Maryland Health Benefit Exchange
Board of Trustees

June 21, 2022
2 p.m. – 4 p.m.
Meeting Held at the Maryland Health Care Commission and via Video Conference

Members Present:
Dennis Schrader, Chair
S. Anthony (Tony) McCann, Vice Chair
Ben Steffen, MA
Dana Weckesser
Maria Pilar Rodriguez
Mary Jean Herron

Members Excused:
K. Singh Taneja
Kathleen A. Birrane

Members Absent:
Dr. Rondall Allen

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Andy Ratner, Chief of Staff
Venkat Koshanam, Chief Information Officer, MHBE
Tony Armiger, Chief Financial Officer, MHBE
Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration, MHBE
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Tracey Gamble, Procurement Officer, MHBE
Dania Palanker, Co-chair, SAC Health Equity Workgroup

Welcome and Introductions:

Mr. McCann opened the meeting. He welcomed Maria Pilar Rodriguez to her first meeting as the newest member of the Board.

Approval of Meeting Minutes

The Board reviewed the minutes of the May 16, 2022, open meeting. The Board voted unanimously to approve the minutes.

The Board reviewed the minutes of the May 31, 2022, closed meeting. The Board voted unanimously to approve the minutes.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her remarks by expressing the MHBE's appreciation for the time commitment and dedication of the Board's volunteer members. She announced the hiring of Tim Cook as the agency's new Social Media Specialist and provided some highlights of his background.

Next, Ms. Eberle announced that, on May 19, the Baltimore chapter of the American Marketing Association awarded the MHBE "best social media campaign" during its MX Awards Gala.

Ms. Eberle then discussed the impact of recent federal government action on the MHBE. She noted that expanded tax credits under the American Rescue Plan Act (ARPA) may not be extended through reconciliation due to competing priorities among legislators. She added that the MHBE is highly concerned by this possibility due to the likelihood that it will lead to reductions in enrollment in the following plan year.

Next, Ms. Eberle noted that the MHBE believes the COVID-19 public health emergency will be extended by federal authorities to at least October of 2022, and possibly to January of 2023.

Ms. Eberle then introduced Maria Pilar Rodriguez as the newest member of the Board and provided some highlights of her background and accomplishments. Ms. Rodriguez greeted the Board and thanked Ms. Eberle.

Next, Ms. Eberle explained that all participating insurers have submitted their proposed premium rates for the next plan year. The plans have an average rate increase of 11%, ranging from 7.2% to 25.9%. She noted that the Maryland Insurance Administration will now work toward approving the rates but cautioned that all rates were calculated assuming the continuation of ARPA tax credits and may need to be refiled should ARPA expire.

Ms. Eberle then announced that the MHBE has re-established its Affordability Work Group. She noted that the previous iteration of the body developed the Value Plans offered on Maryland Health Connection (MHC) and that they will be asked to assess the performance of the young adult subsidy, investigate vision plans, and consider how to adjust health plan cost sharing to promote health equity.

Next, Ms. Eberle discussed the Small Business Work Group, newly mandated by the Maryland General Assembly. She noted that the group will consist of 17 people and will begin their work in the next few weeks.

Ms. Eberle concluded her remarks by stating that the MHBE has submitted comments on the Internal Revenue Service's proposed regulation to address the family glitch, as discussed in previous Board meetings.

Mr. McCann directed the Board's attention to the list of proposed Board meeting dates for 2023: January 17, February 21, April 17, May 15, June 19, July 17, September 18, October 16, and

November 20. He moved to approve the 2023 Board of Trustee meeting dates as presented. Ms. Herron seconded. The motion was approved.

Finance/Audit Committee Report

S. Anthony (Tony) McCann, Vice Chair

Mr. McCann summarized the Committee's recent meetings by noting two major items discussed. First, he described the Committee's evaluation of the MHBE's budget status, noting that the agency continues to run under-budget and should work toward closing that gap. Next, he discussed the Committee's deliberations over the role of the MHBE Chief Compliance Officer, including methods of Board oversight. He explained that the topic remains open while the Committee gathers information from other Boards and how other institutions govern the role.

Secretary Schrader asked for confirmation that the Committee's discussion of the Chief Compliance Officer's oversight by the Board was in reference to the role rather than the person currently occupying the role. Mr. McCann answered in the affirmative. Ms. Herron added that the discussion occurred after she requested that the agency disaggregate the role of Chief Compliance Officer from oversight of the agency's compliance operations.

Standing Advisory Committee (SAC) Report

Dana Weckesser, SAC Board Liaison

Ms. Weckesser provided an overview of the SAC's recent meeting, where they heard a report on MHBE data for 2022. She noted that the MHBE ranked 5th among 18 state-based marketplaces for enrollment growth and 2nd on average premium cost. Across the entire country, Maryland ranked 5th for proportion of enrollment in gold plans. The SAC received an update on the Prescription Drug Affordability Board, heard presentations on the statuses of the expanded tax credits and young adult subsidies, and unanimously accepted the recommendations of the Health Equity Workgroup.

SAC Health Equity Workgroup Report

Dania Palanker, Co-Chair, SAC Health Equity Workgroup
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE

Ms. Palanker thanked the Board for the opportunity to co-chair the workgroup. She explained that her work at the Center on Health Insurance Reforms at Georgetown University concerns health equity and that she has published on the topic.

Ms. Palanker expressed the importance of health equity. She explained that ensuring equal coverage is an important part of health equity but is not enough to ensure that health equity has been achieved. She described the difference between equality and equity, a distinction that the workgroup sought to keep in mind throughout their work. Ms. Palanker explained that her definition of health equity is ensuring that enrollees have a just opportunity to live as healthy a life as possible.

Ms. Palanker stated that the workgroup met from August 2021 to December 2021. The group included 20 members representing a broad array of stakeholders, as well as geographic diversity. The workgroup held eight meetings. Guest speakers presented to the workgroup, including representatives from the qualified health plans (QHPs). They also considered what other states were

doing in the area of health equity. Together, the workgroup came up with the packet of recommendations presented today, which was unanimously approved by all workgroup members.

Ms. Palanker explained that the MHC application contains demographic questions including questions that ask enrollees to specify their race and ethnicity. However, under federal law, applicants cannot be required to disclose their race or ethnicity, so there must be a way for respondents to elect not to do so. Currently, fewer than 70% of enrollees provide their race and ethnicity data, meaning that data are missing for over 30% of enrollees. Ms. Palanker stated that these numbers are middle of the road in comparison to other states but still present an issue, as the MHBE does not know the demographics of enrollees, hindering its ability to target health equity strategies.

Ms. Palanker stated that the workgroup discussed best practices regarding race and ethnicity data collection, including action taking by the New York marketplace to revamp their application questions. The New York marketplace made the race and ethnicity questions on its application mandatory but added “prefer not to say” and “don’t know” response options, which Ms. Palanker explained could garner responses from people who might otherwise just skip the question. Another best practice from New York was that the state marketplace provided training and information for brokers and enrollment assisters so that they would not skip the question or downplay the importance of answering. After implementing their changes, New York saw response rates for these questions increase from 80% to 90%; Ms. Palanker stated that this shows that steps similar to what the workgroup is recommending can lead to a significant increase in response rates.

Ms. Palanker explained the workgroup’s recommendations: that the race and ethnicity questions on the MHC application should be redesigned, the MHBE should set response rate goals, and that there should be other data collection strategies used to increase the response rate. This work will include convening a data-focused workgroup, whose deliberations will include a discussion of insurers’ collecting race and ethnicity information directly from enrollees. This step is in line with Washington, D.C. recommendations. California requires insurers to collect the data from enrollees directly or to receive it from providers so that every insurer reaches a threshold of 80% of enrollees for whom they have race and ethnicity information. In addition to recommendations for the race and ethnicity questions, the workgroup recommends that the questions regarding sex and gender be redesigned to be non-binary inclusive, a step which Washington State is working on.

The workgroup also discussed the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction, recommending that all issuers receive this distinction. However, ,the NCQA is moving away from the Multicultural Health Care Distinction to instead focus on a more comprehensive Health Equity Accreditation. California has updated its recommendations to be specific to the new accreditation, while Washington, D.C., has not updated its recommendations for the new accreditation but still does require carriers to achieve the Multicultural Health Care Distinction. Ms. Palanker explained that having the same requirements between Maryland and Washington, D.C. will reduce administrative burden, given that many of the insurers operate in both jurisdictions. Ms. Palanker stated that the NCQA Multicultural Health Care Distinction includes requirements for data collection, language assistance, cultural responsiveness, quality improvement, and reduction of health care disparities.

Ms. Palanker next covered health insurance literacy. She explained that health insurance literacy may be lower among certain marginalized groups and that it was important to ensure that enrollees understand how their health insurance works. She stated that the workgroup recommends partnering with community organizations for the development or delivery of a health insurance literacy curriculum. Additionally, the workgroup recommends changes to the MHBE website to help with plan choices and with understanding utilization of benefits. These recommended updates include changes to the chatbot, adding tooltips, enhancing the "Choose a Plan" and "Consumer Assistance" fact sheets to make sure they are explaining in ways that applicants can engage with, and conducting focus groups to test the accessibility of the materials. These focus groups should include enrollees of color and enrollees with limited English proficiency to ensure that the populations being targeted for health equity understand the information. The workgroup became aware of issues with the Spanish translation on the website, so the group also recommends conducting an audit of the Spanish translation of the website's text and its search engine optimization in Spanish—the workgroup was made aware that the site was not coming up when searching in some of the main web browsers in Spanish.

The workgroup also discussed the importance of community health workers for reaching populations of color and immigrant populations in Maryland. She explained that the workgroup does not currently feel able to make specific recommendations about how best to support community health workers but is simply recommending that the MHBE and insurers continue to discuss alternative payment models that support community health workers.

Ms. Palanker then moved onto covering the workgroup's discussion of reduced cost sharing for high-disparity conditions. She explained that other states have very detailed standardized plans: for instance, as of the implementation of its 2023 standardized plan, Washington, D.C. will have eliminated cost sharing for services to manage Type 2 Diabetes, and they hope to expand that to other health issues that disproportionately affect people of color. Massachusetts is doing something similar with their Connector Care program, a program offering separate plans for Massachusetts residents making under 300% of the federal poverty level (FPL). Colorado is offering no cost sharing for other services—including primary care visits, mental health services, and prenatal and postnatal services—in standard plans in their public option (meaning plans offered through the marketplace). The workgroup recommends exploring the feasibility of reducing cost sharing for high-disparity conditions. However, Ms. Palanker acknowledged that Maryland works differently in that there is not a standardized plan.

Ms. Palanker then talked about the workgroup's discussion of implicit bias. Many members of the group felt that it was important for the organization strive for health equity in all pieces of the work. As such, the workgroup recommends implicit bias training for MHBE staff and working to support and participate in other state implicit bias work rather than starting from the ground up. They also recommend continuing to explore the ways that staff can reduce bias at the point of care. Ms. Palanker acknowledged that the Maryland Insurance Administration (MIA) is integrating cultural competency into network adequacy regulations: implicit bias may enter the system at the point of care if a provider has bias, and this can be addressed in some ways through cultural competency training with providers. She explained that the workgroup did not recommend taking any action regarding this kind of regulation but simply wanted to acknowledge that MIA is conducting that work.

Ms. Herron asked about the recommendation for the MHBE to monitor implicit bias at the point of care; she stated that the MHBE has no influence on providers and expressed concern about the recommendation. Ms. Palanker responded that the workgroup just meant to recognize that the bias is there. She stated that they meant to do so in two ways: first, to acknowledge any implicit bias among MHBE staff; and second, to encourage the MHBE to consider making requirements of participating insurers. She explained that other states are requiring participating insurers to demand implicit bias training for providers to be a part of their network. Ms. Palanker noted that CareFirst is implementing such a requirement in Washington, D.C. She explained that the workgroup is not actively recommending this type of action, as it recognizes that MIA is exploring that option. Ms. Palanker explained that the workgroup's intention was to encourage support of the work happening elsewhere in the state when possible, and to explore the extent of carriers' efforts around implicit bias. She stated that the carriers play a role in providing the networks and that some carriers go above and beyond implicit bias training. Furthermore, the workgroup recommends looking out for opportunities in this area where the MHBE can play an active role, but there is no such direct action that the workgroup currently recommends.

Ms. Palanker then moved onto partnership and collaboration. She stated that the workgroup recommends holding listening sessions with connector entities, other partners that work directly with consumers, and consumers themselves if possible. The insights raised in these listening sessions should inform future strategy. One issue raised was that it may be important to compensate participants directly; this may be especially important for reaching low-income groups and those with difficult work and childcare schedules. The workgroup's other recommendation regarding partnerships and collaboration was to continue coordinating with MIA and other state agencies regarding health equity work. Additionally, the group recommends keeping an eye out for opportunities to form new partnerships with community organizations to work on health equity.

Ms. Palanker explained that there was a good deal of discussion regarding immigrants and coverage for immigrants who are currently ineligible for MHBE coverage. She stated that the group decided this issue was outside of its scope and that they could not recommend that ineligible people become eligible. However, she explained, she still wanted to bring it to the Board's attention, as it was an area of concern for many people in the workgroup.

Ms. Fabian-Marks then began presenting about implementation of the workgroup's recommendations. She explained that, for each of these recommendations, the MHBE has implemented the change, is in the process of implementing it, or has a plan to implement it. The race and ethnicity data collection question was redesigned and implemented, and the MHBE will be collecting data to track the effect this change has on response rates. The plan is for the NCQA Multicultural Health Care Distinction to be included in the proposal to the Board for plan certification standards this fall. The health insurance literacy items are in the strategic plan, and their implementation is generally being led by Betsy Plunkett, Director, Marketing & Digital Strategies at the MHBE and her team over the next year or two. The remaining recommendations will be implemented within the next year or two as well. Specifically, the recommendation for reducing cost-sharing for high-disparity conditions is being discussed with the Affordability Workgroup currently, and a proposal to the Board regarding the change will be included in the upcoming plan certification standards for their consideration in September.

Ms. Weckesser asked for clarification regarding the recommendation to reduce cost-sharing for high-disparity conditions. She stated that Ms. Palanker described reduced cost-sharing for Type 2 Diabetes, but the SAC had discussed reduced cost-sharing for all types of diabetes. She asked whether Ms. Palanker had meant to communicate that the workgroup had changed its mind regarding which diabetes types should have reduced cost-sharing. Ms. Palanker responded that she was just trying to give examples and communicate that other states are doing different forms of reduced cost-sharing for high-disparity conditions. Washington, D.C. is focusing on Type 2 Diabetes. Ms. Weckesser expressed appreciation for the clarification, stating that the SAC had approved reduced cost-sharing for all diabetes types unanimously.

Ms. Herron asked whether, by recommending that the MHBE explore alternative payment models to support community health workers, the workgroup is proposing that the money to support these workers should come out of the MHBE's budget. She stated that funding for these workers currently comes from insurers and many of the connector agencies. Ms. Fabian-Marks responded that the recommendation was a high-level directive to explore how the MHBE can work with insurers to support community health workers. She explained that the recommendation is meant to prompt the MHBE to figure out what they may be able to do in FY 2024, and there is no specific plan on the table. There is no specific initiative that would need to be financed from the MHBE's budget.

Mr. Steffen asked for more detail on the NCQA Multicultural Health Distinction. Ms. Palanker responded by explaining that NCQA has since shifted to the Health Equity Accreditation program, which is similar but has two levels. The Multicultural Health Distinction program has requirements for insurers to collect various demographic data that includes race and ethnicity as well as age and sex from enrollees. She explained that this falls under the banner of "self-collected data," along with data that enrollees give to network providers, who then share the data with the insurer, which is allowed given that they are "related business entities" under HIPAA. Ms. Palanker stated that it is not required that insurers get the data in all these different ways but that she wanted to provide examples of ways in which the information could make its way to insurers. She shared further examples: demographic information might be collected over the phone through a customer service line or on the online portal. She explained that each of these could be another point of contact to get that information. She then stated that the program also has detailed requirements on language access, including translation of materials and standards that ensure network providers are offering adequate translation and culturally competent care. She explained that the requirements are dense and stated that she may have left something out.

Ms. Fabian-Marks noted that the carriers were represented on the workgroup, so they were part of this conversation. Ms. Herron asked whether the carriers have relationships with NCQA. Ms. Palanker responded that NCQA already provides certifications to health insurers, either pursuant to legal requirements or to meet certain quality standards. As such, insurers are very familiar with NCQA. Ms. Palanker further explained that the federal government is considering requiring this distinction for QHPs on healthcare.gov and that the National Conference of State Legislatures is looking at recommending that insurers get this distinction or at least include elements of the requirements. She stated that insurers are familiar with these requirements. Washington, D.C. is going to require the distinction and it is the same insurers participating in D.C. and Maryland, so insurers are happy with the work so long as the requirements are not more progressive in Maryland.

Secretary Schrader stated that the MHBE has a process for conducting plan design, and he suggested that some of these recommendations be taken up by the group that does plan design. Ms. Fabian-Marks responded that the cost-sharing recommendations are being discussed and fleshed out in the Affordability Workgroup that is meeting over the summer, and that group will help to refine those recommendations and make them more specific. She stated that the Board will be asked to review proposed and then final plan certification standards for 2024 in the fall. At that point, a very specific list of proposals will be brought before the Board. Prior to that, the proposals will be discussed with the SAC in August, and after the September Board discussion, there will be a public comment period. Then the Board will be asked to vote on final plan certification standards, typically in November. Ms. Fabian-Marks stated that, throughout this process, there will be much more engagement on the plan certification standards with the public and the Board.

Secretary Schrader asked about the recommendation regarding community health workers: he stated that it seems to him that this would have to do with how the plans are designed. Ms. Palanker responded that the recommendation was made with the understanding that there are workgroups that will work on the issue and look into whether there is a way to reduce or eliminate cost-sharing for certain services for high-disparity conditions. She explained that this might look like eliminating cost-sharing for certain office visits or medications to treat diabetes. However, she explained, it was done with the recognition that Maryland is different from other states because Maryland insurers must independently determine how they are going to achieve these cost-sharing reductions—what other costs will be raised to accommodate the change—whereas Washington, D.C. and Colorado are looking at the entire cost of the plan. Ms. Palanker stated that the process of making this change is more complicated in Maryland but that the idea was to use the process that already exists in Maryland around cost-sharing requirements while seeking ways to improve access to healthcare through reduced cost-sharing.

Mr. Steffen asked if the workgroup had any creative ideas for how to gather race and ethnicity data. He stated that enrollees may fear discrimination based on the information they are inputting. Despite changes in the insurance market, some people might still worry that the information they disclose will be harmful to them. He asked for confirmation of the percentage of people who respond to the race and ethnicity items. Ms. Fabian-Marks responded that the number is between 60% and 70%. Mr. Steffen stated that this number is good, as there are some players in Maryland who would struggle to get 30%, but that it still may be daunting to provide this information in the enrollment process. He reiterated his question about whether the workgroup discussed any creative ways to collect this data.

Ms. Palanker responded by saying that she has thought about this issue quite a bit. She stated that a response rate of 100% at the point of enrollment is unlikely, and considering the current response rate in Maryland, even reaching 90% is unlikely. She explained that following New York's example by providing sample scripts to navigators, enrollment assisters, brokers, and agents as well as training these individuals is an important piece of helping to improve response rate for the race and ethnicity items. Part of that training instructs these individuals to let applicants know why they are being asked these questions to counter the idea that this information will be used to discriminate and inform them that it will instead be used to improve care for all populations. When New York took these steps and reworded the question to make it mandatory, the response rate increased from 80% to 90%, which shows that these steps can contribute to progress. Ms. Palanker stated that insurers are working to improve response rates in a variety of ways throughout the country. She explained that many of the methods being used attempt to get responses from as many points of contact as possible, such as

over the phone when someone calls the insurance company or in the app. She stated that some people may be more willing to share information that they would not be willing to share somewhere else when setting up the app because people have gotten used to sharing personal information on phone apps. Another major strategy is trying to establish data sharing with providers. Many providers ask for race and ethnicity information and input the data into an electronic medical records system. Although there will always be some who do not report it, many do, especially during an office visit. Ms. Palanker stated that the combination of as many methods and points of contact as possible is what will be most effective for increasing the response rate, and this is what California is working on.

Ms. Herron asked if the Board needed to vote on these recommendations. Mr. McCann said that they need to move on but that they can set up another time if there is more that they need to discuss.

Young Adult Subsidy Update

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

Mr. McCann asked for a review of the young adult subsidies program. Ms. Fabian-Marks said that the program is a two-year pilot program that allows the MHBE to spend up to $20 million. This amount was authorized by the legislature and comes from state reinsurance dollars. 2022 is the first year of the program, and 2023 is the second year. She said that she would be asking the Board today to approve both a regulatory change and an update to the program parameters based on the proposed change that she presented during the Board's meeting on May 16.

Ms. Fabian-Marks stated that there was a provision included in HB 937 which directs the Exchange to use the state subsidy to cover the non-essential health benefit portion of premium for individuals who would have a zero-dollar plan but for the fact that they need to pay one or two dollars to cover the non-essential health benefit (non-EHB) portion. She explained that this comes into play if the plan covers abortion care, adult dental, and adult vision, all of which are non-essential health benefits for which enrollees cannot use their federal subsidy and currently cannot use their state subsidy. The bill directs the MHBE to use the state subsidy to cover these benefits so that enrollees who have a low enough income that they would otherwise get a zero-dollar plan can get it. It also directs the MHBE to track the impact of this change in order to explore whether it improves enrollment or reduces termination rates because people are no longer being terminated for not paying that nominal amount.

Mr. McCann asked how much this would cost. Ms. Fabian-Marks responded that the estimated cost is somewhere in the range of $400,000. She stated that this is fairly nominal and that the MHBE can absorb it within the state subsidy cost. She then displayed the specific regulatory language that is proposed to enact this change, and she explained that this language was shared with stakeholders in a preliminary informal public comment period, and no feedback was received. She then shared a timeline for the regulation updates: they are on a path to finalizing these in October 2022. She explained that the goal today is for the Board to vote to approve publication of the proposed regulations in August, after which there would be a formal 30-day public comment period.

Ms. Herron asked for confirmation that they are just voting to approve the publication. Ms. Fabian-Marks responded in the affirmative.

Secretary Schrader asked for clarification on what the Board is approving for a regulatory change. Ms. Fabian-Marks responded that the change is pursuant to state legislation that directs the MHBE to

update the regulation to amend the payment parameters for the state subsidy for enrollees with a zero percent premium contribution, which, in effect, is enrollees aged 18-34 and below 150% of the FPL or up to age 31 and below 200% FPL. She provided the caveat that these parameters are with ARPA in place and explained that, if ARPA goes away, those people will not have a zero percent expected contribution, and this will be a moot point. However, assuming ARPA continues, that age and income bracket qualifies for a zero-dollar expected contribution, and for them this change would allow the young adult subsidy dollars to cover their non-EHB portion of premium, which averages $1.30 per person. The state subsidy would cover this $1.30 monthly premium.

Mr. McCann asked for confirmation that, if ARPA is not continued, a subset of this group will be required to pay a premium. Ms. Fabian-Marks responded in the affirmative. Mr. McCann asked whether those people would then be dropped out from eligibility for this new allocation of the state subsidy. Ms. Fabian-Marks responded that everyone is paying a premium currently because of that nominal charge, so people are accustomed to paying a premium. Their premiums will go up if ARPA ends, but for the most part, they will be going from a low nonzero amount to a higher amount as opposed to going from zero to paying something. If ARPA continues and this regulatory change goes into effect, they will go from a nominal amount to zero.

Mr. McCann moved to approve the proposed young adult premium subsidy regulation update for publication in the Maryland Register as presented. Ms. Weckesser seconded. The Board unanimously approved the regulation update.

Ms. Fabian-Marks then asked the Board to approve the program parameters. She reviewed the 2022 program parameters: in order to be eligible, enrollees must be aged 18-34, ineligible for Medicaid, and make less than or equal to 400% of the FPL. In addition, an enrollee's expected contribution is reduced by a certain percentage depending on age and FPL, with the most generous subsidies going to the youngest and the lowest income in the cohort. The Board approved these 2022 parameters last spring.

Ms. Fabian-Marks stated that she is now asking the Board to approve 2023 final parameters. These parameters were presented to the Board last month as "proposed," then published for public comment. No comments were received. Now, the Board is asked to finalize what is proposed. She explained that the proposed changes are a repeat of what she shared about the regulatory change being made but that the timelines are out of sync because regulations take a while to finalize. The Board is asked to maintain the 2022 parameters for 2023, with the one adjustment previously described for the non-EHB portion of premium for enrollees with a zero percent expected contribution.

Mr. McCann asked for confirmation that, if ARPA is in effect, it costs the MHBE more than if ARPA goes away. Ms. Fabian-Marks responded in the affirmative. She explained that, with ARPA as it is, the people making up to 150% FPL have a zero percent expected contribution because the federal subsidies are fully covering their costs; there is no state subsidy cost for those people because they are fully subsidized federally. If ARPA goes away, those people will start having to pay, and then they will start receiving state subsidies to reduce the amount they pay, which is why costs will increase. Mr. McCann asked for further clarification, as the projections in the Board materials seemed to say that there would be a decrease in costs from around $17.9 million to $17.6 million if ARPA is not extended. Ms. Fabian-Marks responded that costs per person are projected to increase but total cost is projected to decrease because they are anticipating fewer enrollments without ARPA.

Mr. McCann moved to approve the final young adult premium subsidy parameters for plan year 2023 as presented. Ms. Herron seconded. The Board voted unanimously to approve the final program parameters for plan year 2023.

Fulfillment Services Procurement Award

Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration
Tony Armiger, Chief Financial Officer, MHBE

Ms. Forsyth began her remarks by reminding the Board of the role of the MHBE fulfillment services contractor—to perform printing services as well as both inbound and outbound mail processing. She explained that the current contract is awarded to vendor Art & Negative Graphics, who prints various consumer notices, tax forms, voter registration forms, managed care organization (MCO) enrollment packets, and Medicaid membership cards as well as receiving and processing incoming mail. The request for proposals (RFP) closed on April 18, with MHBE having received only one bid from the incumbent vendor for a two-year base term with one two-year option term. Ms. Forsyth explained that the unconventional contract length was instituted to stagger the end of the contract with other large MHBE contracts. Ms. Herron asked whether the number and expense of tax forms has declined. Ms. Forsyth replied that it has, due to the agency's no longer sending Form 1095-B to enrollees.

Next, Ms. Forsyth discussed the pricing of the single proposal received. She explained that, due to the high cost of the proposal, the agency sought insights from other states as to the cost of their fulfillment operations as well as from other printing firms to find out how the RFP could be modified to generate additional interest from potential bidders. Noting that the incumbent vendor has been an excellent partner to the MHBE, Ms. Forsyth requested the Board to approve the award of the contract to Art & Negative Graphics and to approve the not-to-exceed (NTE) amount of $5.8 million for FY 2023.

Ms. Herron asked why the Board is not being asked for approval of both base years. Ms. Forsyth clarified that she is asking for two distinct Board actions—one to approve the award of the two-year contract, and the other to approve the NTE amount of the first year.

Mr. McCann asked whether the contract could be subdivided in a manner similar to the agency's information technology contracts under the indefinite delivery, indefinite quantity (IDIQ) vehicle. Ms. Forsyth replied that there may be challenges to such an approach but that it would be worth a thorough investigation.

Mr. Steffen asked how much more expensive the contract is slated to be in 2023 compared with 2022. Mr. Armiger replied that the 2022 contract costs roughly $1.8 million compared to the proposed $5.8 million for 2023.

Mr. McCann asked whether the proposed contract's price could increase between its first and second year. Ms. Forsyth replied that the cost is tied to volume and is thus variable. Mr. Armiger added that the per-piece rate for both years is specified in the contract, and thus variation in price year-over-year would be mostly due to volume.

Secretary Schrader expressed displeasure at the more than threefold increase in price for these services, noting that the MHBE is printing far fewer items than before, meaning the per-piece price has skyrocketed. He noted that printing has traditionally been a highly competitive business with many market participants vying for contracts. In reply, Mr. Armiger explained that he had reached out to a friend in the printing industry seeking insights on this matter and learned that several aspects of the MHBE contract, including the compliance and geographic requirements, limit the pool of available bidders. In addition, he noted that many smaller printers went out of business during the COVID-19 pandemic.

Secretary Schrader asked how much money is budgeted for these services for FY 2023. Mr. Armiger replied that the budget is set at $3 million, adding that it is possible the agency could move more of its required notices online to help offset the costs. Ms. Forsyth added that the MHBE has already taken some steps to reduce printing, including requiring enrollees to opt out of paperless notices and adding a call to action on each notice asking enrollees to go paperless.

Ms. Weckesser, noting the already high amount requested for FY 2023, asked how much the agency will ask to spend in the following fiscal year on this contract. Ms. Forsyth answered that the amount will depend on the volume of material printed and sent. Mr. Armiger added that the contract established an increase of $0.02 per page between years one and two of the contract.

Mr. McCann expressed that the Board should have a further discussion on how to address the problem of having only one bidder, including whether the current contract construction best serves the needs of the MHBE. He moved to approve the recommendation to award the Fulfillment Center contract to Art & Negative Graphics for a two-year base, two-year option term and to approve the not-to-exceed amount of $5.8 million for FY23 as presented. Ms. Herron seconded.

Secretary Schrader asked whether an operational analysis of the Fulfillment Center contract is best placed as an amendment to the motion or as a separate item. Mr. McCann replied that the Board should have a report in an upcoming session on this topic. Ms. Forsyth added that the agency could consider extending the geographic area requirement further.

The motion was approved.

Language Line FTE for FY23

Heather Forsyth, Director, Consumer Assistance, Eligibility & Business Integration
Tracey Gamble, Procurement Manager, MHBE

Ms. Forsyth presented a request to approve language line funding for FY 2023. She began by explaining that the MHBE uses the Maryland State contract through the Board of Public Works. She requested that the Board approve a purchase order through that contract for FY 2023. She added that the agency intends to issue a request for information (RFI) to evaluate language line service options going forward, potentially involving technology upgrades.

Mr. McCann asked whether the Health Equity Workgroup has been consulted on the future of language line services at the MHBE. Ms. Forsyth answered in the affirmative.

Ms. Gamble stated that the MHBE requests that the Board approve the request to secure Language Line services through the State contract with Board of Public Works in the not to exceed amount of $450,000 for FY23. Mr. McCann moved to approve the request as presented. Ms. Herron seconded.

Secretary Schrader asked which languages are typically used on the Language Line for the MHBE. Ms. Forsyth replied that Spanish is the most common language used, followed by Korean, then various languages in very small numbers.

The motion was approved.

Corticon Support License Option Year

Venkat R. Koshanam, Chief Information Officer, MHBE
Tracey Gamble, Procurement Manager, MHBE

Mr. Koshanam reminded Board members that the MHBE uses Corticon Business Rules Engine software to automate eligibility and enrollment decision making. He noted that the agency continuously reviews the product and its usefulness and is considering replacing it in the coming years. Ms. Gamble summarized the Corticon procurement with its total cost, license period, and approved reseller. Mr. Koshanam explained that the MHBE is requesting expenditure approval for the second year of the license agreement already in place.

Secretary Schrader asked whether the Centers for Medicare & Medicaid Services (CMS) covers the cost of the rules engine and how involved they are in decision making on this issue. Mr. Koshanam replied that CMS covers 75% of the cost of the rules engine and requires certain components to be separate from the rest of the MHBE systems. Without that CMS requirement, he explained, the MHBE could write the rules directly into system code.

Ms. Gamble asked the Board's approval to renew the Corticon software licenses for Contract Year 2, from August 1, 2022 to July 31, 2023, through the approved reseller vCloud Tech Inc. in the total amount of $333,906 with Federal participation amount of $220,378 and State participation amount of $113,528. Mr. McCann moved to approve the request as presented. Ms. Herron seconded. The motion was approved.

2022–2025 Strategic Plan

Michele Eberle, Executive Director, MHBE

Ms. Eberle gave the Board an overview of the MHBE 2022-2025 Strategic Plan. She began by outlining the process by which the plan is developed and implemented. Roughly a year ago, the agency began planning sessions with a focus of transitioning from a start-up into a mature exchange. The MHBE contracted a strategic planning consultant, conducted meetings, developed the plan components, and finalized the strategic plan on May 12, 2022.

Next, Ms. Eberle described how the team approached restating the agency's Mission, Vision, and Values statements given the changes in the last ten years. She explained that the MHBE faces new challenges in its second decade, including keeping plans affordable, closing the equity gap, better serving rural residents, attracting more young adults, and adjusting to political change.

Ms. Eberle then discussed the first strategic priority identified in the plan, Organizational Strength. She described five objectives to support this priority: ensure a comprehensive approach to risk, invest in our team's development and capabilities, ensure continuation of a secure and stable financial position, strengthen the organization through data, and cultivate strong Board leadership and governance practices. For the second strategic priority, Telling Our Story, Ms. Eberle listed three objectives: expand our outreach, build and leverage partnerships and collaborations, and support our storytelling with data. The third strategic priority, Product Growth, resulted in three objectives as well: expand to serve the small group market, ensure availability and accessibility of products, and maintain product affordability. Ms. Eberle then described what actions the agency has taken and will take to accomplish the objectives. She discussed 33 action items in 5 categories: policy & governance, human resource development, technology & data, outreach & consumer assistance, and finance & compliance.

Ms. Herron asked, regarding one action item under finance & compliance, whether the agency intends to complete the external U.S. Department of Justice (DOJ) effective compliance risk assessment. Ms. Eberle replied that the MHBE completed the DOJ self-assessment in FY 2021 and would like to bring in a consultant to repeat that effort.

Secretary Schrader, noting the large volume of action items, asked whether the Board will be asked to approve the plan, whether it will be used for compensation or performance appraisal, and whether the action items have been ranked by priority. Ms. Eberle replied that many of the action items are already in process and welcomed the Board's formal approval of the plan. She added that the agency leadership team has set goals and measured themselves against them and has been doing so for five years. She noted that the strategic plan formalizes what has already taken place and involves the Board directly. Ms. Eberle expressed confidence that all action items set for completion in FY 2023 will be achieved.

Mr. McCann stated that the Board should read the strategic plan in detail and discuss it in upcoming sessions.

Mr. Steffen asked that the plan be focused on key endpoints, as distinct from systems and methods.

Meeting Adjournment

Mr. McCann adjourned the meeting.