Maryland Health Benefit Exchange Board of Trustees

September 16, 2019
2 p.m. – 4 p.m.
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Members Present:
Robert R. Neall, Chair
S. Anthony (Tony) McCann, Vice Chair
Mary Jean Herron
Ben Steffen, MA
Dana Weckesser
K. Singh Taneja

Members Excused:
Alfred W. Redmer, Jr.
Dr. Rondall Allen

Members Absent:
Linda S. (Susie) Comer

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Andrew Ratner, Chief of Staff, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Tony Armiger, Chief Financial Officer, MHBE
Caterina Pañgilinan, Chief Compliance Officer, MHBE
Sharon Stanley Street, Principal Counsel, Office of the Attorney General
John-Pierre Cardenas, Director, Policy & Plan Management, MHBE
Aaron Jacobs, Director, Organizational Effectiveness and Human Resources, MHBE

Welcome and Introductions:

Secretary Neall opened the meeting and welcomed all participants.

Approval of Meeting Minutes

The Board reviewed the minutes of the July 15, 2019 open meeting. Ms. Herron moved to approve the minutes, and Mr. Taneja seconded the motion. The Board voted unanimously to approve the minutes of the July 15, 2019 open meeting.

Public Comment

Secretary Neall invited members of the public to offer comment. No members of the public offered comment.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle announced that the agency has hired an Information Technology (IT) Quality Assurance (QA) specialist and has an open position for an Advanced Accountant. She added that the Board is searching for a new member and that the agency is recruiting for the Director, Policy & Plan Management position soon to be vacated by Mr. Cardenas.

Next, Ms. Eberle announced that the MHBE has submitted its Managing for Results (MFR) documents to the Maryland Department of Budget and Management (DBM). The MFR documents contain performance metrics established by the MHBE itself including enrollment numbers, system enhancements, customer service, and the Maryland uninsured rate.

Ms. Eberle then explained that the Centers for Medicare and Medicaid Services (CMS), each year, conducts an open enrollment readiness review with each of the state-based marketplaces. The MHBE recently passed its review with flying colors.

Next, Ms. Eberle described the first meeting of the Easy Enrollment Advisory Working Group earlier that day. A group of more than 20 stakeholders from a broad range of interested communities gathered to develop implementation plans for the new enrollment path.

Ms. Eberle then announced that the United States Census Bureau recently released figures on the uninsured in each state, explaining that Maryland's uninsured rate declined from 6.1 percent to 6.0 percent. She pointed out that, while the decline is not statistically significant, Maryland's rate is headed downward while the nationwide rate is rising.

Next, Ms. Eberle described recent activity in the small group market, including the creation of the Small Business Health Options Program (SHOP) Advisory Committee, MHBE presentations at the Maryland Association of Counties annual meeting, meetings with Chambers of Commerce throughout the state, and work with the Realtors' Association. She announced that the agency will soon release a request for proposals (RFP) for SHOP backend services.

Ms. Eberle then explained how the MHBE is reacting to recent changes in federal policy around the public charge rule. The agency is developing marketing materials to explain what it means for consumers as well as training materials to prepare call center workers for the change.

Next, Ms. Eberle noted that the upcoming plan year will see the introduction of Value Plans with caps on deductibles and out-of-pocket costs for consumers.

Ms. Eberle then listed several states, including Maine, Nevada, New Jersey, New Mexico, and Pennsylvania, that are becoming state-based marketplaces (SBMs) and withdrawing from the federal system. She added that these states' marketplace directors are meeting with the cadre of existing SBM directors in the upcoming week.

Ms. Eberle concluded her remarks by describing the agency's preparation for the upcoming open enrollment period. Activities include updated training modules, marketing campaign, and IT enhancements in addition to the recently completed transition to the Maryland Total Human Services Integrated Network (MD THINK) platform. She noted that the MD THINK transition was not without problems, including 39 hours of downtime.

MD THINK Update

Venkat Koshanam, Chief Information Officer, MHBE

Mr. Koshanam gave the Board an update on the status of the migration to MD THINK. He expressed the agency's gratitude to the Board for its having extended the deadline for migration as well as to the MD THINK team for its efforts during the transition. He explained that, on August 29, the MHBE certified the remaining two environments nearly a month ahead of schedule, bringing to an end the first stage of the migration. With that milestone achieved, the agency has begun decommissioning the Conduent-housed hardware, expecting to complete that task in October.

Next, Mr. Koshanam gave the Board an overview of the migration effort, noting that significant progress toward operational goals have been achieved by the team. While there have been issues and areas that require improvement, he expressed confidence that the MHBE's systems will perform well. He added that there was some downtime on the system during the transition period, only a portion of which occurred on the production environments. The team from MD THINK must continue to strive toward operational maturity, stability, and reliability.

Ms. Herron asked, based on the reported 39 hours of downtime, what changes the MD THINK team has made to their approach and tactics to avoid such shutdowns in the future. Mr. Koshanam replied that one major difference between the current MD THINK host and the previous Conduent host is in response time to issues, especially given the very different skillset required between setup and operations. He listed a few behavior changes that MD THINK has committed to, including applying effort of key operations team members immediately in response to a severity 1 ticket and a focus on reestablishing system availability and uptime as opposed to root cause analysis.

Ms. Herron agreed that implementation and operations generate different cultures and expressed concern that the MD THINK culture does not include the level of urgency the MHBE requires. Mr. Koshanam answered by pointing out that implementation and operations are two different teams at MD THINK. He added that the implementation team is currently in the process of transferring their system knowledge to the operations team and that the implementation team will continue to serve as the fallback should further performance issues occur.

Mr. Steffen asked how the 39 hours of downtime were distributed across the various environments. Mr. Koshanam responded that not all of the downtime hours occurred on production. When the system went live on the first day, the consumer portal had to be taken down due to an issue. Also, in the worker portal, supervisors were unable to assign work items to workers—a function that, while

critical, did not shut down the entire system. Most of the downtime occurred in lower environments, allowing staff to contain them before they spread to production.

Mr. Steffen asked for the cumulative downtime experienced in the production environments. Mr. Koshanam answered that they were down for 4 hours in total.

2020 Plans and Reinsurance Parameters

John-Pierre Cardenas, Director, Policy & Plan Management, MHBE

Mr. Cardenas gave the Board an overview of the 2020 qualified health plans (QHPs) and the State Reinsurance Program (SRP). He began by demonstrating the impact of Value Plans combined with the SRP on the overall market, with consumers having access to before-deductible services that were unavailable in 2019, all while deductibles decline and actuarial value improves.

Secretary Neall asked that the agency improve the manner in which it communicates the availability of before-deductible services to the public. Mr. Cardenas replied that, given the public health importance of 2020 bronze-level QHPs offering consumers a vehicle through which they can both manage their chronic illnesses and save money, the MHBE's marketing budget will include these messages.

Mr. McCann asked that the Board be briefed on this marketing effort at its next meeting. Ms. Eberle replied that such a briefing is already being prepared.

Mr. Cardenas continued by reminding the Board of the background of the SRP, including its parameters, actions to date, and the cost of the previous year's SRP. He pointed out that the SRP performed better than expected in 2019, meaning federal dollars are enough to cover the costs of the entire program. The program parameters for 2020 were established in April and will not be changed.

Next, Mr. Cardenas discussed the interaction between the SRP and the federally-administered Risk Adjustment (RA) program, wherein consumers whose total claims reached the SRP threshold were likely to be covered by RA payments—a situation in which a very sick, risky consumer could be more profitable to a carrier than a healthy one. To address this distortion, the MHBE contracted an actuarial firm, Lewis & Ellis, to analyze the interaction between these two programs using three distinct methods (claims-based, adjusted claims-based, and risk-based) and recommend a dampening factor to be applied to payments under the SRP to account for the overlap with RA.

Mr. Cardenas concluded by presenting three staff recommendations to the Board. First, the staff recommend that the Board set the attachment point for the 2020 SRP to $20,000. Second, the Board should resolve that a market-wide dampening factor is necessary for the 2020 SRP. Finally, the Board should release for public comment the proposed risk-based methodology for determining the dampening factor for 2021.

Ms. Herron asked what insights the agency intends to gain from public comment. Mr. Cardenas replied that the MHBE intends to seek different perspectives, given that someone with high risk will not necessarily generate high claims.

Ms. Herron asked what program parameters might change based on the use of a risk-based approach, particularly whether the attachment point might change. Mr. Cardenas responded that the MHBE thinks the risk-based approach will provide the Board a better view of the true extent of the interaction.

Ms. Herron moved to approve the final parameters for the 2020 State Reinsurance Program in accordance with COMAR 14.35.17. The motion was approved unanimously.

State Benchmark Plan Workgroup Report

John-Pierre Cardenas, Director, Policy & Plan Management, MHBE
Leni Preston, Chair, State Benchmark Plan Workgroup

Mr. Cardenas introduced the chair of the State Benchmark Plan Workgroup and invited her to address the Board.

Ms. Preston thanked the Board and the MHBE staff for the transparent and inclusive process they employed in this effort. She noted that the group assembled to prepare the report was diverse and included experts in the appropriate domains and that they achieved consensus. Ms. Preston explained that, rather than prescribing benefits, the workgroup recommends a strategic process that encompasses legislative changes along with a number of research studies of benefit mandates, consumer understanding of insurance benefits, and the intersection of health benefits with social determinants of health.

Mr. Cardenas then gave the Board an overview of the workgroup and its report. He began with the background of the state's responsibility under the Affordable Care Act (ACA) to ensure that plans available through the marketplace offer essential health benefits (EHBs). He explained that, due to regulatory changes at the federal level, the MHBE has the opportunity to align the State Benchmark Plan (SBP) with changes in the broader healthcare landscape under the Total Cost of Care waiver.

Next, Mr. Cardenas described the workgroup's charge: to determine whether the current SBP meets the needs of the individual market, to provide recommendations on whether to change the SBP, to include feedback from the Standing Advisory Committee, analysis of the market impact of the change, and estimated costs or savings, and to provide a public comment period on release of the report.

Mr. Cardenas then summarized the workgroup's findings. In comparison with other states, Maryland's plan stands out in a number of areas. Maryland's SBP does not include weight loss programs nor routine foot care benefits, but has one of the most generous formularies nationwide and covers acupuncture without limitation. He noted that existing state law precludes Maryland from modifying the SBP without a directive from the U.S. Secretary of Health and Human Services.

Next, Mr. Cardenas laid out the workgroup's three recommendations. First, the workgroup created a philosophical approach and analytical framework against which to test options. They composed a definition of an ideal SBP and a cost/utility framework for evaluating benefits for inclusion. The report also recommends special consideration of the potentially differential impact of changes to the SBP on specific sub-populations. The second recommendation from the workgroup is that the MHBE

undertake the studies Ms. Preston referred to earlier. Finally, the workgroup recommends that Maryland's Insurance Article § 31-116 be modified to allow the SBM effort to move forward.

Ms. Weckesser noted that none of the recommended studies will look into the overall impact of the MHBE's efforts in the state and suggested that questions to that end be included in the studies. Mr. Cardenas replied that the agency has undertaken to address those questions separately from the workgroup, and that the Board will hear more information on that at its October meeting. The Hilltop Institute, he explained, will establish logic models for such evaluations. Mr. Taneja asked whether the Board will receive study concept in October. Mr. Cardenas answered that the Board will be presented with a range of possible study models from which to choose.

Ms. Herron, noting that the existing SBP was modeled on the Medicaid package of benefits, asked how proposed changes to the SBP will interact with Medicaid, especially given the population of people who cycle between Medicaid and QHPs. Mr. Cardenas replied that the interaction of the two programs will be a major consideration in any SBP decision.

Mr. McCann urged the MBHE to address the necessary legislative changes as soon as possible. Secretary Neall agreed, noting that the time of year for new legislation is at hand. Ms. Eberle and Mr. Cardenas noted that any modification to the Insurance Article will require close coordination with the Maryland Insurance Administration (MIA).

Secretary Neall offered the example of Naloxone, a medication that the Maryland Department of Health has made freely available everywhere but remains covered under the SBP. Mr. McCann suggested that the SBP cover the drug only if the state ends the subsidy. Mr. Cardenas noted that the MHBE must balance keeping costs reasonable with having a healthy future. He added that the agency will provide the Board with details of the modifications made to the SBP in Illinois.

Secretary Neall asked how the MHBE intends to address the SBP formulary. Mr. Cardenas answered that many states have hired clinicians to perform a comprehensive formulary review.

Mr. Steffen asked whether the agency has evidence that a higher number of drugs in a formulary is linked to higher drug costs. Mr. Cardenas replied that additional investigation would be necessary to make such a link. Mr. Steffen agreed, and urged the MHBE to study what constitutes waste.

Mr. McCann moved that the MHBE, in consultation with the MIA, submit to the Governor an amendment to Article 31-116 to provide the state with more flexibility to update its benchmark plan. The motion was passed unanimously.

Affordability Workgroup Report

John-Pierre Cardenas, Director, Policy & Plan Management, MHBE
Beth Sammis, Co-Chair, Affordability Workgroup
Ken Brannan, Co-Chair, Affordability Workgroup

Mr. Cardenas introduced the Co-Chairs of the Affordability Workgroup and invited them to address the Board.

Ms. Sammis noted that it remains true that young people are the most likely to be uninsured while those with chronic disease are the most likely to purchase coverage. The MHBE, she explained, addressed that problem of adverse selection through the SRP. The workgroup developed three ideas, including value plans to bring down deductibles, a separate prescription drug deductible, and individual state subsidies for young adults. She added that the workgroup recommends the state provide more vigilance and oversight of the insurance industry.

Mr. Brannan thanked his Co-Chair, Ms. Eberle, and the entire workgroup team. He stressed the importance of health literacy, especially among young people, in making a positive impact on the risk pool.

Mr. Cardenas then gave the Board an overview of the workgroup's efforts. He began by explaining the logical framework used to understand how individuals make decisions around purchasing coverage and using the healthcare system. He demonstrated the breakdown of the uninsured population by age and income as well as the prevalence of chronic disease across age groups. He described the characteristics of the first intervention population, young adults aged 18 to 34 years and offered recommended near-term and long-term policy options to encourage them to get coverage. For the second intervention population, individuals with chronic diseases, Mr. Cardenas shared recommendations to control costs.

Secretary Neall, noting that Chronic Disease Management Programs are among the recommendations, expressed a desire for evidence of such programs' effectiveness.

Ms. Herron asked how the agency can coordinate overlapping care coordination systems among the insurers, hospitals, and others. Mr. Cardenas responded that achieving alignment across the health system is necessary. Ms. Herron agreed, noting that such an undertaking is beyond the MHBE's scope.

Ms. Weckesser expressed concern that the report includes nothing about health data and data sharing. The Board discussed the role of the Chesapeake Regional Information System for our Patients (CRISP) as the state's Health Information Exchange and the disparity of participation among the various categories of health providers.

Mr. Steffen noted that value-based plans seem promising and asked whether the MHBE defines such plans as those that offer before-deductible services. Mr. Cardenas replied that the agency will return at another time to address that issue.

Mr. Steffen cautioned that the Maryland Primary Care Program is limited to the Medicare patients attributed to a particular practice. While one can hope that the program will spill over to other areas of the system, it cannot be guaranteed, he explained.

Secretary Neall noted that a statewide diabetes plan will be available soon that pays attention to health disparities and the lack of access in areas of the state.

Proposed 2021 Plan Certification Standards and MHBE Regulations

John-Pierre Cardenas, Director, Policy & Plan Management, MHBE

Mr. Cardenas gave the Board an overview of the proposed 2021 plan certification standards. He began by showing how average annual health insurance costs have risen in both premium and deductible every year since 2013. He described the 2021 standards and policy concepts broadly, noting that they seek to achieve a number of outcomes. They are intended to build on the improvements in 2020, to manage consumer expectations of out-of-pocket costs, to align consumer incentives in utilization, to increase the rate at which individual applicants effectuate coverage, to align carrier incentives to manage members with high costs, and to increase access to stand-alone dental coverage.

Next, Mr. Cardenas discussed the proposed value plan standards, beginning with the prevalence of three select conditions, hypertension, diabetes, and depression, among the privately insured Maryland population. He then demonstrated that spending growth on prescription drugs between 2016 and 2017 is not only higher than other categories of care, but far outstrips the growth rate of prescription drug utilization. He showed that brand drugs, as opposed to generic drugs, are driving the rising costs and shared a list of expensive drugs covered under the high deductible health plan (HDHP) parity rule.

Mr. Cardenas explained that the HDHP parity rule expanded the list of services, i.e. the list of drugs, allowed to be offered before deductible in HDHPs. The MHBE proposes to apply that expanded list to non-HDHP plans for certain services and seeks input as to the scope and impact of the policy change.

Next, Mr. Cardenas laid out a plan to stabilize deductibles and out-of-pocket costs. The MHBE proposes to use value plan structures to increase the use of high-value care while decreasing the use of low-value care and limiting premium increases. Such an effort can have positive external effects, from encouraging more carriers to participate in the individual market, to creating incentives for value-based product innovation and aligning the individual market with the statewide Total Cost of Care Waiver. In 2020, each carrier would be required to offer at least one value plan at the bronze level, and would have the option to offer them at silver and gold levels. These plans would make certain services available before deductible and would have a deductible ceiling on the silver and gold levels.

Mr. Cardenas then described how the proposed plans would change in 2021. While the bronze plan would remain unchanged, both the silver and gold plans would be updated. The Value Silver plan in 2021 would include generic drugs and exclude imaging from before-deductible services. The Value Gold plan in 2021 would offer 2 options to reduce out-of-pocket costs for brand drugs, either a prescription drug deductible ceiling up to $250 or including certain preferred brand drugs as a before-deductible service. Both the silver and gold plan would be updated in 2021 to offer carriers additional flexibility around other services to achieve the targeted actuarial value.

Ms. Herron noted that many chronic conditions require monthly lab services in conjunction with medication and expressed concern that carriers' plan designs might complicate chronic disease management. Mr. Cardenas replied that the flexibility is provided to allow the carriers to achieve the required actuarial value while limiting out-of-pocket costs.

Next, Mr. Cardenas described the rules to be implemented in future years. In 2022, the agency would establish a formula to determine the yearly allowable increase in the deductible ceiling for the Value

Silver and Value Gold plans. In 2023, the agency would implement the deductible increase factor established in 2022.

Ms. Weckesser asked whether the agency's modelling included stagnation or decreases in deductible in future years. Mr. Cardenas agreed that the MHBE should avoid loading the generosity of the plans entirely into the deductible.

Mr. Cardenas then described several other newly proposed plan certification standards for 2021. These include a requirement that participating carriers provide a web link, or PayNow URL, for consumers to immediately pay their first month's premium upon selecting the plan, if they so desire. Another would require additional transparency from carriers regarding their co-pay accumulator programs. Stand-alone dental coverage would be made available during special enrollment periods, and small businesses would be given access to at least one plan at bronze, silver, and gold levels that allow for composite rating. Finally, the MHBE would lower administrative barriers to new carriers entering the market by offering sample plan designs at bronze, silver, and gold levels.

Next, Mr. Cardenas gave an update on MHBE regulations. He explained that the comment period for the SHOP regulations closed with minimal feedback. He described yearly federal conformity regulations that the agency must adopt in response to changes in federal policy. As requested by the Board, the update includes regulations on grant applications and awards. Finally, he summarized amendments to the consumer assistance regulations which would remove unnecessary language and clarify training requirements.

Mr. McCann moved to approve the MHBE staff recommendations to release the Proposed 2021 Plan Certification Standards, adopt the final SHOP Exchange Regulations, and release proposed federal conformity regulations to the Maryland Register for public comment. The motion was passed unanimously.

FY 19 Q4 Compliance Update

Caterina Pañgilinan, Chief Compliance Officer, MHBE

Ms. Pañgilinan gave the Board a report on the MHBE Compliance Program. She began by highlighting several improvements including newly executed agreements, updated fraud, waste, and abuse, privacy, and IT security training, as well as other achievements. She noted that errors among call center workers decreased year-over-year while document misloads increased over the same period.

Next, Ms. Pañgilinan reported the status of the FY 2019 audits at the MHBE. She noted three new open findings since the previous quarterly report. She then outlined the corrective actions taken to address the audit findings.

Ms. Pañgilinan concluded her presentation with figures on the use of the Compliance Hotline as well as fraud, waste, and abuse allegations during the fiscal year. She summarized a number of actions the MHBE undertook in its audit and monitoring program, ranging from internal reviews to external audits and site visits.

Adjournment

The meeting was adjourned.