



## MHBE

### 2024 Value Plan Workgroup

June 25, 2024

12:00PM – 1:30PM

Online Via Google Meets

#### **Members Present:**

Nikki Blake

Ken Brannan

Evalyne Bryant-Ward

Matthew Celentano

Steven Chen

Ashton Nicole DeLong

Brian Espindola

Brandy Guy

Justin Giovannelli

Emily Hodson

Stephanie Klapper

Allison Mangiaracino

Kathleen McGuire

Lisa Solomon

David Stewart

#### **Staff**

Becca Lane

Amelia Marcus

Pooja Singh

Amy Barley

Andrew York

Michele Eberle

#### **Members of the Public**

Kakia Prasad

Kerry Vayda

#### **Welcome and Introductions**

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), welcomed everyone to the second meeting of the 2024 Value Plan Workgroup. She provided an overview of the Workgroup objectives and meeting agenda.

Ms. Lane then reported the results from the online survey regarding the charter and co-chairs. The Workgroup approved the charter and appointed Evalyne Bryant-Ward and Emily Hodson as the co-chairs. David Stewart moved to approve the minutes of the June 11, 2024 Value Plan Workgroup meeting as presented. Ms. Bryant-Ward seconded the motion. The Workgroup unanimously approved the minutes.

#### **Equity-Focused Standardized Plan Features from Other States**

Ms. Lane explained that plan features can be aligned with Maryland's Statewide Integrated Health Improvement Strategy (SIHIS) to ensure that the value plans address Maryland's health needs. She provided an overview of the SIHIS population health focus areas which include diabetes, opioid use disorder, and maternal and child health.

Ms. Lane shared examples of service-specific reduced cost sharing in the following states: Washington, Connecticut, and Colorado. Washington implemented a \$1 copay

for the first two primary care visits and the first two mental health office visits. Connecticut implemented low, pre-deductible copays for laboratory services. Colorado implemented \$0 copays for office visits commonly used to manage chronic conditions and high disparity conditions such as primary care, behavioral health, and substance use disorder visits. Please see the presentation slides for more details.

Evalyne Bryant-Ward asked if it is possible to have reduced cost sharing for annual visits instead of a \$1 copay for the first two primary care visits. Mr. Stewart responded that the annual wellness visit does not have cost sharing and there are also preventive services available without cost sharing, but the challenge is encouraging individuals to utilize these services as they may not be aware of it.

Ms. Lane then provided an overview of condition-specific reduced cost sharing, which has been implemented in Washington, DC standard plans. DC has \$5 pre-deductible copays for pediatric mental health visits and prescriptions as well as no cost sharing for cardiovascular and cerebrovascular care. Ms. Lane reported that Massachusetts has \$0 copays for certain drugs for conditions with a disproportionately high impact on communities of color such as diabetes, hypertension, coronary artery disease, asthma, and substance use disorder.

Mr. Stewart noted that it would be beneficial to have clinical guidance on these cost sharing strategies and potential impacts. He commented that it is very difficult for individuals to access substance use disorder (SUD) treatment through private insurance compared to Medicaid recipients. For example, methadone clinics in Mr. Stewart's region do not accept private insurance. He explained that it is important to consider the availability of providers and services while examining cost sharing strategies.

Nikki Blake asked for data on the impact of the cost sharing strategies implemented by the other states. She noted that it would be difficult to implement Washington state's approach of service-specific cost sharing based on the number of visits.

Ms. Hodson commented that if the cost sharing reduction requires certain diagnosis codes, it may be difficult to train providers and their billing teams on how to correctly record the diagnosis codes so that the cost sharing reduction is applied to the visit.

Allison Mangiaracino agreed with Ms. Hodson and explained that in her experience with the DC standard plans, the diagnosis code must be listed first as the primary diagnosis for the cost sharing to apply which has been a challenge for carriers to implement. Service-specific cost sharing would be easier to implement and more equitable. Ms. Mangiaracino expressed concern about choosing a small number of conditions for reduced cost sharing when there are several high disparity conditions.

Matthew Celentano commented that some people think DC's condition-specific approach is ineffective in addressing health equity. He also noted that consumers may find the differences in cost sharing based on diagnosis code confusing. Mr. Celentano

explained that, from the carrier perspective, the service-specific reduced cost sharing has been more effective and falls in line with the MHBE's past policy approach.

Mr. Stewart commented that consumers may understand service-specific reduced cost sharing more easily. He also noted that in the past he worked with the billing team at a community health center to maximize the center's revenue and he found it very helpful when some carriers provided information on the proper way to code. He agreed that billing and coding on the provider's side can be complicated so it may be difficult to implement condition-specific reduced cost sharing.

Kathleen McGuire noted that reduced cost sharing for labs may be appealing from both the consumer standpoint and a health equity perspective because consumers with certain conditions such as diabetes may need regular lab work. She noted that unexpected high copays for lab work could be a barrier for many consumers.

Ms. Bryant-Ward commented that the large number of value-based care plans in Maryland has resulted in improvements in health literacy and coding quality so she believes that coding would not be a barrier to implementing condition-specific cost sharing. She agreed that reduced cost sharing should be targeted to where consumers are feeling the most impact. She noted that copays for office visits are already low so reduced cost sharing for lab work and radiology may have a bigger impact, particularly for consumers with multiple comorbidities and chronic conditions.

### **2024 Plan Comparisons**

Ms. Lane then presented a comparison of the highest-enrollment gold and bronze plans to the gold and bronze value plans. She also showed a comparison table of the \$0 deductible bronze plan and bronze value plan. Please see the presentation slides for more details.

Justin Giovannelli asked if the difference in enrollment between the high enrollment plans and value plans is driven simply by the premium. He asked for more information on this issue. Ms. Lane responded that she would look into it but noted that premiums for value plans are similar to the other plan premiums.

Mr. Stewart commented that consumers generally focus on the premium first and the deductible is less of an issue. He explained that, for gold plans, many services are available pre-deductible so the deductible is a smaller issue for consumers, but makes a bigger difference for silver and bronze plans. Mr. Stewart commented that, in his region, consumers are gravitating towards the carrier with the lowest premiums. He added that it is difficult for consumers to go through a large number of plans so the new limits on the number of plans carriers may offer could help consumers better navigate the plans. He asked for more enrollment data by age and metal tier to see whether more young people are enrolling in bronze plans. Ms. Lane responded that the MHBE plans to do more enrollment analysis regarding age and income.

Mr. Stewart added that older people are more likely to have co-morbidities. He asked for data analysis assessing whether this population is enrolling in the plans that best fit their needs to determine if further education of older adults is needed. He explained that navigators routinely face the challenge of informing consumers that the premium is not necessarily an indicator of the total annual cost for a plan and that cost sharing should be considered.

### **Discussion**

Ms. Lane posed the following discussion questions to the Workgroup. Which of the ideas from other states, if any, would you like to see reflected in the draft designs? Which services, conditions, or drugs (if any) should be prioritized if MHBE adopts one of the cost-sharing reduction approaches from other states? What are your impressions of the value plan vs. popular plan comparisons? What changes, if any, would you like to see prioritized in draft designs for plan year 2026?

Ms. Bryant-Ward expressed interest in more information regarding the carriers' performance in serving the enrollee and paying claims. She explained that, when trying to address problems or denials with United Healthcare, she finds it challenging to find the right customer service representative because there are so many United plans. Ms. Lane responded that this issue falls outside of the scope of the workgroup but thanked Ms. Bryant-Ward for sharing that concern.

Ms. Lane summarized that she is hearing members express support for service-specific reduced cost sharing, specifically reduced cost sharing for labs, and a desire for hearing a clinical perspective on cost sharing for health equity.

Mr. Stewart commented in response to Ms. Bryant-Ward's concern that the Maryland Insurance Administration (MIA) will be the best resource for information regarding carrier performance. He added that during the recent legislative session, parity legislation was passed that has required reporting on behavioral health services so there may be more information available in the future through the MIA.

### **Next Steps**

Ms. Lane explained that the next Workgroup meeting is on July 23 because the July 9 meeting is cancelled. She explained that the upcoming meetings will focus on the plan design drafts.

### **Public Comment**

No comments offered.

### **Adjournment**

The meeting adjourned at 12:45 PM.