Maryland Health Benefit Exchange
Board of Trustees

September 19, 2022
2 p.m. – 4 p.m.
Meeting Held at the Maryland Health Care Commission and via Video Conference

Members Present During Open Session:
Dennis Schrader, Chair
S. Anthony (Tony) McCann, Vice Chair
Ben Steffen, MA
Dana Weckesser
Kathleen A. Birrane
Dr. Rondall Allen

Members Excused:
K. Singh Taneja
Mary Jean Herron
Maria Pilar Rodriguez

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Andrew Ratner, Chief of Staff, MHBE
Tony Armiger, Chief Financial Officer, MHBE
Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Brad Boban, Chief Actuary, Maryland Insurance Administration

Meeting Call to Order

Mr. McCann called the meeting to order. He reported on the closed session that took place on July 18, 2022. The closed session was held for the purpose of consulting with legal counsel about pending potential legislation and discussing the contents of a proposal, and it was a closed session because public discussion would adversely impact the ability of the public body to participate in the competitive bidding and proposal process. Secretary Schrader, Mr. McCann, Ms. Weckesser, Ms. Herron Mr. Taneja, Dr. Allen, and Mr. Steffen attended the closed session. During that meeting, the Board approved the closed meeting minutes from June 27, 2022, and discussed the pending appeal of a bid protest with counsel. The Board voted unanimously to defer its decision on whether to hold a hearing on the appeal until September. The closed meeting was adjourned at 4:23 pm.

Approval of Meeting Minutes

The Board reviewed the minutes from the Board's July 18, 2022, public meeting. Mr. Steffen moved to approve the minutes. Ms. Weckesser seconded. The Board voted unanimously to approve the minutes.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her executive update by sharing that the expanded tax credits through the American Rescue Plan Act were continued for an additional three years, through the end of 2025, which should dampen the impact of rate increases and allow many enrollees to continue to afford health insurance. She also shared that the MHBE collected its fourth "CIO 100" award this year for its technology innovation, noting that more information will be presented at next month's meeting. She continued, noting that the MHBE recently deployed a major update to its mobile application and encouraged attendees to try the improved app and sample the new features. She praised the staff involved in developing the app update.

Ms. Eberle then stated that the MHBE is ready for open enrollment. She noted that renewals are being run this week. She explained that notices will be sent out beginning October 1, 2022, and will include proposed new rates and consumers' existing rates and subsidies for comparison.

Ms. Eberle then discussed new hires at the MHBE, including Nicole Quigley, the organization's new Assistant Attorney General; Amy Barkley, a web content specialist; Theresa Battaglia, the organization's first ever Small Business Outreach Manager, part of the MHBE's push to focus on small businesses; and Tamara Gunter, the new Director of Consumer Assistance. Ms. Eberle expressed excitement over Ms. Gunter's recent presentation to the Governor's Performance Improvement Committee on the MHBE's online help, live agent, BrokerConnect, Medicare card replacement, and consumer outreach programs, as well as on the two-tiered Call Center initiative.

Finally, Ms. Eberle shared federal updates. The public health emergency (PHE) is set to expire on October 15, but the lack of the promised expiration notice from federal authorities implies that it will be extended through January 15, 2023, meaning that the PHE will be active through the election cycle and open enrollment. She expressed relative certainty that the PHE will expire on January 15, 2023, noting that the Call Center will be essential for holding onto enrollees at that point. Ms. Eberle closed by explaining that the MHBE is closely following the case *Braidwood Management v. Becerra*, wherein a lawsuit seeks to strike down requirements for health plans to cover and waive cost sharing for many critical preventive services. She expressed optimism that these requirements will remain in place, as many have already been codified in Maryland law.

Standing Advisory Committee Update

Dana Weckesser, Board Liaison

Ms. Weckesser presented on recent activities of the Standing Advisory Committee (SAC). The SAC's last meeting included a preview of draft 2024 standard plan designs from Ms. Fabian-Marks, along with context from the Affordability Workgroup's discussions. The goals for these plans are affordability, simplicity, alignment with state health goals, equity, and minimal market disruption. The Workgroup's recommendations will be communicated to the SAC and the Board in November.

Ms. Weckesser continued, stating that Ms. Fabian-Marks also presented to the Committee an update on the State Reinsurance Program (SRP), which largely reflected what was presented to the Board in July. She added that Ms. Fabian-Marks told the Committee that the Board had approved the final 2023 SRP parameters as well as approving a range for the attachment point.

Next, Ms. Weckesser shared that Mimi Hailegeberel, Manager of Small Business Programs at the MHBE, gave the Committee an update on the Small Business and Nonprofit Health Insurance Subsidy Program (SBNHISP) Workgroup. The Workgroup has been considering objectives and metrics for the program, its scope and design, and its cost. The Workgroup will continue to narrow down options in subsequent meetings and present to the SAC for review. Its final report is due to the Governor, the State Finance Committee, and the House Health and Government and Operations Committee by October 1, 2022, and will include the Workgroup's findings and recommendations.

Ms. Weckesser closed by explaining that the SAC was given an overview of the federal No Surprises Act review by Maryland Assistant Attorney General Kimberly Cammarata. The Act has been in effect since January 1, 2022. It protects consumers from surprise medical bills and improves price transparency, provider directories, and continuity of care.

Policy Committee Update

Kathleen A. Birrane, Commissioner, Maryland Insurance Administration

Commissioner Birrane shared an update on recent activities of the Policy Committee. The Committee met on August 15, 2022, and expects to recommend the creation of a Board Governance Committee for the purpose of establishing Board policies and processes that facilitate effective and efficient governance. The Policy Committee has been examining the recommendations of the Maryland State Transparency and Accountability Reform Commission. When it meets again on November 17, 2022, the Policy Committee will discuss the charter for the Board Governance Committee.

Commissioner Birrane then reviewed the updates that the Policy Committee received from each of the Workgroups. The Affordability Workgroup has one meeting remaining. The group has discussed transitioning from value plans to standard plans in order to make high-value coverage affordable, expanding value of value plans' $0 insulin and glucometer costs to all plans except Health Savings Account-eligible plans, making plan shopping straightforward by limiting the number of plans or metal levels, and what to recommend for the future of the Young Adult Subsidy Program as the pilot concludes.

Next, Commissioner Birrane shared that the Policy Committee received an update from the SBNHISP Workgroup, which also has one meeting remaining. The Workgroup is wrapping up its discussions and will submit a final report on whether to invest in a small group subsidy program to the General Assembly by October 1, 2022.

The Policy Committee noted that the Abortion Workgroup has been formed and will be meeting shortly to discuss the information to be disseminated regarding abortion care.

Finally, the Policy Committee discussed easy enrollment updates. The opportunity for individuals to enroll by checking a box while filing for unemployment insurance has been extremely successful, more so than the tax filing "check the box." A full presentation will be given to the Board at its November meeting.

Financial Projections

Tony Armiger, Chief Financial Officer, MHBE

Mr. Armiger shared that financial projections for fiscal years (FYs) 23 and 24 are over-budget, with a projected budget shortfall of $3.5 million and $5.27 million, respectively. For FY 23, the increase is a result of increased Call Center and Fulfillment contract costs. He explained that some increase in the cost of these contracts was expected given the volume of more complex calls and the impact the pandemic has had on the call center and fulfillment industries. He stated that the FY 23 projection is $35.55 million, while the projection for FY 24 is $37.27 million. FY 24 costs will include further increases in the Fulfillment and Call Center contracts, as well as a purchase of 13 contractual PINS and increases in the cost of Indefinite Delivery Indefinite Quantity (IDIQ) procurements. He explained that earlier projections had shown state savings in other areas that could help but that they may not be able to count on those.

Next, Mr. Armiger presented potential actions that the MHBE could take to address the projected shortfalls. For FY 23, Option 1 is to make reductions to Call Center services; this has the disadvantage of potentially increasing call volumes and wait times, especially after the expiration of the PHE. Mr. Armiger noted that Call Center services are currently greatly reduced because the $3 million budget cut that the Legislature enacted was taken entirely out of the Call Center, but he stated that the MHBE most likely will not be able to make similar reductions in FY 23 or FY 24.

Ms. Eberle stated that the Call Center's cost was always expected to grow and that the $3 million cut from the Legislature was enacted in part because the MHBE had not been spending the full amount that they projected would be needed in future years. She noted that the $35 million number was originally intended to be the base funding amount for the MHBE but that it was treated like the ceiling because MHBE had not been spending the full amount. She identified asking for additional funding as another option to cover the budget shortfall.

Mr. Armiger continued, explaining that Option 2 for FY 23 is to rebid the Fulfillment contract with fewer restrictions and a new scope, which could generate more competition than when it was previously bid. Mr. McCann asked whether they would be able to rebid the contract without consequences. Mr. Armiger answered that there is an allowance for cancellation for convenience.

Mr. Schrader asked whether Maryland Medicaid stakeholders have been contacted about this so that they can participate in the discussion, noting that Maryland Medicaid is a key customer making up a high percentage of the Call Center's utilization. Ms. Eberle responded in the negative, adding that only the Finance Committee has been involved thus far. She continued by noting that they have other options available for ways to get funding.

Mr. McCann asked what these other funding sources are. Ms. Eberle replied that the MHBE could assess carriers with a fee or apply for grant funds. She added that statutes require the Department of Budget and Management (DBM) and the Legislature to allow MHBE to be funded to the extent necessary for their operations.

Mr. Steffen asked how Call Center expenses are shared with Maryland Medicaid. Mr. Armiger explained that the split depends on the type of call, but it ranges from 50-50 to 75-25.

Mr. Steffen asked for confirmation that the Call Center is primarily used by Medicaid recipients rather than people on Maryland Health Connection (MHC). Mr. Armiger clarified that the Call Center distinguishes between calls that are Medicaid-related versus those related to qualified health plans (QHPs). Mr. Steffen commented that grants could be helpful but most likely would not be sustained, meaning that they would not be a long-term solution. Mr. Armiger noted that Option 3 for reducing costs would be to incentivize consumers to opt in to receive notices electronically rather than through the mail, as consumers doing so has already decreased fulfillment costs.

Mr. McCann asked whether this would reduce costs by a few hundred thousand dollars. Mr. Armiger responded in the affirmative, adding that, between the cost of printing notices and postage, it could mean substantial savings, but it would depend on the number of people who opt in.

Mr. Armiger continued, reviewing the options for FY 24 in addition to Call Center service reductions. These include cutting contractual positions that were projected and using technology to decrease volume in the Call Center through self-service Interactive Voice Response, which he acknowledged would frustrate some users. He added that, while reducing the IDIQ may help to drive down costs, it may result in higher call volumes. He asked for feedback from the Board.

Ms. Eberle commented that all of the options presented are related to service reduction rather than increasing revenue. She asked for an explanation of the Medicaid State Match that the MHBE pays. Mr. Armiger stated that the amount that Maryland is obligated to match is about 30% of the federal funds.

Mr. Schrader expressed reluctance to cut service before discussing with stakeholders from the Maryland Medicaid program, including Steve Schuh, Deputy Secretary for Health Care Financing and Medicaid at the Maryland Department of Health (MDH), and Tricia Roddy, Deputy Medicaid Director at MDH. Mr. Armiger noted that the federal fund participation rate is the lowest for fulfillment services, making them the most costly for the state. Ms. Eberle asked whether much of that cost goes to Medicaid. Mr. Armiger responded in the affirmative. Ms. Eberle suggested that this might be a pass-through. Commissioner Birrane agreed with Mr. Schrader about the need to discuss with Maryland Medicaid, adding that this should come before services are reduced or new technologies are implemented that could make consumers struggle to negotiate the Call Center.

Mr. McCann recommended that MHBE staff meet with Maryland Medicaid stakeholders and discuss options. He stated that more details about how to achieve specific budget numbers should be presented at the October or November meeting. He also noted that it is important to consider whether the $35 million budgeted for the MHBE is a reasonable number. He suggested that MHBE staff draft a rough budget.

Mr. Armiger stated that a budget analyst with whom he spoke recommended putting in a budget over the $35 million target and noted that the Legislature is unlikely to pass a Budget Reconciliation and Financing Act (BRFA) this year like the one in 2021 that cut the MHBE's funds by $3 million.

Commissioner Birrane stated that they have other tools at their disposal, including budget amendments. She expressed concern over the critical role the Call Center will play when people are rolled off Medicaid soon, with many of them joining MHC.

Mr. Schrader noted that the Board may not fully understand the cost structure of the support they give Medicaid, adding that understanding that support is doubly important because costs are tight. Mr. McCann asked for confirmation that the new Governor will revise the budget that Governor Hogan submits. Mr. Schrader responded in the affirmative. Mr. McCann suggested that MHBE staff continue to explore options with Medicaid, DBM, and BRFA, as well as options for cutting services if it becomes necessary. Ms. Weckesser noted that last month's meeting included a discussion of money that was supposed to be for the SRP but is being used by other state agencies. She asked if that money can be used for the Call Center. Ms. Eberle responded in the negative, noting that it would require legislation. Ms. Weckesser agreed with Mr. McCann and added that staff should explore ways to recoup excess SRP money. She commended staff for keeping costs low but stated that Marylanders are being hurt when the MHBE is very frugal.

Mr. McCann commented that the MBHE will continue to grow, meaning that the $35 million may soon be irrelevant, and he added that the SRP pool of funds will soon decline to $0. He suggested that the staff consider the budget for FY 26 through FY 28 and requested an informal update in October, perhaps with a more formal update in November. Ms. Eberle noted that the MHBE's statute requires that anything in their fund at the end of year has to be returned to the general fund. She commented that legislation would be required to change this. Mr. McCann asked for confirmation that the MHBE has reverted at least $6-7 million to the general fund over the last few years and $10-12 million over 10 years. Mr. Armiger answered that they have reverted a great deal of money but that those numbers may be slightly high.

Mr. Ratner added that technology improvements have allowed them to consistently spend less than the costs that were projected for the Call Center. He contended that service reductions to the Call Center may result in greater costs for the Call Center in the long term. Mr. McCann agreed and congratulated Mr. Ratner and the Information Technology Department for their technology improvements.

2023 Individual Market Landscape

Johanna Fabian-Marks, Director, Policy & Plan Management, MHBE
Brad Boban, Chief Actuary, Maryland Insurance Administration (MIA)

Ms. Fabian-Marks presented on the Maryland health insurance plan landscape. She showed a map of the carriers' service areas by county for the individual market. CareFirst and United Health Care (United) are statewide, while Kaiser Permanente (Kaiser) has full or partial service areas in only some counties. Next, she showed the number of QHPs by metal level, noting that Kaiser and United will offer an additional bronze plan each in 2023 but that there is little change otherwise. Ms. Fabian-Marks continued with a snapshot of deductibles and actuarial values (AVs) from 2022 to 2023. Both measures remained consistent, with some deductibles increasing slightly while others saw reductions. She then presented the number of on-exchange dental plans by network type and tier, noting that there is no change in the number of plans and that all dental carriers operate statewide.

Mr. Boban presented a graphic showing the individual market rates that carriers originally filed in May in comparison with the actual rates that were just approved. The MIA approved rates that averaged a 6.6% increase since the previous year, the highest increase since the SRP was implemented. However, Maryland remains at the lower end of rate increases nationally; the average increase

nationwide was 10%. Since the SRP was implemented, rates are down 25% overall, including this 6.6% increase.

Mr. Boban continued by explaining that the MIA disagreed with carriers on assumptions about trend (the year-over-year increase in claims cost, driven by utilization and unit cost of services), morbidity, reinsurance, and risk adjustment. The SRP is a major factor in keeping rates low, and the flexibility given to Commissioner Birrane to lower the attachment point was instrumental. The MIA was able to keep half of the $100 million that was going to be transferred to Maryland Medicaid and use it to lower the attachment point from $20,000 to $18,500. This attachment point was chosen to retain flexibility for the future, allowing it to be kept below $20,000 for multiple years.

Next, Mr. Boban showed the lowest-cost plan for each carrier for bronze, silver, and gold metal levels for 2022 and 2023. He noted that there is variation in premiums among carriers and that the majority of consumers receive subsidies that reduce the rates they pay. He then presented a graphic displaying rate increases in the small group market. Carriers originally asked for rates that averaged a 10% increase, while the final approved rates average a 7.6% increase, the largest since the Affordable Care Act (ACA) was passed. Rate increases have generally been low. He noted that the small group market does not have the SRP and the attachment point to keep rates down.

Mr. Boban noted that the driver of this increase is trend, which is increasing more markedly in the small group market than the individual market. He stated that both the claims component and unit cost component of trend are increasing, putting upward pressure on trend with no signs of stopping. Carriers see large trends from provider and drug costs especially. Mr. Boban clarified that trend is high even after accounting for COVID's impact on claims.

Mr. Schrader asked whether the 25.3% cumulative reduction was time-adjusted. Mr. Boban replied that there was no adjustment made for inflation. Mr. Schrader asked whether inflation is relevant to this discussion. Mr. Boban responded that it could be used and that the argument could be made that the SRP could be even more impactful than the numbers presented.

Next, Mr. Boban presented the lowest-cost silver and gold for carriers in the small-group market. These rates are generally higher than the individual market due to the small group market not benefitting from the SRP. Rates vary widely by carrier.

He then went over the ACA individual dental market. The average rate increase requested by carriers was 4.5%, and the MIA approved an average increase of 4.4%. CareFirst is the only carrier increasing rates, and he expressed that the increase was justified. Mr. Boban then presented the premiums for the most popular dental plan from each carrier, noting that dental premiums are generally lower than medical premiums, meaning that rate increases will result in a less than $10 increase for most consumers if they see an increase at all. Almost half of consumers are enrolled in plans that saw no change or got cheaper.

Mr. Steffen asked what service categories drove the rate increases. Mr. Boban replied that drug and especially professional services were the largest drivers of increases across all carriers. Drug prices have previously been outrageously high and are beginning to move in that direction again.

Mr. McCann noted that the Board had hoped United's entry into the market would help press down rates. He asked whether this result has been observed. Mr. Boban stated it is reasonable to assume that United's entry factors into Kaiser's and CareFirst's pricing strategies given that United took business from them. Commissioner Birrane emphasized that the individual rates shown are the unsubsidized rates.

Ms. Weckesser noted that CareFirst appears to have the highest rates across the board. She asked what factors are driving that. Mr. Boban agreed that the CareFirst preferred provider organization (PPO) has the highest rates, and that is largely driven by self-selection into the PPO by high utilizers. He stated that divergence in health maintenance organization (HMO) rates is due to different claims results, approaches in setting assumptions, and differential aggressiveness in pricing. Mr. McCann expressed that the Board may need to consider whether the SRP and risk adjustment need to be reevaluated because of this divergence in rates, as their goal is to keep rates similar.

Out-of-Pocket Maximums in the Individual ACA Market Presentation

Brad Boban, Chief Actuary, MIA

Mr. Boban began his presentation with a review of background information on the maximum out-of-pocket amount (MOOP). These maximums do not include premium payments but include amounts paid for deductibles, copays, and coinsurances. The ACA set a limit on MOOPs: in 2014, the limit was $6,350 for individual plans, matching the Internal Revenue Service's MOOP limit for high-deductible health plans, but the ACA's limit has since increased much more quickly than the IRS' limit. The ACA's MOOP limit for 2023 is $9,100. MOOPs are lower for individuals than families and lower for those with lower incomes

Since 2014, MOOPs have increased rapidly as they were used by carriers to fit plans into required AV parameters, with slower increases since 2019. Because of these increases, the MIA was asked to collect and analyze data on the number of members reaching their MOOP. They collected data for 2019 through 2021 from all carriers.

Mr. Boban presented a summary of the proportion of members who reach their MOOPs in Maryland, drawing on aggregated data from all carriers for 2019 through 2021. Bronze plans have the highest percentage of consumers who reached their MOOP across carriers each year. This surprised Mr. Boban, who expected gold plans to have the most consumers reaching the limit due to gold plans having lower MOOPs and higher claims costs. Mr. Boban explained that the unexpected result is likely due to the more restrictive deductibles that consumers with bronze-level plans have to pay before coverage kicks in.

Mr. Steffen asked whether the data presented includes only consumers enrolled through MHC or whether it also includes those enrolled off-exchange. Mr. Boban responded that the data includes those on and off the exchange.

Mr. Boban then presented on the differences in consumers who reach their MOOPs on- vs. off-exchange. Across carriers and years, those with off-exchange plans are much more likely to hit their MOOPs, with around 2% more members with these plans reaching their limits than their on-exchange counterparts. Mr. Boban explained that he is still formulating thoughts on why this could be.

Next, Mr. Boban transitioned from data on self-only contracts to family contracts. Those with family contracts are much less likely to hit their MOOPs, which are generally almost double what they would be for self-only contracts. Much less than 1% of consumers with family contracts hit their MOOPs on average. He explained that it is very unlikely for families to hit their MOOP because only an amount equivalent to any individual family member's MOOP can be counted toward their family MOOP, negating the effects of particularly high-cost family members.

Finally, Mr. Boban showed a comparison of consumers reaching family MOOPs on- vs. off-exchange. While 0.8% more consumers in bronze plans off-exchange hit their MOOPs than those in on-exchange bronze plans, in general, there is no meaningful difference in the percentage of consumers hitting MOOP for on- vs. off-exchange plans. Appendix slides with more detail for each year from 2019 to 2021 are available in the materials for this meeting.

Mr. Schrader asked if there is data on the income mix by plan. He expressed interest in examining the MOOPs for individuals who own their own business and comparing their plan choices to other consumers. Mr. Boban responded the MIA does have this data. He stated that the average income of those who enroll off-exchange is higher than that of those who enroll on-exchange, meaning that off-exchange consumers have less income constraints preventing them from purchasing lots of services and reaching their MOOPs.

Mr. Schrader asked for an explanation of the major differences between on-exchange and off-exchange plans. Mr. Boban responded that on-exchange and off-exchange plans are part of the same risk pool, meaning that they have consistent pricing. However, advance premium tax credits and cost sharing reductions are only available on MHC. People who know that their income makes them ineligible for subsidies are attracted to off-exchange plans, making that pool consist of higher-income individuals overall.

Mr. Steffen asked if any plans are offered off-exchange exclusively, incentivizing some consumers to enroll off-exchange. Mr. Boban responded that there were no such plans when these data were collected, but he noted that there will be some plans available exclusively off-exchange as of 2023 because of federal AV changes.

Ms. Weckesser asked if people who buy bronze plans tend to have lower incomes. Ms. Eberle responded that this is not necessarily the case, as the out-of-pocket cost for bronze plans is high even if premiums are low. Ms. Eberle expressed interest in comparing on- and off-exchange enrollment before and after the introduction of informational tools for consumers on MHC and the use of Navigators. Mr. McCann asked if any of the tools available on MHC inform consumers of whether they would be best served off-exchange. Ms. Eberle responded in the negative.

Ms. Weckesser expressed concern that so many people have to pay so much money before they can use their insurance. She expressed a desire to increase health care affordability and access. Ms. Fabian-Marks noted that the enhanced subsidies that are newly available on the individual market have changed the landscape by providing silver plans that are nearly or completely free to low-income individuals. Additionally, the removal of the income cap for subsidy eligibility has made many more people enroll on-exchange because they are newly eligible for subsidies.

Closed Session

Mr. McCann announced that the Board is going into closed session to obtain advice about a pending legal matter. This topic falls under the closed meeting exceptions: consulting with counsel to obtain legal advice, consulting with counsel about potential litigation, and discussions of the contents of a proposal because public discussion would adversely impact the ability of the public body to participate in the competitive bidding or proposal process, pursuant to the General Provisions Act. Mr. McCann moved to meet immediately following this session in closed session in order to consult with counsel to obtain legal advice regarding the resolution of a legal matter pursuant to General Provisions Article §3-305(b)(7)(8,14). Mr. Steffen moved to move into closed session. Ms. Weckesser seconded. The Board voted unanimously to move into closed session.

Ms. Weckesser moved to adjourn. Mr. Steffen seconded. The Board voted unanimously to adjourn.