MHBE

Standing Advisory Committee

September 8, 2022
2:00PM – 4:00PM
Via Google Meets

Members:
Ken Brannan, Co-Chair
Jon Frank, Co-Chair
Matthew Celentano
Dr. Evalyne Bryant-Ward
Ben Fulgencio-Turner
Bryan Gere
Katherine Grason
Diana Hsu
Sophie Keen
Stephanie Klapper
Scott London
Allison Mangiaracino
Marietherese Oyalowo
Dylan Roby
Alyssa Sinagra
Kathlyn Wee
Dana Weckesser, Board of Trustees Liaison

MHBE Staff
Michele Eberle
Johanna Fabian-Marks
Becca Lane
Andrew Ratner
Makeda (Mimi) Hailegeberel

Members of the Public
Marie Grant
Jessica Pappas
Sheena Ogee
Brad Broban
Philemon Kendzierski
Brenna Tan
Sandy Walters

Welcome
Co-Chairs Ken Brannan and Matthew Celentano welcomed everyone to the meeting.

Executive Update
Michelle Eberle provided the executive update. Ms. Eberle thanked the SAC members and MHBE staff for all of their hard work during the summer. She noted that the next Board meeting is on September 19, and most of that meeting will be centered on the 2023 plan year with the approved plans and rates. The Maryland Insurance Administration (MIA) will provide a presentation on the rates for 2023, how they were determined, and the issues involved. They will also talk about the medical loss ratio rebates, which is a big issue every year. Under the Affordable Care Act (ACA), the carriers have to spend a certain amount on clinical services, and if they don't spend that amount, then they have to provide rebates back to consumers. The Board is interested in understanding how that program works because it is based on the carrier's

experience in the previous three years. Ms. Eberle noted that in the past she has asked how carriers can provide $1,800 rebates to enrollees when premiums are increasing, and the MIA will explain this to the Board. The MIA will also present on out-of-pocket maximums and how many people reach those maximums, which has been an area of interest for the Board. There will also be an overview of the plans for fiscal year 2023. MHBE will be presenting a new feature on Maryland Health Connection that was rolled out this year called Broker Connect, which connects consumers to a broker for assistance within 15 minutes.

Ms. Eberle reported that the Board Policy Committee met in August, and they will be suggesting that the Board form a Board Governance Committee. They feel that the Committee would help with the Board's self-governance and overall effectiveness. The Committee's purpose would include examining how the Board evaluates itself and determining what trainings would be helpful.

Ms. Eberle then provided an update on federal news. She expressed joy that the Inflation Reduction Act passed and included a continuation of the expanded tax credits. She noted that the extension means continued coverage for many people in Maryland.

Ms. Eberle continued, reporting that a proposed rule came out on August 4 that would reinterpret a part of section 1557 of the ACA that prohibits discrimination based on race, color, national origin, sex, age, or disability in a health program or activity that is receiving federal financial assistance. There was a change under the Trump administration that rolled back some of these protections, and the proposed rule would restore those protections. For anyone interested, Ms. Eberle encouraged submitting public comments, which are due on October 3. She added that the MHBE will be submitting a letter of support. Ms. Eberle explained that they are still waiting for a final decision on the public health emergency (PHE) unwinding and still believe that it won't occur until January 1, 2023, allowing MHBE to do open enrollment as they have in the past.

Ms. Eberle reported that the Coalition of State-Based Marketplaces is looking forward to the post-election season and is discussing the items that are most important for state-based marketplaces for providing quality, affordable health coverage for citizens. They are also discussing their responses depending on the election outcomes and the makeup of Congress.

Ms. Eberle reported that the MHBE is also monitoring local and statewide elections and will make plans accordingly, including the policymakers that will need to be introduced to the MHBE. She noted that it is budget season for all state agencies, so the MHBE is heavily involved in finalizing the budget and submitting it to the Department of Budget and Management. Ms. Eberle noted that Johanna Fabian-Marks and her team have been working hard on legislatively mandated work groups, and the MHBE is preparing for the legislative session. Ms. Eberle reported that Heath Forsythe, the Director of Consumer Assistance, left the MHBE. She thanked Ms. Forsythe for her years of hard work. Ms. Eberle noted that Tamara Cannida-Gunter, the Deputy Director of Consumer

Assistance, has been promoted to Director. Ms. Eberle explained that they are preparing for the MHBE's tenth open enrollment. She expressed excitement that the expanded tax credits have been continued but stated that they are anxiously waiting for the 2023 rates to be released. The rates will probably be lower than the average 11% increase that was filed by carriers, but they do expect an increase in premium rates for 2023.

Mr. Brannan asked about the link for the proposed rule on discrimination and noted that there are SAC members who could potentially help submit comments for this proposed rule.

Scott London asked if the MHBE expects any problems after the PHE ends and Medicaid redeterminations start again and whether they expect to see a large number of people lose Medicaid eligibility. Ms. Eberle responded that this issue is at the forefront in the minds of federal officials and legislators, and everyone is very concerned. She noted that Maryland has an integrated eligibility system with Medicaid and the qualified health plans, so they have the ability to move people between programs, and Maryland has never stopped doing the redeterminations during this period although Medicaid coverage was not terminated. This means that Maryland has kept up to date with address and income information. The biggest impact that the MHBE envisions is based on timing: if the PHE ends during open enrollment, then the call center could be overwhelmed with calls from people trying to enroll in qualified health plans and people dealing with Medicaid redeterminations. Maryland is going to take a full year to do the redeterminations, and the communication and assistance plan is already laid out, so the MHBE is not concerned. Ms. Eberle expressed the importance of doing their best to ensure that nobody gets lost in the unwinding process.

Diana Hsu asked if any public documents will be released, such as the Medicaid plan or MHBE plan. Ms. Eberle responded that she does not know and will follow up with the SAC when she has an answer. Ms. Eberle expressed certainty that they can make the plan public and noted that the Maryland Department of Health (MDH) has put a large packet together, and she is not sure of their plans to make that public.

2024 Standardized Plan Design (Draft) Preview

Johanna Fabian-Marks gave the SAC a preview of the draft standardized plan designs for coverage year 2024. She began by noting that the designs are in a draft state and that she intends to present the final designs at the next SAC meeting.

Ms. Fabian-Marks explained that the plan designs are being developed in consultation with the Affordability Workgroup and shared the questions that guided their deliberations around affordability, conditions with disproportionate impact such as diabetes, and ease of plan shopping. She cautioned that, while the Affordability Workgroup has been charged with developing recommendations on the future of the young adult subsidy, that topic will not be covered in the current presentation. She outlined the policy recommendations being discussed by the Workgroup, including transitioning from value plans to standard plans, using plan design to address health equity, simplifying plan

shopping by limiting the number of plans each carrier can offer at each metal level, and expansion of the no-cost insulin and glucometer benefits to all plans where not prohibited.

Next, Ms. Fabian-Marks described the structure and membership of the Affordability Workgroup, noting that it includes representation from a wide variety of perspectives and is co-chaired by David Stewart, an experienced MHBE Navigator, and JoAnn Volk, a Georgetown University professor of Health Policy.

Ms. Fabian-Marks then provided a breakdown of how the current value plans are structured for plan year 2023. Carriers are required to offer at least one branded value plan at each of the bronze, silver, and gold metal levels. Beyond the value plans, carriers are limited to three additional plan designs at each metal level. She explained that the concept of value plans came out of work done by a previous Affordability Workgroup that was focused on the affordability of plan cost sharing as opposed to premium. The move toward standard plans in Maryland mirrors that undertaken by other states and by the federal marketplace.

Next, Ms. Fabian-Marks discussed rationales for implementing standardized plans, including increasing health care access, promoting insurer competition, simplifying plan choice, and setting a coverage “floor.” She explained that the Workgroup weighed those rationales and, through its robust discussion, established goals for the standard plans: affordability, simplicity, alignment with state health goals, equity, and minimal market disruption.

Ms. Fabian-Marks then shared the current proposed standard plan designs, showing the deductibles, maximum out-of-pocket costs (MOOPs), and copays for services for each metal level (Bronze, Base Silver, Silver CSR 73%, Silver CSR 87%, Silver CSR 94%, and Gold). She explained that the standard plans for the silver and gold metal levels introduce separate deductibles for medical care and drugs, with the drug deductible being much lower than the medical deductible, allowing consumers to better afford their prescriptions without first having to meet their full medical deductible. She pointed out that all metal levels establish a copay for generic drugs that is available without meeting any deductible.

Next, Ms. Fabian-Marks discussed the MOOP designs, pointing out an innovative feature introduced at the silver and gold levels where the plans offer separate MOOPs for medical and drug coverage. As with the separate deductibles, the separate MOOPs for drugs are much lower than the medical MOOPs, allowing consumers with more prescription costs to access full coverage by the carrier much sooner than is possible in the current market.

Ms. Fabian-Marks demonstrated that the plan designs have, within each metal level, the same copay amount for commonly used outpatient services including primary care visits, mental health and substance use disorder (MH/SUD) visits, speech therapy services, and occupational and physical therapy services.

Next, Ms. Fabian-Marks focused on the bronze standard plan design, showing that, as compared with the currently available bronze value plans, five additional service types are offered pre-deductible: specialist visits, speech therapy, occupational and physical therapy, laboratory outpatient and professional services, and X-rays and diagnostic imaging.

Diana Hsu asked what is covered in the MH/SUD category. Ms. Fabian-Marks replied that the category is intended to cover outpatient office visits and shared that the Workgroup is also working to develop a copay amount for other MH/SUD services that could not be characterized as either inpatient stays or outpatient office visits, but she noted that the work is still underway and not yet ready to present.

Mr. Brannan asked those SAC members from the carrier community who were part of the Affordability Workgroup to comment on the plan designs. Catherine Grason replied that her organization, CareFirst, has appreciated the collaborative way in which the plan designs were developed and is keeping close watch on how the plan designs will impact premium rates. Kathlyn Wee of United HealthCare echoed Ms. Grason's comments regarding the plan design process. Allison Mangiaracino of Kaiser Permanente also expressed support and appreciation for the collaborative process undertaken by the Workgroup, adding that her organization has experience with similar standard plan designs in other states and finds it does help to simplify and improve the plan shopping experience for consumers.

Dylan Roby expressed support for standardized plan designs, citing experience with similar structures in California. He shared that, often, consumers do not understand the distinction between pre-deductible and post-deductible copays, leading to suppressed utilization of pre-deductible services. He recommended that the plans be marketed to both consumers and media in such a way as to clearly demonstrate the "first-dollar" coverage available with pre-deductible copays. Mr. Brannan asked for further detail on this last point, and Mr. Roby explained that media coverage in California focused entirely on plan deductibles as a benchmark of plan affordability without regard to the services available pre-deductible.

Sandy Walters, noting that plans have traditionally been presented to the public with the deductible as the first and most prominent feature, recommended that the Maryland plans be presented with pre-deductible services up front and the deductible amounts shared later.

Ms. Hsu cautioned that, while it is commendable to highlight the pre-deductible services, consumers need to be made aware of their potential liability for more costly events such as inpatient hospitalizations.

Mr. Brannan asked whether the MHBE's Navigators are trained on these distinctions and how best to communicate them to the public. Ms. Fabian-Marks replied that Navigators are fully trained on the ins and outs of plan designs but are constrained by

regulation from certain behaviors that might constitute recommendations or steering. She also reminded SAC members of the MHBE's total cost of care calculator tool available to consumers to help with their decision.

Mr. Brannan echoed Mr. Roby's comments regarding the media, noting that the public often first encounters information about their plan choices in this way. If the media coverage does not reflect the true value of the plans, consumers may be unnecessarily disadvantaged.

Ms. Hsu noted that, in her experience, media coverage of the underinsurance issue tends to focus on services that are not covered but are medically necessary. Mr. Roby replied that much of the media coverage goes directly to the plans' deductibles without reference to pre-deductible services, adding that plan deductible is often used as the measure of plan generosity.

Jon Frank noted that health insurance is a complicated purchasing decision and that consumers do not often spend as much time as may be needed to fully understand how the coverage works. He added that the problem is universal and may not be soluble by the MHBE but supported efforts to fine-tune communications to help alleviate the issue.

Ms. Fabian-Marks concluded her remarks by sharing next steps for the standardized plan designs. The Workgroup continues its work by considering how to standardize additional services, such as those not considered in the federal actuarial value calculator, and how to implement reduced cost sharing for diabetes care based on the Washington, DC design. Plan designs will be finalized by the end of the month and presented to the MHBE Board in November.

2022 State Reinsurance Plan Update

Ms. Fabian-Marks began her remarks by noting that premiums fell through the first three years of the State Reinsurance Plan (SRP) but began to rise slightly once again in 2022. Despite this rise, the 2022 premiums are more than 30% below their level prior to the SRP's inception. She demonstrated that premiums in Maryland are lower than in the U.S. and that the SRP has helped to boost enrollment to an all-time high in 2022.

Next, Ms. Fabian-Marks shared that the 1% assessment fee on insurance providers used to support the SRP in combination with federal funds was extended through 2028 during the 2022 Maryland legislative session. That law requires the MIA to lead a Workgroup in consultation with MHBE to evaluate the impact of the SRP and possible alternative funding sources, the appropriateness of the 1% fee, and market reforms needed to provide affordable individual market coverage. This Workgroup's report is due on December 1, 2023.

Ms. Fabian-Marks then shared the expenses and income of the SRP projected for 2023. She noted that the SRP is projected to remain solvent but that the legislature has pulled funding from the program for other initiatives in 2022. The SRP is expected to begin spending down its state funding balance in 2022 and 2023 after having exhausted all

federal funding, whereas in previous years the program was able to operate on federal funding alone and stockpile state funds. She added that SRP costs are expected to outstrip the inflow of both federal and state funding in the coming years. Based on that analysis, MHBE expects current federal and state funds to be insufficient for SRP operations after 2025. For this reason, the SRP must identify additional or alternative funding arrangements, adjust its program parameters, or both.

Ms. Fabian-Marks concluded her remarks by sharing the 2023 SRP parameters, noting that the program will not be changing apart from the attachment point. While in previous years the attachment point was set by the MHBE Board at $20,000, the 2023 parameters authorize the Insurance Commissioner to set the attachment point within a range of $15,000 to $20,000. She noted that the MHBE is currently beginning the process of obtaining a second waiver from federal authorities to continue to operate the SRP.

Matthew Celentano asked what impact changing the attachment point would have. Ms. Fabian-Marks explained that reducing the attachment point increases the cost of the SRP. The changes do not inherently have differential impact on carriers.

Mr. Celentano, citing the previously discussed funding shortfall in the coming years, asked whether it is wise to allow a reduction in the attachment point, thus increasing program cost. He wondered whether the Board should rather take proactive measures to improve the solvency of the program in the future. He also asked when the Workgroup will begin. Ms. Fabian-Marks replied that, while the MHBE is consulting, the MIA is the convening agency for the Workgroup. Regarding the attachment point question, Ms. Fabian-Marks pointed out that the Board authorized a range that will not necessarily result in a reduction, and that the potential for a reduction in the attachment point is taking place alongside conversations around additional and alternative funding sources for the SRP or reductions in funding outflows from the program.

Mr. Celentano asked whether the Workgroup will be able to discuss the SRP more broadly, potentially even alternatives to the SRP altogether. Ms. Fabian-Marks replied that the charge from the legislature was clearly to focus on funding for the SRP.

Mr. Celentano and Ms. Hsu expressed great interest in getting involved with the Workgroup.

Small Business and Nonprofit Health Insurance Subsidies Program Workgroup Update

Mimi Hailegeberel introduced herself to the SAC and presented on the activities of the Small Business and Nonprofit Health Insurance Subsidies Program (SBNHISP) Workgroup. Senate Bill (SB) 632 mandated that the MHBE convene a Workgroup to study and make recommendations relating to the establishment of a subsidies program to assist small businesses and nonprofit employers and employees in purchasing health insurance. Ms. Hailegeberel reviewed the Workgroup's membership.

She then described key discussion topics that have been covered in the Workgroup, which include objectives, target metrics, scope, design features, and cost considerations for a subsidy program. Specific design features discussed include subsidy eligibility requirements, duration, and availability off-exchange.

Ms. Hailegeberel continued by reviewing the two subsidy design options to which the Workgroup had narrowed its proposal so far. Option 1 is a traditional small business subsidy in that employers would see reduced premiums for a group plan. The major disadvantage that the Workgroup highlighted is that employees could lose eligibility for Advance Premium Tax Credits (APTC) if employers offer a subsidized group plan. Option 2 is an additional state subsidy on the individual market for employees of small businesses. Employers would be responsible for applying for the subsidy and providing their employees with a code that could flag them for eligibility, and this model has the advantage of employees retaining APTC eligibility. However, employers do not have a direct incentive to handle the administrative duties that would be introduced by this model.

Ms. Hailegeberel explained that concerns about the loss of APTC eligibility and about funding sources led to the Workgroup's two recommendations: that the legislature ensure MHBE has the funding necessary for a significant expansion of marketing and outreach to small employers in order for them to help educate employees on the health insurance options available through MHC and help facilitate enrollment; and that the MHBE reconvene stakeholders to discuss the creation of a new subsidy in the future if it appears likely that the enhanced APTC currently available on the individual market will expire.

Ms. Hailegeberel stated that the Workgroup has two meetings remaining. At the final meeting, the Workgroup's members will review a draft of the final report due to the legislature by October 1.

Jon Frank, who co-chairs the SBNHISP Workgroup, noted that both subsidy design options were flawed. He explained that the enhanced subsidies that continue to be available on the individual market due to the Inflation Reduction Act make the individual market very attractive. He stated that members of the Workgroup will continue to work on these issues after submission of the report.

Mr. Brannan acknowledged the importance and complexity of creating something that works for both small business owners and their employees. He praised the Workgroup for its efforts on a short timeline and stated that introducing a subsidy may make more sense in two to three years' time.

Sandy Walters explained that an additional complication is ensuring that a program is reaching the uninsured, not just moving those who are already insured between markets.

Mr. Brannan agreed with Mr. Walters and pointed out that brokers are an important stakeholder in this discussion. He also noted the importance of employer-sponsored healthcare as an incentive for employee loyalty but stated that it is unaffordable for many small businesses.

Mr. Frank stated that the Workgroup's report will include much more detail on its discussions.

No Surprises Act Overview

Kimberly Cammarata, a member of the Health Education & Advocacy Unit (HEAU) of the Attorney General's Office, provided a presentation on the federal No Surprises Act, a consumer protection bill. Detailed slides are available in the presentation for this meeting.

Ms. Cammarata explained that the No Surprises Act protects consumers from surprise medical bills, offers price transparency for consumers, improves provider directories, and ensures continuity of care. These requirements apply to most individual and group health plans but do no apply to Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or Tricare. As of January 1, 2022, providers and facilities cannot balance bill for out-of-network emergency services or non-emergency services by nonparticipating providers at certain participating health care facilities. The Act prohibits balance billing for air ambulance services by nonparticipating providers. Providers are also required to provide a good faith estimate in advance of scheduled services, or upon request for uninsured or self-pay individuals. The No Surprises Act also provides new continuity of care requirements when a provider's network status changes while the patient is continuing care, requires improved provider directories, and provides help to enrollees who rely on inaccurate directories.

Ms. Cammarata provided examples of surprise billing that the HEAU has seen. She also provided an overview of the balance billing protections under the No Surprises Act. Health plans are required to apply in-network cost sharing requirements, and out-of-network providers, facilities, and providers of air ambulance services are prohibited from billing patients more than the in-network cost sharing amounts in certain circumstances. She went over the process for determining a patient's cost share and the provider reimbursement amount when the balance billing prohibition is applicable.

Ms. Cammarata then provided an overview of emergency services and what qualifies as an emergency service. Under the No Surprises Act, out-of-network providers and out-of-network emergency facilities cannot balance bill an individual who gets covered emergency services for an emergency medical condition. Certain post-stabilization services are considered emergency services and are subject to the balance billing prohibition. The emergency service provisions apply to physicians and other health care providers acting within the scope of their practice, emergency departments, hospitals, and independent freestanding emergency departments. Ms. Cammarata explained that the Act uses a "prudent layperson" definition for emergency medical conditions instead of solely relying on the diagnosis codes. In limited circumstances, emergency facilities

and some out-of-network providers can use the No Surprises Act's notice-and-consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for certain post-stabilization services.

Ms. Cammarata noted that out-of-network air ambulance service providers cannot balance bill for medical transport by helicopter or airplane. She explained that this is a huge improvement for consumers, as the HEAU has seen a large number of air ambulance bills in the $40,000 to $70,000 range, and there was very little consumers could do. The No Surprises Act does not apply to ground ambulance services, but Maryland law offers some balance billing protections.

Ms. Cammarata provided an overview of non-emergency services. Out-of-network providers cannot balance bill for non-emergency items and services that are part of a visit at an in-network health care facility, except in limited circumstances where the notice-and-consent exceptions apply. Non-emergency services include equipment and devices, imaging services, telemedicine services, lab services, and preoperative and postoperative services. Ms. Cammarata noted that the ban on balance billing only applies to non-emergency services covered by an individual's health plan.

Ms. Cammarata explained that the balance billing protections can be waived by patients in some limited circumstances, but only when the Act's notice and consent requirements are met. The Centers for Medicare and Medicaid (CMS) provide a template for the notice and consent forms. The balance billing protections can never be waived for ancillary services, which includes services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology and services provided by assistant surgeons, hospitalists, and intensivists.

Ms. Cammarata reported that the law also requires providers and facilities to notify patients about their new protections under the No Surprises Act. The HEAU and the MIA have developed state-specific language for the notices to assist providers and facilities in satisfying this notice requirement. The law also expands appeal rights for consumers. Coverage decisions that involve whether a health plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act protections are eligible for external review.

Ms. Fabian-Marks asked if Ms. Cammarata could finish her presentation at the next SAC meeting on October 13 because this topic is of interest to the SAC. Mr. Brannan added that he has some questions and would like to continue the presentation at the next meeting. Ms. Cammarata responded that she can finish her presentation at the next meeting.

Public Comment
None offered.

Adjournment
The meeting adjourned at 4:00 PM.

Chat record:

00:06:14.576,00:06:17.576
Stephanie Klapper: Would be great to get the link about the proposed rule

00:09:35.645,00:09:38.645
Michele Eberle -MHBE-:
https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities

00:50:55.237,00:50:58.237
Catherine Grason: i have to step away for just one moment but will be right back.

00:53:29.539,00:53:32.539
Catherine Grason: back sorry about that

01:06:32.697,01:06:35.697
Diana Hsu: When will MHBE open applications for the work group?

01:07:28.666,01:07:31.666
Becca Lane -MHBE-: We haven't discussed that yet Diana but we will definitely let the SAC know when we do!

01:07:56.121,01:07:59.121
Diana Hsu: Thanks Becca!

01:11:13.667,01:11:16.667
Diana Hsu: Also, my apologies, I meant MIA. Thanks again Becca!