which the Board approved.

Ms. Fabian-Marks then provided details on the 2021 value plan requirements, noting that the goal of all value plans is twofold—increasing access to plans that offer lower deductibles and greater pre-deductible coverage, and promoting cost-sharing structures that increase the use of high value care and align with state population health goals. For each of the metal levels, she listed the detailed requirements, including deductible ceilings, services that must be included before deductible, and how many value plans each carrier must offer.

Next, Ms. Fabian-Marks explored the rationale for value plans. She pointed out evidence showing that many consumers are in precarious financial situations and cannot handle an unexpected expense, and that large numbers of people put off care due to out-of-pocket costs. She described research showing that health insurance shopping is often overwhelming to consumers who often choose plans that are not the most financially advantageous for their situation. She also explained

that reducing out-of-pocket costs is shown to make care more accessible and improves patient outcomes, while reducing disparities.

Ms. Fabian-Marks then discussed how the value plans have performed, showing that four of the top ten most-chosen plans for plan year 2021 are value plans. Together, the value plans have 38 percent of all QHP enrollments for the year, an increase from 28 percent the prior year. She provided a breakdown of expected out-of-pocket costs for both value and non-value plans in all three metal levels when dealing with three typical medical encounters—having a baby, managing type-2 diabetes, and a simple bone fracture. In nearly every scenario, the value plans offered lower total out-of-pocket costs. Of all 27 scenarios explored, only one, having a baby with bronze-level coverage in a United Healthcare plan, resulted in higher out-of-pocket costs in the value plan.

Next, Ms. Fabian-Marks explored more deeply into the value plan offerings at the various metal levels, showing that, among all bronze plans, only the value plans offer meaningful coverage before deductible. For both the silver and gold metal levels, value plans from all carriers offer the lowest deductible.

Mr. Steffen asked whether the actuarial value of the value plans is distinct from other offerings of the same metal level, as compared with the federal benchmark. Ms. Fabian-Marks replied that the bronze value plans' actuarial values are all at the top end of the allowable range. She explained that she did not have the silver and gold data to hand, but expected similar outcomes at those metal levels.

2022 Plan Certification Standards – Bronze Value Plans

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks presented proposed modifications to the plan certification standard for bronze value plans. She explained that, at its November 2020 meeting, the Board elected to delay the bronze value plan standards until after the release of the 2022 actuarial value calculator by the federal government. The calculator was released on December 6, 2020, allowing the MHBE to publish the proposed plan certification standards for public comment on December 30. Whereas the 2021 standard required that carriers must offer at least three office visits before deductible, the 2022 proposed standard sets maximum deductible amounts for primary care, mental health and substance use disorder (MH/SUD) outpatient visits, and generic drugs.

Next, Ms. Fabian-Marks demonstrated that the proposed requirements are similar to how carriers implemented the 2021 bronze value plan designs, albeit some elements would have to be modified under the proposed standard.

Ms. Fabian-Marks then presented analysis by staff at the Maryland Insurance Administration that supports the proposed copay limits as being largely in line with existing plan designs. She further showed carrier-specific scenarios. Among all carriers, the majority of enrollees, 87 to 89 percent, do not meet their deductible during the year. The remaining consumers (11 to 13 percent) either meet the deductible but not their maximum out-of-pocket cost limit (MOOP) or exceed the MOOP. Under the proposed standard, those who do not reach their deductible will experience cost sharing savings; those who reach their deductible but not their MOOP will see no change in out-of-pocket costs on average. Those who meet or exceed the MOOP will see an average increase in cost sharing

expenses for the year. Combining all three groups together, the average enrollee will experience cost sharing savings under the proposed standard.

Next, Ms. Fabian-Marks discussed the MHBE's intention to encourage carriers to consider lower copay values in general, but particularly for generic drugs. She shared research indicating that, nationwide, bronze plan enrollees typically fill an average of 6.75 generic prescriptions while only having one primary care visit and less than one MH/SUD visit per year. She further showed that copays of $40 cover 25 to 32 percent of the total cost of a primary care or MH/SUD visit, whereas a copay of $20 on generic drugs typically covers 64 percent of the cost. She noted that reducing copays on generic drugs may support medication adherence, a key to better health outcomes.

Ms. Fabian-Marks then summarized the public comment received on the proposed standards, showing that no carrier opposed the standards, and that the proposal received support from both the Maryland Hospital Association and the Maryland Citizens' Health Initiative.

Ms. Fabian-Marks concluded her remarks by asking the Board to approve the proposed bronze value plan certification standards.

Mr. Steffen noted that uptake of value plans by consumers thus far has been good but not great and asked whether the MHBE is marketing the plans correctly. Ms. Fabian-Marks pointed out that the MHBE has just launched the consumer out-of-pocket cost calculator this year, making it the first tool available for consumers to estimate their costs. She noted that the topic of total out-of-pocket costs for individual health insurance is complicated and requires additional health literacy for many consumers, and that consumers may be making their decision based only on monthly premium cost rather than total out-of-pocket cost. Since value plan premiums are typically slightly higher, that may explain the slow uptake. She added that the MHBE has discussed highlighting value plans on the MHC system in some way to further encourage selection of these plans.

Ms. Herron asked how many people selected bronze value plans for plan year 2021. James Williams of the Maryland Insurance Administration stated that, as of June 30, 2020, approximately 25,000 Marylanders were enrolled in bronze value plans.

Ms. Herron moved to approve the 2022 Bronze value plan certification standards for services covered before the deductible—primary care visits with a copay of not more than $40, mental health and substance use disorder outpatient visits with a copay of not more than $40, and generic drugs with a copay of not more than $20. Mr. Taneja seconded the motion. The motion was approved with no opposition.

Closing

Mr. Taneja noted that the Board's documents do not contain any task orders for the indefinite delivery, indefinite quantity (IDIQ) contract, but that the existing contracts lists shows several large contracts ending June 30, 2021. He further noted that, last year, the Board was asked to approve several such contract extensions without sufficient time to evaluate the options. He asked that the Board be made aware of any issues around these contracts with enough time to evaluate other options. Anthony Armiger, Chief Financial Officer of the MHBE, replied that the agency intends to analyze the potential need to increase NTE amounts on several contracts and will present its findings

during the April meeting. Mr. Koshanam added that some task order amounts will likely require increases due to projects related to the COVID-19 emergency, and that the MHBE has taken over several IT tasks from contractors and will reduce the required contract staff based on that.

Adjournment

The meeting was adjourned.