



MHBE

2024 Value Plan Workgroup

June 11, 2024

12:00PM – 1:30PM

Online Via Google Meets

Members Present:

Nikki Blake

Ken Brannan

Evalyne Bryant-Ward

Steven Chen

Matthew Celentano

Ashton DeLong

Brian Espindola

Emily Hodson

Justin Giovannelli

Brandy Guy

Allison Mangiaracino

Kathleen McGuire

Tim Ross

Lisa Solomon

David Stewart

Adam Zimmerman

Staff

Becca Lane

Amelia Marcus

Members of the Public

None

Welcome and Introductions

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), welcomed everyone to the first meeting of the 2024 Value Plan Workgroup. All members present introduced themselves. Evalyne Bryant-Ward, Emily Hodson, and Allison Mangiaracino are co-chair candidates.

Background and Overview of Workgroup Goals

Ms. Lane started with an overview of the MHBE, which is a state-based health insurance marketplace/exchange that launched in 2014. The MHBE operates the Maryland Health Connection (MHC) enrollment platform, and its authority includes conducting outreach and enrollment activities, enhancing the MHC to improve the enrollment experience, setting plan certification standards for individual plans sold through the MHC, and administering affordability programs such as the reinsurance and young adult subsidy programs. The purpose of the MHBE includes reducing the number of uninsured Maryland residents, facilitating the purchase and sale of qualified health plans (QHPs) in the individual market, and assisting individuals in accessing public programs, premium tax credits, and cost-sharing reductions (CSRs).

Ms. Lane then provided an overview of the MHBE's affordability initiatives, which include the reinsurance program and the young adult subsidy program. The reinsurance program reimburses insurers for a portion of their claims costs, and the lower costs allow insurers to charge lower premiums. As a result of the reinsurance program, rates

have decreased more than 20% compared to 2018 and enrollment has increased. The young adult subsidy program started in 2022 and is a state-funded premium subsidy pilot to reduce the amount young adults pay for health plans. Over 44,000 young adult enrollees are receiving an average subsidy of \$38 per month, and young adult enrollment has increased 41% year-over-year. Ms. Lane reported that Maryland's lowest cost plans are 25% to 35% lower than the average premiums nationwide.

Ms. Lane then provided an overview of the history of value plans, which are plans with standardized cost-sharing determined by the MHBE. Carriers must offer one value plan at each of the bronze, silver, and gold metal levels. The goals of the value plans are to improve health care access and affordability, promote insurer competition, and simplify plan shopping. Ms. Lane provided an overview of past Workgroup recommendations, which include the launch of value plans in 2024 and a new limit of three plans per metal level to be implemented in 2025. Ms. Lane showed an excerpt of 2025 value plan standards and an example of diabetes cost-sharing for 2025 value plans. She noted that value plan enrollment decreased in 2024. MHBE has value plan-specific shopping tools. Please see the presentation slides for more details.

Ms. Lane explained that the Workgroup objectives are to recommend updates to value plan standards for 2026 and beyond, including recommendations on changes to cost-sharing that promote affordability of commonly used services but do not exceed actuarial value (AV) constraints and recommendations on whether and/or how to make changes to support health equity and align with statewide health goals.

Discussion

Ms. Lane posed two questions to the Workgroup for discussion. She asked the Workgroup members about their initial impressions and opinions about adding \$0/reduced cost-sharing for another high-disparity condition versus keeping copays low for other commonly used services. She asked about other ideas for value plans in 2026 and beyond.

Lisa Solomon commented that United Healthcare offers a zero deductible bronze plan that allows enrollees to receive certain services such as MRIs before meeting the deductible, so even though it has higher co-pays than the value plan it may be more appealing to consumers. Ms. Lane thanked Ms. Solomon for her comment and agreed that benefits such as this may be more attractive to consumers than the value plans. Ms. Solomon also noted that a consumer's health needs are a factor in plan selection.

David Stewart agreed that in general the bronze plans were more attractive to consumers this year and noted that the value plans may stand out more next year when the three-plan limit goes into effect. Ms. Lane asked Mr. Stewart for more information regarding consumers' preference for bronze plans this year. Mr. Stewart responded that in general the bronze plans had more pre-deductible care and the premiums were lower. The bronze plans were more appealing to younger and healthier consumers and there are more young adults enrolling in coverage through the exchange.

Mr. Celentano noted that individuals who were disenrolled from Medicaid for ineligibility during the public health emergency (PHE) unwinding may have received large subsidies that they used to enroll in more generous plans rather than the value plans. He asked if there have been any analyses regarding the PHE unwinding. Ms. Lane responded that the MHBE has not conducted any analyses regarding this issue, but she will look into it.

Mr. Celentano commented that lower value plan enrollment may indicate that consumers are able to enroll in more generous plans due to subsidies. Ms. Lane responded that this was a good point, and it is likely that eligible consumers would opt for a more generous silver plan with CSR over a value plan.

Mr. Celentano noted that people who were disenrolled from Medicaid due to ineligibility probably have low household incomes and would be more likely to enroll in gold plans.

Mr. Stewart added that it is a challenge to educate consumers on the value of CSR when the premiums of the plans with CSR are equivalent or higher than similar plans without CSR. Specifically, consumers may not be aware that the monthly premium cost does not indicate the full cost paid over the year after receiving services. Mr. Stewart stressed the importance developing strategies to educate consumers about the value of CSRs.

Ms. Bryant-Ward asked if there is any data available regarding the performance of enrollees with high-disparity conditions or the positive impact of zero cost-sharing for high-disparity conditions. She explained that she monitors the quality metrics for her medical group, and the biggest challenge they face is patients with hypertension and diabetes not being compliant with treatment plans. Ms. Lane responded that they do not currently have this data. She noted that there are two possible reasons for eliminating cost sharing for high-disparity conditions, which are to change patient behavior and be more equitable. Another consideration is the amount of time it takes for interventions for high-disparity conditions to show improvements in the patient health data. Ms. Lane explained that the MHBE collects carrier accountability reports for the reinsurance program and the MHBE looks at whether any of the carrier's care management initiatives such as diabetes management have an impact on the cost of care. So far, the MHBE has found that the time scale may be too short to see the impact of care management initiatives in the form of significant cost savings. Ms. Lane noted that while data on this issue is not currently available, she can look at the experience of other states who have added more high-disparity conditions and report back to the Workgroup during a future meeting.

Mr. Stewart suggested taking a more holistic approach instead of picking specific conditions for reduced cost sharing since people with high-disparity conditions such as diabetes may have other intersecting conditions.

Ms. Hodson suggested keeping general co-pay levels low for all services and conditions because there are so many high-disparity conditions that require different services and specialists. Ms. Lane responded that Washington has taken this approach with

standardized plans where there are \$1 co-pays for the first two primary care and mental health care visits.

Ms. Bryant-Ward agreed with Ms. Hodson that often patients have multiple co-morbidities that can make treatment more difficult. There may also be socio-economic factors that impact patients so it would be beneficial to keep co-pays low because patients may need a number of services and specialists. Ms. Lane responded that she is hearing agreement from members that keeping co-pays levels low will help enrollees manage conditions.

Justin Giovannelli recommended the Workgroup discuss this issue more in the future with specific examples, focusing on the trade-offs.

Tim Ross commented that cost is a huge factor in patient treatment compliance, but it is not the only factor and other social determinants of health have an impact. He suggested the Workgroup have the flexibility to discuss improving patient compliance through enhancing other factors.

Ms. Mangiaracino commented that regarding zero cost-sharing for high-disparity conditions, the other consideration is that it requires identifying specific diagnosis codes which can be administratively complicated. She also recommended that the Workgroup discussions and recommendations account for the essential health benefits non-discrimination rules, which prohibit discrimination based on age and chronic conditions.

Ms. Lane asked Ms. Mangiaracino about her experience with the District of Columbia (DC) exchange, which has added many high-disparity conditions with reduced cost sharing and whether it has been difficult to implement administratively. Ms. Mangiaracino responded that Kaiser Permanente is still working on the member experience from a coding perspective, and it can be difficult when a patient has multiple co-morbidities to correctly code a visit so that the patient gets the appropriate reduced cost sharing. The other issue is that Kaiser does not have a way of communicating these benefits in the summary of benefits and coverage, which is in a federally mandated template that does not give the option of adding certain line items.

Ms. Lane summarized the discussion. The Workgroup discussed learning from other state experiences, having a holistic approach due to the prevalence of co-morbidities, the administrative burden of reduced cost sharing for specific conditions, and the factors contributing to lower value plan enrollment.

Next Steps

Ms. Lane explained that the Workgroup will vote on the co-chairs and bylaws through an online survey. The next meeting is on June 25, and regular meetings will continue through August with a vote to finalize recommendations on September 3. The Workgroup will reconvene in December 2024 after the AV calculator is published.

Public Comment

Adam Zimmerman with the Maryland Insurance Administration explained that the draft version of the actuarial value (AV) calculator is not released until November. He noted that there may not be any changes that are needed for cost sharing for next year if the maximum out-of-pocket amount is increased by the federal government.

Adjournment

The meeting adjourned at 1:01 PM.

Chat Log

N/A