Maryland Health Benefit Exchange Board of Trustees

March 17, 2015
1:00PM – 4:00PM
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Members Present

Van Mitchell
Darrell Gaskin, Ph.D.
Kenneth Apfel, M.P.A (by phone)
Georges Benjamin, M.D.
Jennifer Goldberg, J.D., LL.M.
Michelle Gourdine, M.D.
Al Redmer
Thomas Saquella, M.A. (by phone)
Ben Steffen, M.A.

Also in attendance: Carolyn Quattrocki, Executive Director at the Maryland Health Benefit Exchange (MHBE).

Opening and General Updates

Secretary Mitchell welcomed everyone to the Board meeting and stated that he looks forward to working with the Board. Ms. Quattrocki welcomed the new members to the Board. She reported that the open enrollment went well, and the MHBE is pleased with the results. A special enrollment period will be available from March 15 through April 30, 2015, for individuals who became aware that they owe a tax penalty for 2014 after the 2015 open enrollment ended. The MHBE has mailed 58,000 tax forms, and a few hundred more are being sent this week after discrepancies are resolved. The call center has received 10,000 calls regarding the tax forms, most of which requested general information. About 2,000 calls dealt with specific requests, and 1,000 calls were for perceived incorrect forms. The MHBE has made 500 corrections to the tax forms. Ms. Quattrocki noted that the MHBE will soon start preparing for the next open enrollment. Chairman Gaskin welcomed the new members to the Board.

Approval of Meeting Minutes

The Board reviewed the minutes for the January 20, 2015 Board meeting; no amendments were made. Mr. Steffen motioned to approve the minutes, which was seconded by Ms. Goldberg. The Board voted unanimously to approve the January 20, 2015 minutes.

2015 Open Enrollment Update

Andrew Ratner, Director of Marketing and Outreach at the MHBE, provided an update on the 2015 open enrollment. He reported that 289,131 people enrolled in coverage through Maryland Health Connection (MHC), with 87,007 people enrolled in qualified health plans (QHPs) with subsidies, 37,771 enrolled in QHPs without subsidies, and 166,353 enrolled in Medicaid. Mr. Ratner noted that Medicaid enrollment will continue to increase because people are free to enroll in Medicaid at any time, and Medicaid enrollees will be moving from the old system to the new system.

Mr. Ratner provided an overview of a variety of graphs that showed enrollment by county, metal tier, region, and carrier, as well as weekly cumulative totals. A map illustrated the percentage of uninsured Marylanders likely eligible for Medicaid or QHP subsidies by county. He noted that areas such as the eastern shore have a higher percentage of uninsured Marylanders and are harder to reach, which will require greater focus in the future. A graph of enrollment by carrier showed that there was more diversity in plan choice in the second open enrollment, and CareFirst and Kaiser had the largest increases in enrollment.

- Secretary Mitchell asked if there were any regions that had a greater percentage of their population enrolled in coverage. Mr. Ratner responded that enrollment aligned with regional population size. He noted that it is difficult to get accurate numbers regarding the number of uninsured and the number of newly insured in Maryland.
    - Secretary Mitchell asked if marketing strategies will be modified next year to target particular regions with lower enrollment. Mr. Ratner responded that the outreach campaign will focus on the harder to reach populations.

Mr. Ratner provided an update on the outreach campaigns. He reported that the MHBE entered into a partnership with the AFRO American Newspaper, which disseminated information to organizations serving African Americans. He noted that the MHBE team can assess the success of digital ads, and found the ads targeting African Americans were successful. The MHBE increased paid advertising that targeted the Latino community during the second open enrollment, reaching 87 percent of Spanish-speaking households with ads on Entravision and Telemundo. The MHBE also placed ads online, with Latino radio stations, and in Spanish-language newspapers. Mr. Ratner noted that outreach to the Latino community is an area that needs improvement; the MHBE has hired a new outreach coordinator to increase outreach to the Latino community. The MHBE team used digital advertising and a successful Facebook advertising campaign to reach young people (ages 18-34). The MHBE hired a social media coordinator to bring the social media outreach in-house. Mr. Ratner reported that the Connector Entities have interacted with more than 35,000 Marylanders by providing information and enrollment assistance. He noted that the Connector Entities' outreach has been creative and effective. For example, the lower eastern shore Connector Entity held an enrollment event on Smith Island to reach waterman, and the One-Stop Job Market was effective in reaching unemployed Marylanders, many of whom are also uninsured. The Door to Health Care in the western region collaborated with a local Asian American organization to make contacts with Asian-owned small businesses.

- Commissioner Redmer asked why Harford County was included in the upper eastern shore region. Mr. Ratner responded that that Harford County falls under the jurisdiction of Seedco, so it got included in the upper eastern shore region with the other counties covered by Seedco.
- Mr. Saquella asked if the enrollment numbers for the Small Business Health Options Program (SHOP) are available. Michele Eberle, Executive Director of the Maryland Health Insurance Plan (MHIP) and Interim Director of Plan Management at the MHBE, responded that, as of December 2014, 45 employers with 257 employees and dependents were participating in SHOP. Since then, 12 new employers with 107 employees and dependents have joined the SHOP. Ms. Eberle expects SHOP enrollment to increase as the MHBE continues outreach.
- Mr. Steffen asked about the availability of enrollment data by subsidy amount. He commented that it could be informative to see how many consumers received a large subsidy compared with those who received a small subsidy. Mr. Ratner responded that he will ask the MHBE staff if those numbers are available.

IT Update

Subramanian Muniasamy, the Chief Information Officer at the MHBE, introduced himself to the new Board members and reiterated that he has 17 years of state and federal experience, designing and building large-scale IT programs. Mr. Muniasamy then provided an update on the current IT system.

He provided an overview of the status of the activities being performed for the IT system. The activities are divided into three main work streams: maintenance and operations, enhancements, and special projects. The maintenance and operations releases were completed on schedule, and planning is underway for the June release. The IT team is planning three major enhancements to the IT system. The IT team is developing the functionality of the IT system to automatically generate 1095 tax forms for QHP enrollees, and is streamlining and updating the renewal process to promote the retention of QHP enrollees with subsidies. Dental functionality is also being improved to allow side-by-side comparisons of stand-alone dental plans (SADPs), and to send 834 enrollment transactions to dental carriers. A lower environmental migration to consolidate software into one location to reduce costs is also underway.

The IT team is working on three special projects. First, the IT team is transferring 1095 and 8001 data into the new environment in the IT system. Second, the legacy IT system is scheduled to be decommissioned by the end of March, and the data are being transferred into the new system. Third, the IT team is in the process of completing passive renewals, which involves entering people who were enrolled in a QHP into the new system.

- Secretary Mitchell asked if the special projects are already funded. Mr. Muniasamy confirmed that the special projects are already funded.
- Secretary Mitchell asked when the passive renewals will be complete. Mr. Muniasamy responded that the passive renewals have been completed for all carriers except for CareFirst. The IT team expects it will take three to four weeks to complete CareFirst's passive renewals once CareFirst sends the necessary information.
- Mr. Steffen asked how many people enrolled in SADPs. Mr. Muniasamy responded that he did not have those numbers. Ms. Quattrocki noted that SADP enrollment for 2015 was significantly lower than the previous year. The MHBE team believes this is because the Connecticut IT system did not have the functionality to directly enroll consumers in SADPs, but rather provided a link for enrollment through the dental carriers' websites. This change required an extra step for consumers and prevented consumers from making side-by-side comparisons of SADPs.
    - Mr. Saquella asked if this functionality will be added to the new system. Ms. Quattrocki confirmed that it will be added, and it is one of the planned enhancements.
- Secretary Mitchell how asked how the MHBE will address applications with special needs after the Optum contract ends. Jonathan Kromm, Deputy Executive Director at the MHBE, responded that that IT team is improving the 8001 pathway so that there will be less reliance on Optum by the end of the contract. Meanwhile, the MHBE is determining which functions currently handled by Optum can be assigned to other consumer assistance workers. He recommended doing a new procurement to address the applications that will not be handled by other consumer assistance workers.
    - Secretary Mitchell asked for statistics regarding Optum's work, such as how many cases they are handling each month and an update regarding the plan after the Optum contract ends. Mr. Kromm responded that he will look into this.
- Mr. Steffen asked whether enhancements to the SHOP system will be handled by the IT team or the third party administrators (TPAs). Ms. Eberle responded that it is a combined effort. The MHBE provides the requirements for the SHOP system, and the TPAs perform the work. She added that the MHBE is discussing whether to designate a project manager from the IT team to oversee the creation a fully integrated SHOP platform.
    - Mr. Steffen asked for updates regarding SHOP enrollment as the year progress.
- Dr. Gourdine asked if the passive renewal will only be performed once. Mr. Muniasamy confirmed that the passive renewals will be a one-time event.
    - Dr. Gourdine asked if the consumers have to take any action. Mr. Muniasamy clarified that the IT team will perform the passive renewals, and it will not require consumer involvement.

Mr. Muniasamy reported that the IT team is preparing for the next open enrollment in November. He provided an overview of the schedules, maintenance, and operations releases. The January and February releases fixed 39 defects. The March release focused on hot fixes, such as updates to the Spanish notice template, functionality to support the special enrollment period, and anonymous browsing capabilities for the special enrollment period changes. The April release will fix 17 defects, including leveraging information from the Maryland automated benefits system database for monthly income verification, and updating the plan and benefits template for Kaiser Permanente. Mr. Muniasamy provided more details regarding the three planned enhancements. The improvements to the renewal process and automatic generation of the 1095 tax forms are scheduled to be released on July 31, and the improvements to the SADP will be released on September 25.

Mr. Muniasamy provided an overview of the redetermination and verification activities. Medicaid redeterminations will move approximately one million Medicaid consumers from three different systems into the current exchange system. The increase in Medicaid redeterminations will result in an increased

workload. The MHBE, the Maryland Department of Human Resources (DHR), and the Maryland Department of Health and Mental Hygiene (DHMH) are collaborating to manage the redeterminations and verifications.

- Secretary Mitchell commented that DHMH and DHR staff are very concerned that it will be difficult to process the high number of redeterminations, especially since the call center will be reducing staff from 300 people to 100 people. Ms. Quattrocki responded that the call center's staffing will be maintained at 300 people through the end of April. The MHBE will work with DHMH and DHR staff to leverage the work case workers have historically performed regarding redeterminations and to provide additional support in the call center. The MHBE is also creating an escalated case team to assist with cases that are more complicated. Ms. Quattrocki acknowledged that redeterminations will be a challenge because the workload may exceed the available resources.
    - Secretary Mitchell would like to meet with the MHBE, DHMH, and DHR to create a team to assess the situation. Mr. Saquella agreed with this suggestion, and encouraged the involvement of other departments.
- Commissioner Redmer asked if the redeterminations will occur at the same time that Medicaid enrollees are integrated into the new system.
    - Secretary Mitchell added that this is area of great concern at DHMH because, historically, Medicaid redeterminations have been processed with a paper system, and now the redeterminations will be processed online.

Policy Matters, Board's Deferred Action Items, Proposed Standing Advisory Committee (SAC) Work Plan

Gwendolyn Majette, the Director of Policy and Government Relations at the MHBE, provided an overview of policy decisions that the Board had previously deferred. Ms. Majette noted that the Board should consider whether to merge the individual and small group markets. She explained that the small group market has a small number of enrollees, and an option is to merge these markets as some state exchanges have done. A study on this issue will be completed by the end of December 2016. The next issue for the Board to consider is developing network adequacy standards. The SAC is currently convening a workgroup to examine network adequacy and essential community provider (ECP) standards over the next six months and will provide feedback to the Board.

Ms. Majette provided an overview of three additional issues that the Board might want to consider: value-based insurance design (VBID), web-based brokers, and simplifying plan choice for consumers. Ms. Quattrocki and Ms. Goldberg noted that the Maryland Health Quality and Cost Council (MHQCC) performed a review of VBID, and a representative from MHQCC presented their findings to the Board in November 2014. Ms. Majette explained that VBID is a plan design that incentivizes physicians to provide evidence-based care, and encourages enrollees to engage in wellness activities. Other state exchanges and employer-based coverage have also explored utilizing VBID strategies. The MHQCC representative who spoke to the Board was the former Chief Medical Officer at Perdue Farms, which saw a decrease in insurance costs and an improvement in employee health after Perdue adopted VBID strategies.

Ms. Majette explained that web-based brokers operate solely online to help consumers enroll in insurance. The Board previously discussed the benefits of using web-based brokers to increase outreach. A workgroup was established to examine this issue; however, due to technical problems with the original IT system, the web-based brokers could not be integrated into the MHC website. The federally facilitated market (FFM) system is integrated with the web-based brokers, so consumers can easily transfer between the web-based broker and the FFM website. Now that Maryland's IT system is working properly, Ms. Majette noted the Board can consider greater web-based broker involvement.

Ms. Majette reported that the Board previously made the decision to limit QHP issuers to offering four plans per metal tier in the exchange. The goal was to provide consumers a variety of options without confusing or overwhelming them. There are approximately 56 QHPs available through MHC, and Ms. Majette noted that this could still present an overwhelming number of choices to consumers. The Board may want to consider meaningful choice when developing QHP certification standards. Meaningful choice means that the MHBE will assess whether the features of the plans vary enough to qualify as a

meaningful difference. Ms. Majette noted that the Board should examine the data showing the results of the current plan limitations before making a decision regarding plan simplification.

Ms. Majette next provided an overview of the proposed SAC work plan on network adequacy and ECP standards. The SAC discussed the proposed work plan in February, and it received wide support from the SAC with only one member expressing concern the work plan was too aggressive. The goal of the work plan is to provide input to the Board so the Board can make an informed decision. Ms. Majette noted that physicians and a Medicaid representative were added to the workgroup to ensure that there is a broad array of stakeholders examining this issue.

- Secretary Mitchell asked whether there are groups of other states or multiple stakeholder groups looking at this issue nationally. Ms. Majette responded that national organizations, such as the Alliance for Health Care Reform, are discussing this issue, which the MHBE is monitoring. Ms. Majette noted that the MHBE will be looking at network adequacy at both the national and Maryland level.
    - Ms. Quattrocki added that the SAC will be using the federal rules as a benchmark in developing network adequacy and ECP standards. The National Association of Insurance Commissioners (NAIC) network adequacy model act, which is developed by stakeholders from across the country, will also be an important resource. She noted that the goal is to adjust these national standards to fit Maryland.

Ms. Majette noted that the SAC will look at two national standards in April: the NAIC network adequacy draft model act and the federal rules. The NAIC model act was originally released in 1996 and is currently being revised. Then, the SAC will examine Maryland-specific data sources, such as the Chesapeake Regional Information System for Our Patients (CRISP), which collects carriers' provider directories. In June, the SAC will consider other states' standards, discuss the data sources that should be developed or collected, and continue to assess the federal rules and the NAIC draft model act. The MHBE also wants to reach out to other agencies such as Medicaid, the Maryland Health Care Commission (MHCC), and the Maryland Health Services Cost Review Commission (HSCRC) for data and input. The SAC will provide preliminary feedback to the Board on potential network adequacy and ECP standards in August so the Board will have time to make a decision.

- Chairman Gaskin asked if the August deadline will provide enough time to develop certification standards for the 2017 benefit year. Ms. Majette responded that there should be enough time because the 2017 plan certification standards will be developed in the spring of 2016. This will also give the Board time to review the final federal rules for the 2017 benefit year, which are expected to be released in February 2016.
- Ms. Goldberg emphasized that the ECP portion of the Workgroup should not be overlooked. She noted that it was important to look at exactly what we have here in Maryland.
- Mr. Steffen asked about the next steps for the other policy decisions, such as VBID. Ms. Quattrocki responded that they had previously set up a working group on VBID among the Board members, which can continue to discuss this issue. She noted that the Board can discuss the other two issues later.
    - Secretary Mitchell suggested coming back to these at the next Board meeting.
- Mr. Steffen suggested another policy decision to add to the list: the expansion of the small group market.

Closed Session[1]

Secretary Mitchell announced that the Board would be moving into a closed session. He explained that the purpose of the closed session is to obtain legal advice regarding potential litigation.

Chairman Gaskin motioned to move into closed session, which was seconded by Mr. Steffen. The Board voted unanimously to move into closed session. For topics discussed and actions taken, please see the Statement for Closing a Meeting dated March 17, 2015.[2]

[1] General Provisions Article § 3-305(b)(7) allows a closed session to consult with counsel to obtain legal advice.

2016 Proposed Plan Certification Standards

Ms. Majette provided an overview of the proposed QHP certification standards for 2016. She noted that the Centers for Medicare & Medicaid Services (CMS) released the Final 2016 Letter to Issuers in the FFM, and the Final Notice of Benefit and Payment Parameters for 2016 in February. These federal rules influenced the proposed certification standards. The MHBE posted the proposed certification standards for public comment on its website, with comments due on March 9, 2015. The proposed certification standards were also emailed to stakeholders, carriers, and members of the Implementation Advisory Committee. Fifteen comment letters were submitted by several carriers, two consumer advocacy groups, and several individuals.

Ms. Majette highlighted the proposed certification standards that differed from the 2015 standards. The standards regarding service area remain the same. The MHBE proposed to add a requirement to the network adequacy standards that carriers' provider lists be accurate, complete, and current (updated at least twice a month). Carriers must also display their directory information online in a machine-readable format. These requirements are in line with stronger 2016 federal requirements. Ms. Majette noted that in Maryland, carriers send provider directories to CRISP, which displays the directories online. Ms. Majette noted that the public comments were generally favorable to the stronger requirements regarding provider directories; however, the consumer advocates wanted even stricter requirements. She reported that plans will continue to be required to attest and describe how their networks provide services without unreasonable delay. The MHBE will continue to work with The Hilltop Institute and receive input from the SAC to develop recommended metrics for network adequacy and ECP sufficiency. United recommended using the national standard for "unreasonable delay," and a consumer advocated for stricter ECP standards.

- Commissioner Redmer asked why carriers cannot provide a link to their provider directories on the MHC website rather than submit their provider directors to the MHBE for display on the MHC website. Ms. Quattrocki responded that the Board had previously decided that it would be helpful for consumers to be able to compare carriers' provider directories without leaving the MHC website. Ms. Goldberg added that this also allows consumers to search for a QHP by provider.
- Dr. Gourdine asked if the SAC will define the term "unreasonable delay." Ms. Majette responded that the SAC will take that into consideration.

Ms. Majette reported that the MHBE will continue to require plan attestation that it does not discriminate on any factors prohibited by federal law; no comments were received on this issue. She noted that CMS strengthened the formulary standard to require that a carrier's formulary be up-to-date, accurate, and complete, and be available on the carrier's website in a standard machine-readable format. The MHBE included this requirement in the proposed certification standards. Carriers expressed concern that a formulary available in a machine-readable format could be misused or misrepresented. Kaiser commented that they should not be required to comply with this standard because they have an open formulary. CMS also added a regulatory provision that requires carriers to create an exception process that allows enrollees to request a non-formulary drug, and the carrier must notify the enrollee of its decision within 72 hours. The MHBE has included this requirement in order to comply with federal regulations. Consumers were supportive of this requirement. CareFirst suggested that Maryland law already addressed this issue. Ms. Majette noted that pre-existing federal regulations require an exception process for emergency requests, which requires carriers to respond within 24 hours. The Maryland Insurance Administration (MIA) has proposed a bill during this legislative session, which, if passed, would add the 24-hour emergency requirement to comply with federal regulations. This is the law CareFirst referenced; however, it does not include the exception process for non-emergency request as required by the recently adopted federal regulations. Ms. Quattrocki added that federal law requires the prescription drug rules to be adopted at the state level because it relates to essential health benefits (EHBs).

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[2] Statement for Closing a Meeting, 3/17/2015. *Available at:* http://marylandhbe.com/wp-content/uploads/2015/03/Closed-Meeting-Statement-0317151.pdf.

Ms. Majette reported that the Board will continue to limit carriers to offering four plans in each metal tier. She noted that, moving forward, the Board should examine whether this limitation continues to be effective or whether a meaningful difference review should supplement or replace the limitation approach in 2017. She noted that CMS adopted regulations requiring certain QHP issuers to comply with standards related to quality reporting through the implementation of the Quality Rating System and the Enrollee Satisfaction Survey. The MHBE is proposing to require certain QHP issuers to comply with the federal standard. CMS also adopted regulations that require each issuer to implement a quality improvement strategy in order to obtain QHP certification. A quality improvement strategy is a payment structure that provides increased reimbursement to improve health outcomes. The MHBE is proposing a voluntary standard for QHP issuers that have offered QHPs for two years to submit a quality improvement strategy for 2016; consumers and carriers are generally supportive of this proposal. Ms. Majette reported that the MHBE is proposing to move forward with conducting some compliance reviews in 2016. The scope of this review will be limited to compliance with plan certification standards and will not extend to requirements enforced by the MIA. The requirements regarding employee choice in SHOP and consumer support remain the same as in 2015.

Chairman Gaskin motioned to adopt the proposed certification standards, which was seconded by Dr. Gourdine. The Board voted unanimously to adopt the proposed certification standards.

Voting Session

Mr. Kromm presented the first motion for the Board to consider, whether to approve a procurement with Health Care Access Maryland (HCAM). Mr. Kromm explained that, originally, some Medicaid recipients were supposed to have their data converted into the IT system. However, due to technical difficulties with the original IT system, the MHBE had to enter into a contract with HCAM to establish a workforce to manually process these cases. This Medicaid population is now due for redetermination, and the HCAM workforce is needed to manage these cases for one more year in order to process these redeterminations. Mr. Kromm introduced Debra Ruppert, the Executive Director of Eligibility Services at DHMH, who is in charge of the HCAM workforce processing the redeterminations. Mr. Kromm explained that the HCAM procurement is going through the Board because DHMH delegated eligibility to the MHBE, and the Board has the authority to contract for enrollment work. Mr. Kromm explained that the MHBE's procurement with HCAM is to provide a workforce to manage Medicaid cases, and is paid by DHMH. The total amount of the procurement is $1.3 million for one year starting on April 1, 2015.

- Commissioner Redmer asked if this procurement was a new or existing contract. Mr. Kromm responded that this is an emergency procurement, and it is a new contract. There is a contract with a similar scope with HCAM that ends on March 31, 2015.
- Commissioner Redmer asked why this emergency procurement was not brought before the Board at an earlier date. Mr. Kromm responded that there was a miscommunication internally, and the staff believed they had another month before the existing contract ended.
    - Commissioner Redmer asked why this procurement was not introduced to the Board in January or February. Mr. Kromm responded that the MHBE did not anticipate the need to continue this work past the end of the contract. However, the redeterminations have been a major challenge because of the transition from a paper-based process to an online process.
- Commissioner Redmer asked why this procurement is for one year and not a shorter time period. Ms. Ruppert responded that Maryland received approval from CMS for a delay in redeterminations, and CMS later informed Maryland that it needed to process 95,000 redeterminations starting in August 2014. It is difficult to predict the number of Medicaid recipients who will return, and a huge volume of redeterminations was received. The goal was to complete the redeterminations by March 31, but the workload was larger than expected. Since this Medicaid population is in a system that is ending, it did not make sense to train a new vendor. Therefore, the best approach was to enter into a procurement with the same vendor. The contract does allow the MHBE to cancel this procurement with 30 days' notice, but HCAM will also be able to assist with other workloads regarding the MAGI population.
- Secretary Mitchell expressed concern that this procurement was brought before the Board on such short notice and hopes that this does not occur again.

- Mr. Steffen asked if this procurement could be shortened at any point. Ms. Ruppert responded that the MHBE and DHMH can reassess the situation and terminate the contract as needed.
- Mr. Steffen asked how many people still need their redeterminations to be processed. Ms. Ruppert responded there are 20,000 people left, and that the 2014 redeterminations need to be completed before the 2015 redeterminations begin.
- Ms. Goldberg asked if this needs to be done at the same time as consumers are submitting their 2015 redeterminations in the new IT system. Ms. Ruppert confirmed that simultaneous redeterminations are occurring in three systems: the existing Medicaid system, the new IT system, and the primary adult care (PAC) system.
    - Ms. Goldberg asked if this procurement with HCAM is because HCAM has the expertise to process these redeterminations in the existing Medicaid system. Ms. Ruppert confirmed this. Ms. Goldberg emphasized the importance of processing consumers' redeterminations in a timely manner so that they can keep their coverage
- Chairman Gaskin asked if HCAM can assist with the other workloads. Ms. Ruppert responded that after HCAM finishes the redeterminations, they can assist with the other workloads regarding the MAGI population.
- Chairman Gaskin asked whether another procurement will be needed next year. Ms. Ruppert responded that this is a one-time procurement, and it is not expected to be needed next year.
- Dr. Gourdine commented that it is important to develop a strategy to prevent this from happening again. Ms. Ruppert responded that the enrollees will be moved from the old systems into the new IT system, so it will not need to be done again. Mr. Kromm responded that all Medicaid recipients will be in the same IT system, so other consumer assistance workers will be able to assist.
- Dr. Gourdine asked for status reports on the success of the data conversions. Ms. Ruppert clarified that the data is not being converted; the applicants will apply through the new IT system.
    - Chairman Gaskin commented that the old IT system did not allow any data to be transferred to the new system, including both QHP and Medicaid recipients. This procurement is to enter the data of the Medicaid population into the new IT system.

Mr. Steffen motioned to approve the procurement with HCAM, which was seconded by Dr. Benjamin. The Board voted unanimously to adopt the motion.

Dr. Benjamin asked if the MHBE staff can compile a list of all the contracts for the Board to review so that they do not encounter this problem again. He commented that, now that the IT system is established and functioning well, the MHBE has the opportunity to spend more time deliberating contracts. Secretary Mitchell agreed with this suggestion.

Leslie Lyles Smith, Director of Operations at the MHBE, and Alan Pack, Chief Financial Officer at the MHBE, presented the second motion for the board to consider: whether to approve the fourth quarter award to the Connector Entities. Mr. Pack explained that the MHBE originally planned for the Connector Entities to receive $25 million for the 2015 fiscal year. However, the need to create a new IT system while still operating the legacy system reduced the budget. As a result, the MHBE decided to award the Connector Entities on a quarterly basis rather than for a full year. The motion before the Board is whether to approve an award of $4.1 million instead of the anticipated $5.1 million to the Connector Entities for the fourth quarter of the 2015 fiscal year.

- Ms. Goldberg asked for an explanation of the $1 million budget cut. Mr. Pack responded that the MHBE did not anticipate creating a new IT system, and the current problems with the state budget prevented the MHBE from receiving a full budget. Therefore, the MHBE had to readjust its budget, and this resulted in a reduction of the Connector Entities' funding.
- Ms. Goldberg asked if the Connector Entities are aware of the budget cut. Mr. Pack responded that the Connector Entities have received frequent updates on the budget situation. The MHBE is anticipating lower rates for the 2016 fiscal year as well—approximately $3 million per quarter.
- Chairman Gaskin asked how the budget cut will affect services to consumers. Ms. Lyles Smith responded that the larger Connector Entities will be able to absorb the costs and use carryover funds from previous quarters, while the small Connector Entities may have to reduce staff or navigators.

- Mr. Steffen asked if the need for consumer assistance will naturally decline since two open enrollments have passed and consumers have become more familiar with the system. Ms. Lyles Smith responded that there may be less need for outreach, but some consumers will continue to have questions about the system and using health insurance. Ms. Quattrocki added that the remaining uninsured are the consumers that are the hardest to reach and will require additional assistance.
- Mr. Apfel commented that he understands the rationale for reducing the funding, but the MHBE may need to revisit this over the next few years to reassess Maryland's consumer assistance needs.
- Commissioner Redmer asked if the $4.1 million is part of an existing contract, and if so, why does it require Board approval. Mr. Pack responded that the contract is structured to grant awards on a quarterly basis, and since there is a reduction for the fourth quarter, the MHBE staff wanted to receive Board approval.
    - Mr. Redmer asked if the same Connector Entities are contracted for the 2016 fiscal year. Ms. Lyles Smith responded that it will be the same Connector Entities if they all choose to continue.

Commissioner Redmer motioned to adopt the recommendation, which was seconded by Mr. Apfel. The Board voted unanimously to adopt the motion.

Mr. Pack and Ms. Lyles Smith presented the third motion for the board to consider: whether to approve an increase in the budget for the sole source procurement with Sir Speedy. Mr. Pack explained that the MHBE contracts with Sir Speedy to provide printing services for notices. He noted that the original contract with Sir Speedy did not factor in the costs for postage. The motion for the Board to consider is whether to approve a $360,000 increase in the Sir Speedy budget for a total of $810,000.

- Commissioner Redmer asked why there is a need for a sole source procurement for printing services. Ms. Lyles Smith responded that Sir Speedy was an integrated solution in the system from Connecticut. Sir Speedy handles the notices, and the system is already set up to produce the information for the notices.
- Commissioner Redmer asked which vendor performed printing services for the notices last year. Ms. Lyles Smith responded that notices were not printed last year because Maximus was originally supposed to print notices, but that never came to fruition due to problems with the old IT system.
- Commissioner Redmer asked about the status of the option to renew this procurement in July. Ms. Lyles Smith responded that the MHBE is planning to renew the contract in July.
    - Secretary Mitchell asked for an update on this to be brought before the Board in April or May.
- Dr. Benjamin asked if there is a technical reason to continue to use Sir Speedy. Mr. Muniasamy confirmed that there is a technical reason, but the MHBE is in discussion with DHR to use a different vendor, and it is expected to take six to eight months to implement this solution.
- Dr. Benjamin asked if there is an opportunity to save money on the mailing of the notices. Ms. Lyles Smith responded that Sir Speedy uses another vendor to find the best possible price for mailings.

Dr. Benjamin motioned to adopt the recommendation, which was seconded by Chairman Gaskin. The Board voted unanimously to adopt the motion.

Mr. Pack and Ms. Lyles Smith presented the last motion for the Board to consider, whether to approve the MHBE joining the executive branch agencies' master contract for landlines negotiated by the Maryland Department of Information Technology (DoIT). Mr. Pack explained that the MHBE is not currently a party of the master contract. However, the MHBE has submitted a request to join the master contract. The MHBE also inquired about a separate contract with Verizon, but determined that this option would be more expensive than the DoIT master contract. The motion before the Board is whether to approve joining the master contract.

- Secretary Mitchell asked what the MHBE did last year. Mr. Pack responded that the MHBE participated in the master contract because the MHBE was part of DHMH. This year, the MHBE is an independent agency, and, due to an oversight, it was not included in the master contract.
    - Secretary Mitchell asked how the price compares to last year. Mr. Pack noted that the cost of participating in the master contract is the same as last year.
- Commissioner Redmer asked how the MHBE knows that the master contract is the best price and whether it looked outside of Verizon. Mr. Pack responded that the MHBE did not look outside of Verizon, but they know that DoIT negotiated for the best price for the master contract.
    - Commissioner Redmer commented that calling Verizon for a quote regarding landlines does not qualify as due diligence.

Dr. Gourdine motioned to adopt the recommendation, which was seconded by Mr. Steffen. The Board voted unanimously to adopt the motion.

Essential Health Benefits for 2017

Mr. Kromm provided an update on the selection of an EHB benchmark for 2017. He explained that the EHB establishes a minimum set of benefits that QHPs must offer and includes 10 coverage categories. The current EHB benchmark was selected in 2012 through a process that included broad stakeholder input. The largest small group plan was selected as a benchmark. Maryland choose to add coverage for in vitro and hair prostheses in the individual market, and enhanced mental health and substance use disorder services, adult habilitative services, and pediatric vision and dental benefits to comply with federal law.

Mr. Kromm reported that the 2016 Notice of Benefit and Payment Parameters released in February addresses the selection of a 2017 EHB. These rules define habilitative services, add more specific requirements for the pharmacy benefit, and set the pediatric age limit at 19. HHS wants states to select a new EHB by the fall using 2014 plans to provide carriers enough time to make changes for 2017 QHPs. HHS will provide a list of benchmark plans later this summer from which states can choose. Mr. Kromm provided a brief overview of the proposed legislative approach for selecting a benchmark plan. He noted that legislation is necessary to authorize EHB selection, and a potential approach is to grant the Board the authority to select the EHB benchmark. The MIA, MHCC, and DHMH are represented on the Board, and the SAC could be used to involve stakeholders in the decision. A proposed amendment to the MIA department bill would establish this authority. Mr. Kromm proposed that the MHBE staff pull together a timeline for analysis and selection of a benchmark by the next Board meeting.

Reinsurance for 2016

Ms. Eberle provided an overview of the 2016 reinsurance proposal. Ms. Eberle noted that there is authority to use MHIP funds for the reinsurance program, and both MHIP and the Board have the authority to determine the amount of money to be used. The MHIP surplus funds come from hospital assessments. The Budget Reconciliation and Financing Act of 2014 reduced hospital assessment from 1 percent to .3 percent of net patient revenue for the period from October 1, 2014 through June 30, 2015. The surplus will be suspended as of Jun 30, 2015, with an amount of $83 million, excluding earmarked funds. The federal reinsurance attachment point in 2015 was $70,000 with a cap of $250,000 and a coinsurance of 50 percent. Maryland lowered the 2015 attachment point to $45,000 and supplemented the federal coinsurance rate, increasing it to 80 percent.

Ms. Eberle reported that the proposal is to continue in 2016 to provide supplemental coinsurance to ensure carriers receive a total 80 percent coinsurance for an attachment point between $45,000 and $90,000. She explained that there is sufficient funding for this, and CMS will conduct the audit of claims and provide a summary claim report, so there is limited administrative burden in Maryland. The rationale is that this will help carriers keep their rates at reasonable levels. Ms. Eberle noted that MHIP has postponed making a decision regarding the 2016 reinsurance program until a conference call can be held next week regarding the budget.

- Secretary Mitchell commented that there have been mixed message from the legislature regarding this program. He recommended waiting for the budget conference call. Ms. Eberle noted that rates have to be filed by June 1.

- Mr. Steffen suggested asking The Hilltop Institute for a confidence range regarding the estimated costs of the proposed attachment points. Ms. Eberle responded that the MHBE asked The Hilltop Institute to revise their estimates for 2016 using 2016 medical ratings.
- Mr. Redmer asked how long the run out of MHIP is expected to last. Ms. Eberle responded that she will be addressing the MHIP run out next.

MHIP MOU with MHBE

Ms. Eberle reported that MHIP is predicted to end in December 2015 because the MHIP policies ended in December 31, 2014. Medical claims must be filed within six months, and pharmacy claims must be filed within a year. MHIP will completely closed by June 30, 2016. The MHIP Board approved a transition plan last year; the transition plan included a detailed timeline and a recommendation that the MHIP final operations be moved over to the MHBE. There will be a bill proposed during the next legislative session to do that formally. Ms. Eberle noted that the MOU before the Board is to strengthen the relationship between the MHBE and MHIP. In the transition plan, four positions have been identified that can be moved over to the MHBE. The MOU also formalizes that, prior to the official transfer, MHIP and the MHBE will share resources and staff, as well as office space and equipment. Four of the six staff at MHIP will transfer to the MHBE after MHIP ends. Ms. Eberle reported that legal staff have reviewed the MOU for legal sufficiency and returned it to the Board for approval.

Dr. Benjamin motioned to approve the MOU, which was seconded by Mr. Apfel. The Board voted unanimously to approve the MOU.

Adjournment

Chairman Gaskin noted that the Board took no action during the closed session regarding to the legal advice they received related to potential litigation. Commissioner Redmer motioned to adjourn the meeting, which was seconded by Ms. Goldberg. Chairman Gaskin adjourned the meeting.