



MHBE

2024 Value Plan Workgroup

July 23, 2024

12:00PM – 1:30PM

Online Via Google Meets

Members Present:

Richard A. Amador

Nikki Blake

Ken Brannan

Evalyne Bryant-Ward

Matthew Celentano

Steven Chen

Ashton Nicole DeLong

Brian Espindola

Brandy Guy

Justin Giovannelli

Stephanie Klapper

Allison Mangiaracino

Kathleen McGuire

Lisa Solomon

David Stewart

Tim Ross

Staff

Becca Lane

Amelia Marcus

Pooja Singh

Andrew York

Brad Boban

Michele Eberle

Members of the Public

Jennifer Storm

Becca Lane, Senior Health Policy Analyst at the Maryland Health Benefit Exchange (MHBE), welcomed attendees to the meeting.

Ms. Lane noted that the Workgroup's focus is on the Value Plan standards for 2026 and described the agenda for this meeting. She stated that the MHBE is still working on the additional data analysis that the group requested and will present it at a future meeting but noted that those analyses will not impact the plan designs for 2026.

Evalyne Bryant-Ward asked for confirmation that this means the Workgroup can decide on the 2026 Value Plan standards as long as all of their questions are answered during the meeting today. Ms. Lane replied in the affirmative.

Ms. Bryant-Ward noted the deadline of September 3, 2024, and the subsequent Standing Advisory Committee meeting on September 12, 2024, stating that deciding during the meeting would be desirable, as any information presented after this meeting will only serve to assist with decision-making on future plans, not on these ones.

Ms. Lane noted that some Workgroup members may want to take time to digest the designs discussed in today's meeting but agreed that expediency is important for these decisions.

Lisa Solomon shared input from her broker colleagues. First, she noted that brokers lean toward plans from one carrier due to the \$0 copay for mental health coverage, while some plans have copays as high as \$75 per mental health visit, a significant disparity in cost for those having mental health visits weekly. Another broker concern was the lack of mental health providers available between carriers: some mental health providers only accept CareFirst. Finally, brokers asked whether Maryland Health Connection (MHC) has a limit for the copay amounts allowed for chronic illness, similar to the \$35 per month limit placed on diabetes medications for Medicare.

Ms. Lane agreed that it is unfortunate that some plans require members to pay more for mental health care than others but noted that all Value Plans have pre-deductible cost sharing for mental health care, with no more than a \$35 copay. She explained that some states standardize all their state exchange plans, giving them full control over cost sharing for all their plans, and that this could be an option for Maryland in the future, noting that setting plan certification standards is a lever available to influence cost sharing in the meantime; she suggested that the Standing Advisory Committee can discuss the issue. She acknowledged the limited availability of mental health care in some plans, remarking that limited network availability undercuts the utility of low cost sharing, and noted that the issue could be discussed in another setting. Finally, she explained that she does not think there is a cap on monthly chronic medication cost like the one that exists for insulin but expressed interest in the idea and stated that she can investigate it.

Approval of Meeting Minutes

Ms. Bryant-Ward moved to approve the minutes of the June 25, 2024, Value Plan Workgroup Meeting as presented. David Stewart seconded. The Workgroup voted unanimously to approve the minutes.

First Draft: 2026 Value Plan Designs

Ms. Lane presented on the first draft of the 2026 Value Plan designs. Detailed slides are available in the presentation for this meeting. She noted that the Workgroup has previously discussed following Connecticut's lead by reducing cost sharing for laboratory services rather than for additional conditions. She cited Washington, D. C.'s having raised cost sharing for standard types of care to compensate for reduced cost sharing for some conditions, along with the logistical challenge of relying on diagnosis codes to ensure accurate coverage. The Workgroup has expressed interest in reducing copays for laboratory services given that those with multiple comorbidities and chronic conditions are likely to use them frequently. The MHBE's actuaries produced new versions of the Value Plan designs with reduced costs for laboratory services. For the Gold plan, the Workgroup can either keep the laboratory services copay at \$25 or reduce it to \$20 but increase the specialist copay from \$35 to \$40. For the two most generous Silver cost sharing reduction (CSR) plans, the laboratory services copay could not be lowered due to Actuarial Value (AV) constraints. For the Silver 73, Base Silver, and Bronze plans, the laboratory services copay was reduced from \$80 to \$45.

Ms. Lane continued by noting some considerations when looking at the draft plan designs. The draft 2026 designs are based on the final 2025 designs, allowing the Workgroup to focus on just a few issues since most of the work of balancing copays was done last year. Additionally, the AV calculations have accounted for the continuation of reduced cost sharing for diabetes care management. There are also more standardized service categories to discuss at the next meeting, since they are not part of the AV Calculator. Ms. Lane also gave the caveat that designs may need to be adjusted based on the 2026 Draft AV Calculator scheduled for a December release.

Next, Ms. Lane showed a table comparing the final 2025 Gold Value Plan design to the two options for the 2026 plan design. She then showed views comparing the final 2025 plan design to the draft 2026 plan design for the Silver 73, Base Silver, and Bronze plans, noting that each has a small AV increase associated with decreasing the laboratory services copay from \$80 to \$45 but that it still allows for the reduced diabetes cost sharing to remain in place.

Ms. Bryant-Ward asked for confirmation that one of the options for the Gold plan raises the deductible for specialist visits by \$5 and decreases the copay by \$5 for laboratory visits, meaning the changes are essentially equivalent. Ms. Lane replied in the affirmative.

Ms. Bryant-Ward noted that it may not make much of a difference, as the Workgroup does not know whether enrollees will use more specialist visits or laboratory services.

Stephanie Klapper commented that she imagines seeing the specialist visit number rise from \$35 to \$40 may feel like a large jump for consumers, while the decrease from \$25 to \$20 would feel less significant, indicating that the typical consumer would likely prefer specialist visits and laboratory services to remain at \$35 and \$25, respectively. Ms. Lane noted that Ms. Klapper's point speaks to the value of continuity in coverage year-to-year.

Michele Eberle, Executive Director of the MHBE, asked whether the MHBE has access to utilization data indicating whether specialist or laboratory visits are used more commonly among Gold plan users. Ms. Lane responded that she would investigate the question.

Ms. Eberle also asked whether any of the carrier representatives participating in the meeting have seen participants in their Gold on-exchange plans use either specialist visits or laboratory services more frequently.

Nikki Blake asked to what degree the AV for each plan being discussed is expected to shift based on these updates, noting that changes may be necessary once the 2026 Draft AV Calculator is released. Ms. Lane replied that they used the 2025 AV calculator to approximate each plan's AV, but they will run the plan designs through the 2026 Draft AV Calculator once it is released, after which the Workgroup will likely need to have an ad hoc meeting in December or January to discuss any necessary changes.

David Stewart commented that he sees the costs for Gold plans as a lesser concern because few cost-conscious consumers enroll in Gold plans, and the more pressing concern is making sure that qualifying consumers stay enrolled in Silver plans that grant them CSRs, especially those with the highest levels of CSRs. He also expressed uncertainty over whether the aim is to drive people to the Value Gold plans rather than the other Gold plans. He stated that the Workgroup will be looking in a context where there will be fewer plan designs to choose from, making comparisons easier. Matthew Celentano agreed with Mr. Stewart's points.

Ms. Lane commented that the group seems unconcerned about the Gold Value plan, so it might make sense to leave as-is. She asked for the Workgroup's thoughts on the Silver plan designs.

Ms. Solomon agreed with Mr. Stewart's point but noted that sometimes she enrolls people in a Gold plan rather than the Silver 73 plan because the cost sharing reduction is not as valuable due to the Gold plan's lower premium. She also expressed interest in the Bronze plan's copays. She voiced her support for decreasing the laboratory services copay from \$80 to \$45 in the Silver 73, Base Silver, and Bronze plans but expressed concern about the \$750 drug deductible present in some of the plans, commenting that these may be brand-name drugs for chronic conditions. Ms. Lane acknowledged the deductible is unfortunate but stated that the Silver 73 and Base Silver plans are the lowest-enrollment Silver CSR variants, which limits the deductible's negative impact.

Mr. Stewart commented that people are effectively being discouraged from the Base Silver and Silver 73 plans but noted that may not be a bad thing because the premiums are lower in a Gold plan and because carriers, especially United, have had especially competitive Gold plans this year. He asked for the drug deductibles for each plan. Ms. Lane answered that Base Silver and Silver 73 have deductibles of \$750, while Silver 87 and Silver 94 had deductibles of \$150 and \$0, respectively, in 2025, with the latter two plans set to stay the same in 2026.

Mr. Stewart expressed support for those levels of cost sharing and indicated that a major focus for health insurance stakeholders in the state has been attracting people to enroll in plans with better cost sharing despite higher premiums.

Allison Mangiaracino commented that the MHBE's Decision Support Workgroup will address how to demonstrate the value of CSR 87 and 94 plans over Gold plans. Ms. Lane agreed and stated that she can share more information about the Decision Support Workgroup.

Justin Giovannelli agreed that many enrollees may be better served in a Gold plan rather than the Silver 73 plan but emphasized that the Workgroup should still seek to make the latter the best, most affordable plan possible within the AV constraints. He noted that it may be difficult to explain the choice to reduce the laboratory services copay to \$45 while the specialist copay, which may be more important for some people,

remains \$100. He asked whether they may be able to apply a lesser reduction to both figures, expressing concern over bringing one number down so far without a basis in observed utilization. Ms. Lane acknowledged the value of this point and stated that some changes have more of an impact than others on a plan's AV, so reducing laboratory services copays may have had less impact than a similar change to specialist copays would have. She explained that the MHBE will seek utilization data to better optimize the changes and that she will discuss with the MHBE actuaries whether a middle ground could be reached wherein both numbers are reduced.

Mr. Giovannelli clarified that those numbers were just one example and that his point was to caution generally against making changes without understanding how enrollee behavior will be affected; he noted that changes to certain numbers may encourage or discourage enrollees from using certain types of care, which may or may not be the intention.

Mr. Stewart commented that consumers tend to enroll in a Gold plan rather than a Silver 94 plan because they find the best value in the Gold plan. Richard Amador agreed and noted that consumers are more likely to enroll in a Bronze value plan, with pre-deductible cost sharing available, than in a Silver 73 plan. He stated that these consumers generally have little savings available from advance premium tax credits and may even decide not to enroll in health coverage at all.

Mr. Stewart asked if the carriers have feedback on, or data on the effectiveness of, financial incentives built into plans to encourage healthy behaviors and preventive care use for enrollees, noting that they could be used to help address social determinants of health (SDOH) and that he personally finds them valuable as an enrollee. Ms. Mangiaracino responded that many of her organization's care management offerings, especially for conditions for which there exist significant health disparities, come at no cost, which is itself an incentive for an enrollee to work with providers and health education specialists on their care, with the goal of eliminating health disparities.

Mr. Stewart asked if those types of incentives exist on MHC, noting that he has never discussed those with consumers in his work as a navigator. Ms. Mangiaracino replied in the affirmative, stating that the incentives are available across all lines of business but that some clinical criteria narrow who can use those services.

Mr. Stewart suggested that efforts be made to educate consumer assistance professionals on these incentives so that the professionals can better assist the many consumers they see with significant SDOH needs. Ms. Mangiaracino replied that she can look into it.

Tim Ross expressed skepticism that incentives lowering cost sharing have a significant impact, noting that it could introduce unnecessary complexity for a population that already struggles to understand coinsurance. He expressed a preference for the simplicity of fixed cost sharing.

Ms. Eberle suggested that the incentives could be included in the annual carrier videos for consumer assistance workers.

Mr. Amador asked if Mr. Stewart is referring to incentives that lower cost sharing or perks that enrollees might receive, such as gift cards. Mr. Stewart responded that the former is his intended focus, indicating that he is thinking specifically of reduced cost sharing if enrollees in Value Plans who have a greater need for services, such as those with major SDOH needs or those with diabetes, participate in a care management program.

Mr. Amador asked for confirmation that the intention is to incentivize engagement. Mr. Stewart replied in the affirmative, offering eye exams, annual physicals, and age-appropriate preventive testing as examples of the types of behaviors to be incentivized.

Mr. Amador suggested collaborating with the health coverage assistance team, whose duties include providing health education to Marylanders.

Next Steps

Ms. Lane showed a slide containing the timeline of next steps for the Workgroup. The full slide is available in the presentation for this meeting. She gave a reminder that the next meeting is on Tuesday, August 6, 2024, at which a speaker from the Maryland Department of Health Office of Minority Health and Health Disparities will be speaking on Maryland's health equity priorities. She noted that she is hoping to have a clinician speak at the meeting as well. Finally, data analyses will be presented on premiums, utilization, and Value Plan enrollment by age and income. The September 3 meeting will be the Workgroup's last opportunity to vote on its recommendations. The recommendations established then will be the ones presented to the Standing Advisory Committee and the MHBE Board of Trustees. Then, once the Draft 2026 AV Calculator is released in December 2024, the recommendations will be finalized, and the MHBE Board of Trustees will vote to finalize the designs in early 2025.

Pointing to recent surveys showing low utilization among enrollees in MHC plans, Ken Brannan suggested the Workgroup may need to think through cost adjustments, as this figure may indicate the costs are not conducive to more regular utilization.

Mr. Stewart suggested examining data to determine what has affected behavior change in the past, with a focus on whether plan design can make that kind of change. He noted that he has clients who brag about never having used their plan, whereas enrollees should be using their coverage. He stated that this question may be beyond the scope of this Workgroup, but perhaps another group could address it, and stressed the importance of behavior change for those with major SDOH needs and those who may not trust the health care system. Ms. Lane agreed that this kind of analysis could be valuable but noted that a utilization analysis would need to look beyond the standardized Value Plans because they are in their first year, limiting the amount of available data.

Ms. Mangiaracino asked whether the Workgroup will be reviewing additional modeling at the August 6 and August 20 meetings, such as different cost sharing for office visits. Ms. Lane responded that she would speak to the MHBE actuaries about the impact of making other kinds of changes to the Value Plans but stressed caution due to the delicate balance of maintaining the right AV. She noted that, depending on the actuaries' responses, there may or may not be another round of designs for the Workgroup to consider. Otherwise, the Workgroup may continue discussing the designs presented today, having had a chance to think on them between meetings, in addition to the aforementioned presentations. She stated that she does not have another type of design in mind unless members feel strongly about a change they would like to see modeled.

Mr. Amador asked Mr. Brannan to share the survey he referred to that shows low utilization among MHC enrollees. Ms. Lane expressed interest as well.

Mr. Amador noted that his meetings with federally qualified health centers (FQHCs) have confirmed there is a lack of engagement. He commented that the CEO of Baltimore Medical System, the largest FQHC in the state, told him that over 30% of their clients have not been engaged, either through medical assistance programs or qualified health plans, and the two of them agreed that the issue is tied to a lack of health literacy and of education. He stated that outreach efforts fail to tie into enrollment in a way that addresses the complex forces at work.

Public Comment

No comments offered.

Adjournment

The meeting adjourned at 1:30 PM.

Chat Log

00:03:40.156,00:03:43.156

Matthew Celentano: Don't we need to adopt the minutes from the prior meeting?

00:05:24.926,00:05:27.926

Amy Barley -MHBE-: Not only medications but management tools like CGMs

00:05:48.737,00:05:51.737

Amy Barley -MHBE-: They only cover glucose monitors, and CGMs should be included.

00:08:21.120,00:08:24.120

Matthew Celentano: Insulin costs are capped in Maryland at \$30 a month

00:08:34.559,00:08:37.559

David Stewart, AHEC West: What Matt said

00:27:56.533,00:27:59.533

Allison Mangiaracino: I think MHBE's Decision Support Workgroup will address how to demonstrate the Value of CSR 87/94 over Gold Plans

00:36:18.902,00:36:21.902

Tim Ross: Sorry, my mic doesn't work with this

00:38:11.938,00:38:14.938

Tim Ross: I'm skeptical that incentives that lower cost shares actually have a big impact. Speculate that especially in this population that's unneeded complexity. Most folks struggle to understand "coinsurance". Suggest we keep design as simple as possible, i.e. fixed cost shares

00:38:56.293,00:38:59.293

Michele Eberle -MHBE-: The incentives can be included in the annual carrier videos for consumer assistance workers.

00:39:11.894,00:39:14.894

Richard A Amador: That would be helpful.

00:41:03.943,00:41:06.943

Nikki Blake - CareFirst: David, is that your experience with a marketplace plan?

00:41:24.329,00:41:27.329

David Stewart, AHEC West: nope, my work plan

00:41:43.301,00:41:46.301

Nikki Blake - CareFirst: Thanks

00:43:18.922,00:43:21.922

Ken Brannan: There are a number of recent survey that have shown lack of useage for citizens enrolled in plans through the exchange. We need to think thorough cost adjustments if they don'r really address usage.

00:43:59.200,00:44:02.200

Nikki Blake - CareFirst: Could the slides from today be sent out?

00:44:26.105,00:44:29.105

Nikki Blake - CareFirst: Thank you

00:49:19.034,00:49:22.034

Richard A Amador: Ken, could you share that survey with the group?