Maryland Health Benefit Exchange
Board of Trustees

November 16, 2020
2 p.m. – 4 p.m.
Meeting Held via Video Conference

Members Present:
Robert R. Neall, Chair
S. Anthony (Tony) McCann, Vice Chair
Dr. Rondall Allen
Kathleen A. Birrane
Mary Jean Herron
Ben Steffen, MA
Dana Weckesser
K. Singh Taneja
Robert D'Antonio, PhD

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Andrew Ratner, Chief of Staff, MHBE
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Caterina Pañgilinan, Chief Compliance Officer, MHBE
Sharon Stanley Street, Principal Counsel, Office of the Attorney General

Welcome and Introductions:
Vice Chair McCann opened the meeting and welcomed all in attendance. He expressed thanks to Secretary Neall for all his efforts, especially during the pandemic emergency. Secretary Neall thanked the MHBE and noted that it has become a national model. Ms. Herron wished him well in retirement.

Approval of Meeting Minutes
The Board reviewed the minutes of the October 19, 2020 open meeting. The Board voted unanimously to approve the minutes of the October 19, 2020 open meeting.

Public Comment
Mr. McCann invited members of the public to offer comment. No comments were offered.

Executive Update
Michele Eberle, Executive Director, MHBE

Ms. Eberle began her remarks by expressing thanks on behalf of the MHBE staff for Secretary Neall and his role in supporting their work.

She noted that the U.S. Supreme Court recently held a hearing on a challenge to the Affordable Care Act (ACA). She expressed optimism that the law would remain intact and explained that the timing of a decision would depend on the legal basis employed by the justices.

Next, she stated that open enrollment has begun without any issues. She noted that, while new enrollments are down, renewals have exceeded previous levels.

Ms. Eberle informed the Board that the individual subsidy work group has concluded its work. She explained that the required report will be submitted to the legislature by December 1. She thanked everyone involved in the effort.

She then highlighted staff work in developing the proposed 2022 plan certification standards. In particular, she noted that outreach to stakeholders and broad public participation occurs before the Board receives recommendations.

Next, she stated that the MHBE annual report will soon be posted on the website.

Ms. Eberle noted that the October 2020 data report has been updated and is currently available on the website. She highlighted that enrollment in private plans is up 18 percent year-over-year. Likewise, she noted that enrollment in dental plans is up 26 percent.

She explained that MHBE staff continue to work remotely.

Finally, she noted two small solicitations currently out for bid: one for computers and support, and another for McAfee licensing and professional services.

Mr. Taneja asked, regarding the upcoming COVID-19 vaccines, whether the MHBE would need to take any action or wait for state and federal guidance. Ms. Eberle responded that the MHBE would work with the governor's office and the Maryland Department of Health (MDH) to provide messaging support.

Maryland Health Services Cost Review Commission Update

Katie Wunderlich, Executive Director, HSCRC

Ms. Wunderlich began her remarks by explaining that the overall role of the Maryland Health Services Cost Review Commission (HSCRC) is to regulate the quality and cost of hospital services. In addition to establishing rates for hospital services, she noted that the HSCRC assists the state in developing innovative efforts to transform the delivery system.

She provided an overview of Maryland's unique model for hospital payment. In addition to an agreement with the Centers for Medicare & Medicaid Services (CMS) to waive traditional Medicare payments, she explained that Maryland requires all payers to reimburse a given service the same amount within a facility. She highlighted associated advantages, including cost control, avoidance of cost shifting across payers, and equitable funding of uncompensated care. She then provided a brief

overview of changes in Maryland's unique model over time. Next, Ms. Wunderlich highlighted the role of the HSCRC in assessing fees to support state infrastructure, including the health information exchange, the Chesapeake Regional Information System for our Patients (CRISP).

She then gave an overview of the previous iteration of this model—the All-Payer Model. She highlighted that, by the end of the model period in 2018, nearly all hospital revenue was under a global or population-based budget arrangement. She noted that all model savings targets were met. She did, however, note that some of the savings in hospital spending were offset by shifts in spending to outpatient settings. This, in turn, led to the creation of the current Total Cost of Care (TCOC) model. She noted the model timeline and associated savings targets. Additionally, she highlighted model components that address quality, care transformation, and population health.

Ms. Wunderlich then explained the role of the Maryland Primary Care Program (MDPCP) in improving primary care for Medicare beneficiaries. She added that current state population health priorities include 1) diabetes prevention and management and 2) opioid screening, prevention, and treatment.

With regards to COVID-19, she explained that the Maryland model allows the state to proactively respond to address volatility in volume within hospitals and assure that hospitals have resources needed to address the situation. She noted that the global budget revenue (GBR) system creates stability for hospital finances in a time of uncertainty.

Ms. Herron asked, given the number of baby boomers entering retirement and Medicare eligibility, whether there is flexibility built in around the savings targets. Ms. Wunderlich responded that the HSCRC did consider changing demographics and that the proportion of Marylanders over age 65 will grow in the next 10 to 20 years. However, she noted that the model does not place the same pressure on hospital revenue as is present in other states.

Ms. Weckesser asked what accounted for the reduced costs over time. Ms. Wunderlich replied that, under the All-Payer Model, savings were driven by reduced hospital utilization. She noted that hospitals were able to identify patients who could be served in other settings and worked to address readmissions. Given the shift in cost to the outpatient setting, she added that they are now focused on the entire care spectrum.

Mr. Taneja asked whether uncompensated care rates have ever been reset, and if anything has occurred to resolve potential conflict between the interests of hospitals and physicians in a GBR system. Ms. Wunderlich responded that uncompensated care has declined since passage of the ACA. She added that uncompensated care is evaluated each year, and a projection is used to set the rate for the future year. She noted that, in both 2018 and 2019, uncompensated care increased—likely due to patients with insurance who could not afford their out-of-pocket costs. She then explained that hospitals work within global budgets while providers are still paid on a fee-for-service basis. She added that they are working to put programs in place to better align those incentives.

Mr. Steffen added that the outgoing CMS administrator noted a general disappointment towards many value-based payment models, but highlighted the Maryland model as a program that met its commitments. He stated that there are great opportunities for the program moving forward.

Maryland Health Care Commission Privately Insured Report

Ben Steffen, Executive Director, MHCC
Shankar Mesta, Chief, Cost and Quality, MHCC

Mr. Steffen introduced Mr. Mesta and noted that the data presented come from systems built off insurance claims. He added that the data systems allow states to track spending and utilization within both public and private marketplaces. Mr. Mesta began by explaining that the data presented pertain to individuals under the age of 65 in the individual market—both on and off-exchange. He noted that the state reinsurance program led to a three percent increase in on-exchange enrollment in January 2019 compared to January 2018. Additionally, he stated that enrollment as of year-end 2019 stood around 175,000, with member months stable compared to 2018.

With regard to the health status of the individual market, Mr. Mesta noted that Marylanders are sicker than the national reference population on a measure of illness burden. However, the illness burden did improve between 2017 and 2019.

He added that, while per-member per-month spending increased 8 percent from 2017 to 2018, it slowed to a 3 percent increase in 2019. Mr. McCann asked whether this applied to spending among individuals both on and off-exchange. Mr. Mesta responded in the affirmative. The primary cost driver was an increase in unit costs for all categories of spending except for prescription drugs, which was driven by an increase in utilization. He concluded by noting that the reinsurance program had a positive effect on both stabilizing enrollment and reducing the illness burden of the individual market.

Mr. Steffen noted that, with regards to the illness burden measure, lower numbers represent a healthier population. He asked whether the measures were similar when comparing individuals on and off-exchange. Mr. Mesta responded that the two groups have seen similar trends. Mr. Steffen asked whether the illness burden is slightly higher among the on-exchange population. Mr. Mesta responded in the affirmative.

Ms. Weckesser suggested that the decreasing illness burden of the individual market population be incorporated into public messaging.

Mr. Steffen noted that a key priority area for the state is addressing diabetes among state employees. In response, Mr. McCann asked who defines standards for state employee benefits. Mr. Steffen responded that the Department of Budget and Management (DBM) is responsible and that MHCC partners with them to identify priority initiatives. He added that private insurers also have a role to play.

2022 Plan Certification Standards

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Fabian-Marks began her remarks by highlighting the extensive public comment process undertaken in developing the 2022 plan certification standards. She provided background on the 2021 value plan requirements and noted that the most significant changes were related to the 2022 bronze value plan. Proposed changes include modifying pre-deductible services to include all primary care visits, mental health/substance (MH/SUD) use disorder outpatient visits, and generic drugs. She

noted that, in response to carrier feedback, the MHBE recommends delaying final bronze value plan standards until release of the 2022 actuarial value (AV) calculator.

Next, she outlined proposed changes to silver and gold value plans. She noted that requiring MH/SUD outpatient visits be covered pre-deductible received no opposition, as this is currently the practice for these plans. With regards to the addition of certain diabetes services pre-deductible to the silver and gold value plans, she noted no comments in opposition; however, she did state that the Maryland Insurance Administration (MIA) highlighted an existing requirement to cover diabetic test strips pre-deductible. They also projected a possible premium impact for certain plans. In response, the MHBE proposed removing the requirement to cover test strips, since it is unnecessary.

Next, Ms. Fabian-Marks explained that the provisions around transparency in telehealth coverage received no comments in opposition. Likewise, the proposed standards to align patient data availability standards with federal requirements received no opposition. Finally, the proposed standards around creating a dental provider directory of in-network providers and requiring an "*Important Information about This Plan"* document for consumers to access while shopping received no opposition.

In conclusion, she summarized other public comments received. The MIA pointed out that gold plans in the individual market have out-of-pocket maximums significantly higher than gold plans in the small group market. The MIA also highlighted that, due to AV considerations, the average out-of-pocket maximum for 2021 silver plans will be higher than for bronze plans. In response, Ms. Fabian-Marks noted that the issues would be taken into consideration when formulating 2023 standards.

Ms. Weckesser asked why the MHBE will not be taking MIA feedback into consideration for the 2022 plan standards. Ms. Fabian-Marks responded that the MIA was simply pointing out issues and did not make recommendations. Additionally, the MHBE received no concerns from stakeholders.

Mr. Taneja asked whether the Board will be notified of any issues related to finalizing the bronze value plan standards before being published for public comment. Ms. Fabian-Marks responded in the affirmative.

Mr. McCann asked about the possible impact of changes in the AV calculator. Ms. Fabian-Marks responded that, in some years, the changes are small for bronze plans and in others they are significant. She added that bronze plans are the most difficult to fit services into. Jimmy Williams, MIA, concurred. He added that the three existing bronze value plans are in the upper ten percent of the permitted AV range. Mr. McCann asked whether the result could be increased premiums, increased deductibles, or a reduction in benefits. Mr. Williams responded that it is unclear, and that with the current calculator, CareFirst has no room for further enrichment. He added that the draft calculator should come out in January or February. Mr. McCann then asked when the MHBE must finalize the plan certification standards. Ms. Fabian-Marks responded that the timing depends on MIA filing deadlines. She added that the MHBE is hoping to bring this issue back to the Board at the February meeting.

Mr. McCann noted that there will be a new Board chairman in the coming weeks and asked for a briefing if there will be significant changes related to the bronze value plan. Ms. Fabian-Marks responded that a briefing could be arranged. She added that they are not expecting major changes;

the issue will be the feasibility of incorporating the proposed service categories pre-deductible in the bronze value plan. Mr. McCann then asked for clarity that those identified priority services could be sacrificed. Ms. Fabian-Marks responded in the affirmative. She added that the existing standard for the bronze value plan is coverage for three visits pre-deductible; an alternative could be found somewhere in the middle. Mr. Williams concurred and noted that it is likely that the standard would end up in a middle ground between the existing standard and the proposed standard.

Mr. McCann then asked for clarity on "middle ground," and whether that would require a pullback on the proposed standards or apply elsewhere in the plan. Mr. Williams responded that, depending on the AV calculator, it could be possible to identify one of the three services as a priority to focus on.

Commissioner Birrane added that, with respect to filing deadlines, the MIA would ensure that the Board has the opportunity to review the options and would relax deadlines as necessary. She added that it makes sense to defer conversations around who would stand to benefit, and that the sickest individuals will always hit their out-of-pocket maximum.

Mr. McCann asked whether judgments around altering premiums, co-pays, and deductibles falls to the insurance commissioner or the Board. Commissioner Birrane responded that the role of the MIA is to enforce state and federal law, and that they do not engage in benefit design. She added that the MHBE has taken the approach of having certain value plans in place, and that the role of the MIA would be to help others understand the consequences of certain choices. Mr. McCann noted that it would be a good idea to have a conversation around how MHBE staff balance the relative values of premiums versus co-pays and deductibles as well as benefit changes. Ms. Eberle replied that such a conversation would be worthwhile. She added that, over the last several years, issues around the affordability of medications have been raised by stakeholders. She noted that weighing these various factors is always a balancing act, and that the MHBE tries to maximize value for the consumer.

Mr. Steffen asked about the level of growth in value plans overall. He added that the incentives in the value plans should not drive certain segments of the population to a certain product. Ms. Fabian-Marks responded that approximately one third of enrollees are in value plans.

Mr. McCann moved to approve the 2022 plan certification standards as proposed, with the following exceptions: defer finalization of bronze value plan modifications until after the 2022 AV calculator is released; and remove the requirement to cover diabetes test strips with $0 cost-sharing in gold and silver plans because it is unnecessary due to the requirements of the benchmark plan and §15-822(d)(3) of the Insurance Article. Mr. Steffen seconded the motion. Commissioner Birrane asked for clarification that the motion refers to the plan certification recommendations. Mr. McCann responded in the affirmative, the motion is regarding the plan certification recommendations as amended.

The motion carried.

FY 21 Q1 Compliance Update

Caterina Pañgilinan, Chief Compliance Officer, MHBE

Ms. Pañgilinan began her remarks by explaining that both allegations of fraud, waste, and abuse in the quarter were unfounded.

Next, she gave an overview of the internal review and monitoring program. She explained that, several years ago, there were issues identified related to the hiring process. Under a new director of human resources, there were no findings in Q1.

Ms. Pañgilinan then provided the audit status report. She stated that CMS has indicated that there will be no enforcement action this year related to ensuring that individuals with employer-sponsored coverage are not utilizing the health benefit exchange. However, she noted that the MHBE is still required to perform random sampling and undergo the verification process.

She then highlighted procurement bid security as a key focus area. Regarding compliance with accessibility requirements under Section 508, she noted that MHBE staff are looking into going beyond the minimum requirements. She then stated that there were 37 privacy incidents in the quarter. She added that the decline in privacy incidents is likely due to a lack of required renewals. Similarly, she noted that the error rate for assigning cost sharing reductions also dropped significantly.

Next, Ms. Pañgilinan gave an overview of the privacy program, including implementation of a remote review of the call center contractor, Maximus.

Mr. Steffen asked whether there were any findings stemming from the SOC 2 Type 2 audit of Maximus. Ms. Pañgilinan responded that there was a repeated finding related to individuals who had left employment but had not had their access revoked. Mr. Steffen then asked whether the failed process had been flagged. Ms. Pañgilinan responded in the affirmative. Mr. Steffen then asked whether there would be additional follow-up, given the repeated finding. Ms. Pañgilinan responded that, using desktop review, they would be looking at their processes to ensure that individuals are appropriately certified.

Mr. McCann asked for an update at the next Board meeting as to whether working remotely has raised any further issues.

Closing

Mr. Steffen asked whether the issue identified at the previous Board meeting related to potential reductions in premium subsidies due to the entrance of United into the market has prompted any consumer feedback. Ms. Eberle responded that there has been significant feedback on the matter. She added that the issue applies largely in areas where CareFirst was previously the only carrier and that the connector entity has been effectively communicating with consumers. Additionally, she noted some concerns with network adequacy for certain United plans on the eastern shore.

Mr. Steffen then asked how the MHBE is communicating to individuals who experienced significant reductions in income during the past year. Ms. Eberle responded that the MHBE is encouraging individuals to come back and shop for plans based on their reported income change.

Adjournment

The meeting was adjourned.