MARYLAND
HEALTHBENEFIT
EXCHANGE

Maryland Health Benefit Exchange
Standing Advisory Committee
Thursday November 8, 2018
2:00 – 3:30PM
Maryland Department of Transportation
7201 Corporate Center Drive, Hanover, MD 21076

Members Present

Al Helfenbein
Shirley Blair
Anna Davis
Vincent DeMarco
Holly Mirabella
Karen Nelson
Laurence Polsky
Jacqueline Roche
Evalyne Bryant Ward

Those Calling In

Sheebani Patel
Christopher Keen
Todd Switzer

Others Present

Michele Eberle
John-Pierre Cardenas
Betsy Plunkett
Kathy Ruben
Laura Spicer
Jeananne Sciabarra
Dan Mosebach
Matt Celentano
Stephanie Klapper
Barbara Brocato
Patricia O'Connor

Welcome & Introductions

Alvin Helfenbein called the meeting to order. A vote to approve the minutes for the October 11, 2018 was called. The vote was seconded, and the minutes were approved.

Mr. Helfenbein then introduced Michele Eberle, who provided an Executive Update for MHBE and a review of open enrollment.

MHBE Executive Update

Ms. Eberle began with wishing everyone a happy Diwali. She then noted that Open Enrollment was going well and did not have any issues to report. Numbers in the beginning were slightly lower than usual, but after the election, there was a sudden spike in applications. Media and marketing ads were also increasing now that campaign ads were done running. Ms. Eberle mentioned that the Pay Now button, implemented by Kaiser was also up, and already being utilized. She noted that strategic planning had already begun for next year, and the Exchange would be reviewing its 18 month plan in the upcoming months.

She concluded by asking Dr. Polsky if he would mind placing an Ad in his county newspaper encouraging people to enroll. A template letter was sent to all county health officials that could be placed in their local newspapers. Dr. Polsky noted that his county had actually already placed a letter in their local paper.

HBX Update and Demo

Betsy Plunkett, Director of Marketing and Web Strategies provided an update on changes to the MHBE User Experience. She began by explaining a research study conducted in January to remote webcam five new enrollees and five current users to identify user problems. The top findings were that users need better guidance on the account home page to get started, users needed to be able to move forward and backward throughout the application, users needed clarity on how to enter income and determine eligibility, and branding between application and MarylandHealthConnection.gov home page was inconsistent.

She noted the changes in the webpage to improve consistency, a more streamlined progress indicator for the application, better eligibility determination instructions, and the addition of a chatbot.

Kathy Ruben asked how marketing changes were also incorporating the Exchange's new goals of health literacy. Betsy mentioned plan language reviews that are performed on all content, and the social media word of the day. Michele mentioned that the Exchange was partnering with the University of Maryland Horowitz Center for Health Literacy to participate in a grant to study health messaging.

Jacqueline Roche asked if the Exchange had utilized any materials from CMS. She noted that explaining the concept of APTC was also difficult, and she had utilized CMS's health literacy resources before. Betsy noted that the Exchange did use the Coverage to Care Road Map provided by CMS, but a lot of the materials had to be tweaked for the State. Fact sheets had also been created including, "How do I use my Medicaid", and "What to look for in a plan if you have a substance use disorder".

Holly Mirabella raised a question about the chatbot, wondering if she responded in Spanish, and if the Exchange had found that there was a need for additional languages. Betsy noted that IT was working to make sure the chatbot was first responding to questions correctly in English, and then additional languages would be added.

2017 Standardized Benefit Design Workgroup Report

John Pierre began by noting that Robyn Elliot had requested a recap of this policy priority for SAC members. He then provided background on the work group. Under the 2018 Plan Certification Standards, MHBE was authorized by the Board of Trustees to assemble a work group to develop a set of recommendations on a standardized benefit design. The work group was composed of members from issuers, the MIA, HEAU, consumer advocate groups, and other vital stakeholders.

John Pierre noted that the 1332 waiver only addressed rising premiums, and not out of pocket costs. Depending on your plan, you may see out of pocket costs rise. To address these issues a number of changes could take place, including adjusting Actuarial Values, or merged their marketplaces. He mentioned several other states who had implemented some form of standardized benefits, including Vermont, California, Massachusetts, and New York and the varying differences between their requirements. He noted that Maryland has a rule that an issuer

participating on the marketplace has a cap of 16 plans. So at least one of those plans per metal level would have to be a standardized benefit plan.

The work group considered a number of policy decisions. The general philosophy was that standard plans should offer first dollar coverage before the deductible, the standardized plan should also incentivize people to seek care at lower providers such as urgent care centers or nurse practitioners, the standard plan should also reduce the cost of care for children at the lowest actuarial value possible, the design should be easily understood across all cost sharing structures, the plan should also utilize co-pays over coinsurance, issuers should also offer non-standardized plans.

Some of the outcomes included the marketplace scope. The work group voted that the plan should not be standardized on the SHOP marketplace, but came to an inconclusive vote on whether plans should be standardized on the Individual marketplace. Metal level inclusion was also considered, with the work group voting that plans should be standardized at the bronze, silver and gold metal levels. The workgroup also voted that existing QHP Rules should not be amended, coverage categories in the Summary of Benefits and Coverage should be the standardized categories, non-standard benefits may be offered if such benefits will have a de minimis impact on EHB% of premiums, only in-network cost-sharing should be standardized, and the Board has existing waiver authority to support new market entrants, however, Kaiser opposed the use of the waiver for new market entrants.

Laurence Polsky raised a question about California, which has a large population and is geographically large, and as far as coverage in rural areas, are they able to offer a substantial number of programs that cover the rural areas. JP responded that there are some rating areas in California that have only two issuers participating, but they do not believe that having the standardized benefit design has anything to do with issuers participating in these areas.

Evalyn Bryant-Ward asked about coverage being reduced for nurse practitioners and physician assistants in the standardized benefit design. JP responded that users would just be more incentivized to utilize these practitioners that offer the same standard of care at a lower cost, through reduced copays. Evalyn noted that this did not seem fair to the nurse practitioners in the area.

JP ended by noting that this topic was presented to the Board in January, but it was voted that it should be addressed at a later time. And he encouraged the SAC to provide comments about whether this would be a good option to reduce out of pocket costs for consumers. Tony McCann noted that we could offer a rich standardized plan across the metal levels, but if a consumer was to choose a plan with a provider that was not located within their community, what would they do. JP noted that the standardized benefit design would only be a facet of the answer to improving access to care, and that’s where the network adequacy piece came into play. Joe Fitzpatrick noted that network adequacy reports had just come in. Tony finalized that some communities only have a marginal provider, and sometimes pushing them out who does not meet network adequacy, would only hurt the community further. JP noted essential health benefits could be utilized to incorporate more services.

JP requested that members look at Illinois’s approach to modifying their essential health benefits to include mental health providers and substance use disorder treatment, so payments of APTCs can be applied to these services.

Shirley Blair asked about outreach to entrepreneurs/small businesses. JP noted that marketing had been increased in the SHOP program.

Plan Certification Standards

John Pierre noted that all comments on draft plan certification standards for plan year 2020 had been received and were being incorporated. Comments were mostly supportive of any changes, and also supportive of most of the policy priorities the Exchange was examining. Comments would be shared with the SAC with commenters being de-identified.

Primary Care Visits

Laura Spicer from the Hilltop Institute noted that the Board has requested feedback on primary care visits above essential health benefit requirements. She provided background on preventative health care services offered with no cost-sharing, and noted that not all primary care visits were considered under preventative services, and would therefore be subjected to cost sharing. A study of 2016 FFM plans showed that most require deductibles before covering physician office visits, but some allowed a small number of visits outside the deductible. Another study of 2016 marketplace plans showed that 51% of bronze and 24% of silver plans required deductibles before covering primary care office visits, and Covered California offered 3 non-preventive primary/urgent care visits before deductible across all metal levels.

Laura noted that it should be kept in mind that when adding benefits, actuarial value should be considered. She highlighted what was currently being offered by each carrier in Maryland under each metal level.

For the study, the average cost per primary care visit was estimated at $130, and the assumption was made that an increase in visit costs would have a corresponding increase in premium. The take up rate was taken from the Medicaid enrollees, assuming it would be a conservative estimate. The potential premium impact would be about $20.37 per member per month if 3 visits were added to the policy.

Evalyn Bryant-Ward asked why Medicaid data was utilized, since this population tends to be high utilizers with low risk, and no co-payment. Why would you not utilize a population such s Medicare. Laura responded that Medicaid data was readily available and since this population did not have a co-payment, it would be a similar scenario to the situation being modeled, with an increase in three primary care visits before cost sharing. JP noted that using Medicaid data would give you the most conservative estimate for a premium increase. Evalyn also noted that her patient's wellness visits were currently very low in her primary care practice, despite reminders to her patient's to utilize them before they needed more than primary care. JP noted that the Exchange was working on utilizing their platform to message wellness to reduce future costs.

Laurence asked if OB/GYN visits were currently being factored into the study. Laura noted that OB/GYN visits were usually included in essential health benefits. Laurence noted that OB/GYN were sometimes considered specialists over primary care providers. JP asked it if would be helpful if the average cost per visit were modulated up slightly.

Laura ended her presentation by noting that the purpose of the study was to show that adding an additional primary care visit to the benefit design would increase premiums.

Conclusion

Al moved to end the meeting. The motion was seconded, and the meeting was adjourned at 3:45PM.