Maryland Health Benefit Exchange
Board of Trustees

February 21, 2023
2 p.m. – 4 p.m.
Meeting Held at 100 Community Place, Side A, 1st floor, Crownsville, Maryland and via Video Conference

Members Present During Open Session:
Laura Herrera Scott, Chair
S. Anthony (Tony) McCann, Vice Chair
Ben Steffen, MA
Maria Pilar Rodriguez
Kathleen A. Birrane
K. Singh Taneja
Mary Jean Herron
Dr. Rondall Allen

Members Absent:
Dana Weckesser

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Venkat Koshanam, Chief Information Officer, MHBE
Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE
Tracey Gamble, Procurement Manager, MHBE
Nicole Quigley, Assistant Attorney General, MHBE
Sharon Merriweather, Principal Counsel, MHBE

Meeting Call to Order
Mr. McCann called the meeting to order. The Board welcomed Secretary Herrera Scott and introduced themselves.

Approval of Minutes
Mr. McCann asked for a motion to approve the minutes of the January 17, 2023, open meeting. Ms. Herron moved to approve the minutes without amendment, seconded by Mr. Steffen. The minutes were approved.

Statement on Closed Meeting
Mr. McCann read the following closed meeting disclosure statement:

The Board met in closed session on January 17, 2023, to discuss an MHBE personnel matter that affected one or more specific people.

The following Board members attended the closed session: Dennis Schrader, Chair, Tony McCann, Co-Chair, Dana Weckesser, Kathleen Birrane, Ben Steffen, Mary Jean Herron, Singh Taneja, and Maria Pilar Rodriguez. The following Board staff members were also in attendance: Sharon Merriweather, Principal Counsel; Michele Eberle, Executive Director; Andy Ratner, Chief of Staff; JasCiel Stamp, Director of HR; and Cynthia Wilson, Executive Assistant.

After discussion, the Board determined that no action was needed.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her remarks by welcoming the new Board Chair, Secretary Herrera Scott. She then described the recent kickoff event for the Maryland Easy Enrollment Health Insurance Program (MEEP), noting the attendance of several luminaries, including Lieutenant Governor Miller, Comptroller Lierman, State Senator Feldman, and Senator Van Hollen. She underlined the program's success in enrolling more than 10,000 people in its first three years.

Next, Ms. Eberle described the work underway in partnership with the Maryland Department of Health (MDH) to transition Medicaid enrollees as the public health emergency (PHE) ends, called the PHE unwinding. She explained that, during the PHE, Medicaid was prohibited from disenrolling anyone, regardless of their circumstances. The PHE unwinding will take place over the course of a year, during which enrollees will have their eligibility redetermined. Those who are determined to be ineligible for Medicaid will have access to coverage through Maryland Health Connection (MHC). She gave an overview of efforts to communicate with enrollees through advertising, social media, and the agency's call center, as well as to automate the redeterminations as much as possible through robotic processes and external data sources. She noted that all Maryland agencies involved in the effort are working well together.

Ms. Eberle then discussed the ongoing session of the Maryland General Assembly, noting that both of the MHBE's budget hearings have already taken place. She further noted that the MHBE's budget has been reduced from $35 million to $32 million and that the agency has submitted a budget deficiency for the current year regarding the call center and fulfillment activities. The MHBE will likely receive general funds during fiscal year (FY) 2024.

Next, Ms. Eberle addressed some of the bills underway in the legislature. She mentioned a qualified resident bill that would allow Marylanders to enroll in health coverage through MHC regardless of their documentation status, bypassing federal subsidies for which they do not qualify but still accessing any state funds available. Another bill addressing small business coverage includes a special enrollment period, marketing support, and a potential subsidy for this population. She noted that the MHBE recommended funding for outreach to small businesses rather than a subsidy. A bill to continue the pilot program to provide subsidies for young adults is coming up for discussion this week, and one bill that would have permitted professional employer organizations to offer health insurance was withdrawn.

Mr. Steffen asked whether the MHBE took a position either in support or in opposition to the qualified resident bill. Ms. Eberle replied that the agency submitted a letter supporting the bill's language allowing access to MHC but remained agnostic on the portion of the legislation providing subsidy funding.

Policy Committee Report

Dr. Rondall Allen, *Board Liaison*

Dr. Allen provided an update on the Policy Committee, noting that it had two meetings since the last report: January 23 and February 6. During its January 23 meeting, the committee received an update from MHBE staff on the PHE unwinding. It also discussed policies on appeals of adverse producer authorization decisions, unanimously agreeing to recommend that the MHBE contract with the Maryland Office of Administrative Hearings (OAH) to manage the process. During its February 6 meeting, the committee discussed Board member onboarding and orientation, opportunities for Board member engagement, and a potential mentoring or "buddy" program for new Board members. Finally, the committee heard from the MHBE staff on a potential quarterly speaker series on topics relevant to the Board and to the MHBE in general.

Standing Advisory Committee Appointments

Jon Frank, Standing Advisory Committee (SAC) Co-Chair

Mr. Frank gave the Board a presentation on the 2023 SAC member appointments. He began by explaining that each SAC member serves a three-year term, requiring five to seven new members every year. He thanked the MHBE staff for their help in posting the application for SAC membership, managing the application intake, and for the effort to maintain the committee membership's reflection of the diversity of the state and bolster the breadth of expertise available.

Next, Mr. Frank explained that seven people applied for membership to the SAC, including academic researchers, a Chamber of Commerce executive, healthcare providers, and community advocates. He added that the committee continues to seek a new member from Western Maryland to maintain geographic diversity. He asked the Board to appoint the seven SAC applicants.

Mr. McCann moved to approve the appointment of the 2023 applicants to the Standing Advisory Committee as presented. Ms. Herron seconded. The motion was approved.

Medicaid Transition Easy Enrollment

Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE

Ms. Fabian-Marks presented a request for approval of emergency regulations regarding the Medicaid transition population's enrollment into other health plans. She began by explaining that, due to the end of the PHE, Medicaid coverage terminations will begin once again at the end of May 2023. The goals of the emergency regulation are to simplify the enrollment process of those transitioning out of Medicaid and into qualified health plans (QHPs) through MHC and to increase the number of people who maintain coverage. She added that the proposed process is very similar to the one underway in California.

Next, Ms. Fabian-Marks described the populations who would be eligible under the proposed process. The first is those Medicaid enrollees who undergo a redetermination that finds them eligible for a QHP but who do not select a QHP within a defined time period. The second is those Medicaid enrollees (1) who reported changes in income during the PHE that would make them ineligible for Medicaid, (2) who did not update their information in MHC during their redetermination, and (3) whose attested income was verified by the MHBE using electronic data sources.

Ms. Fabian-Marks then demonstrated the process by which individuals in both categories would be enrolled. Consumers would be sent a notice that they were enrolled in a default QHP and offered the opportunity to confirm the plan choice by either paying their first month's bill or, in the case of young adults enrolled in a plan with no premium, by opting in through their MHC account. She added that consumers would have the option to select a different plan than the default through a special enrollment period (SEP).

Ms. Herron expressed concern that consumers experiencing homelessness may lose coverage through lack of an address at which to receive notices. Ms. Fabian-Marks replied that the MHBE is looking into communication via email and telephone in addition to physical mail.

Next, Ms. Fabian-Marks explained the proposed hierarchy by which a transitioning consumer's default plan would be selected. First, if other members of the household are already enrolled in a QHP, transitioning consumers would be added to that plan. Consumers whose Medicaid managed care organization (MCO) also offers a QHP would be placed in the most cost-advantageous plan available from that same company. In some cases, that would be the lowest-cost Silver plan, while in others, the lowest-cost Gold plan is the best choice. Finally, if the consumer's MCO does not offer a QHP, they will be placed in the lowest-cost Silver or Gold plan available in their region.

Ms. Fabian-Marks then addressed the timing of the regulation, noting that a normal regulation promulgation takes several months. Since the need for this regulation is so urgent, the MHBE is using the emergency regulation process. Emergency regulations can be established before taking public comment but require that public comment be taken within six months in order to become permanent. The proposed process could become effective by April 7, 2023. She added that the MHBE released the proposed regulation to stakeholders for a brief informal comment period and shared some highlights of the feedback received.

Secretary Herrera Scott asked whether the MHBE will track which of the affected consumers have and have not taken action and which consumers end up with no coverage. Ms. Fabian-Marks answered in the affirmative.

Secretary Herrera Scott asked whether the MHBE assumes that the provider network remains the same between a Medicaid MCO and the QHP offered by the same company. Ms. Fabian-Marks answered in the affirmative.

Ms. Herron asked how many consumers will be handled under the new regulation. Ms. Fabian-Marks replied that approximately 100,000 Medicaid enrollees have reported income above the Medicaid threshold.

Mr. Steffen, acknowledging that there is no perfect solution to the unwinding issue, asked what consumers can do if they want to change out of their default plan after paying their first month's premium. Ms. Fabian-Marks replied that, while those consumers can end their coverage by not paying any more premium, they would not be able to access a different plan unless they qualified for another SEP.

Commissioner Birrane asked what SEPs may be available to affected consumers. Ms. Fabian-Marks answered that there are two possible SEPs that could apply. Anyone with modified adjusted gross income at or below 150% of the federal poverty level has a year-round SEP that is not bound by the typical 60-day window of opportunity. In addition, federal authorities have announced an all-purpose SEP for people who lose Medicaid coverage between now and July 2024.

Mr. McCann asked whether the MHBE promotes QHPs to those eligible for Medicaid. Ms. Fabian-Marks answered in the negative.

Mr. McCann recommended that the MHBE prepare for media inquiries about this issue. Ms. Fabian-Marks confirmed that the agency has been doing so.

Mr. McCann moved to approve adoption of the Medicaid Transition Easy Enrollment emergency regulations as presented and authorize MHBE to submit them to the Joint Committee on Administrative, Executive, and Legislative Review for emergency adoption as presented. Ms. Herron seconded. The motion was approved.

Producer Appeals Process

Nicole Quigley, Assistant Attorney General, MHBE

Ms. Quigley presented a proposed modification of regulations governing the appeals process for producer authorizations. She began by noting that the MHBE has, but rarely exercises, the authority to suspend, revoke, or refuse to renew an insurance producer's authorization. When such an adverse action is taken, the affected producer must be given the opportunity to appeal the decision according to the contested case rules in Maryland law[1]. She explained that, historically, the MHBE has only taken these actions after the Maryland Insurance Administration (MIA) has already done so. Recently, the agency has undertaken investigations into consumer grievances about producers. Since such investigations could end in actions against producer authorizations, the MHBE needs to address the appeals process. She added that such occurrences are expected to be rare.

Next, Ms. Quigley described how producer authorization appeals are currently managed. When the MHBE takes action on a producer's authorization, the Board decides whether to hear the appeal themselves or to delegate it to a third party. This decision must be made each time such action is taken, which is cumbersome.

Ms. Quigley then presented the proposed process wherein the Board delegates all hearings on producer authorization to OAH to conduct contested case evidentiary hearings, determine final findings of fact, determine conclusions of law, and issue proposed orders. She explained that the

[1] MD Code Ann., Ins. §31-113

Board would still be the final decision maker on these matters, meaning they would have to hear any exceptions, including oral arguments, arising from the OAH process and issue the final order.

Ms. Quigley concluded her presentation by noting that, should the Board approve the modification, the amendments to the Code of Maryland Regulations would be submitted to the Joint Committee on Administrative, Executive, and Legislative Review and published in the Maryland Register for review. The Board would also execute a delegation letter and hearing agreement between the MHBE and the OAH. Finally, the MHBE would update internal policies and procedures to reflect the changes.

Secretary Herrera Scott asked whether the OAH knows about the proposed arrangement. Ms. Quigley answered in the affirmative. Secretary Herrera Scott asked how many cases are expected. Ms. Quigley responded by noting that no case has ever occurred thus far, and that the agency anticipates one or two per year.

Secretary Herrera Scott, noting the low number of anticipated cases, asked how that few could possibly be cumbersome and time consuming. Ms. Quigley replied that, while it is not necessarily cumbersome for the Board, it is potentially so for the affected producer, who must cease operating while waiting for the Board to convene. Commissioner Birrane added that the MIA may be unable to act quickly in response to a referral by the MHBE and that, in such cases, the Board's interest may be served better under the proposed rules.

Ms. Herron asked whether the MHBE has any existing agreements with the OAH. Ms. Eberle replied in the affirmative, noting that the OAH already works with the MHBE on consumer appeals. Sharon Merriweather, Principal Counsel to the MHBE, added that the OAH is not the appropriate venue for contract protest appeals, meaning the Board is likely to hear those directly.

Mr. McCann asked whether the Board would have to finalize any findings of the OAH. Ms. Quigley replied in the affirmative, adding that producers have the opportunity to appeal to the courts. Ms. Merriweather pointed out that there are certain limited circumstances in which the Board must hear exceptions to the final decision directly.

Mr. Taneja asked whether the Board would be bound by the findings of the OAH. Ms. Quigley replied in the negative, stating that the OAH issues recommendations on final action to the Board.

Mr. McCann moved to approve the proposed regulation amendments to COMAR 14.35.10 as presented and authorize MHBE to submit the proposed regulations for publication in the Maryland Register and to issue a delegation letter and execute hearing agreement with the Office of Administrative Hearings. Ms. Herron seconded. The motion was approved.

Salesforce License Renewal

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

Mr. Koshanam gave the Board an overview of the Salesforce platform used by the MHBE, outlining the various systems for which it is the foundation. He compared the current year license costs with those estimated for next year, noting a year-over-year decrease in the total. Ms. Gamble summarized the procurement for Salesforce, including the renewal period, the procurement method, the vendor, and the total cost. She presented the contract history of the Salesforce platform, with a cumulative not-to-exceed cost from 2021 through 2023 of nearly $3.5 million. She reminded the Board that they were given a preview of the request for approval of the renewal during its January meeting.

Mr. McCann asked for confirmation that the contract negotiation and competitive bidding for this procurement was undertaken by the U.S. General Services Administration. Ms. Gamble answered in the affirmative.

Mr. Steffen noted the decrease in line-item costs for the Sandbox and Enterprise licenses and asked whether that is due to reduced quantity. Mr. Koshanam replied in the affirmative.

Secretary Herrera Scott asked why the cost of data storage is four times higher in the renewal than in the current system. Mr. Koshanam replied that the reasons include the natural growth of the MHBE's database over time and the demands of a more robust disaster recovery plan.

Mr. McCann moved to approve exercising the Intergovernmental Cooperative Purchasing Agreement (ICPA) Second Option Year with Carahsoft Technology Corporation and award the contract to Carahsoft Technology Corporation in the amount of $1,111,009.89 to renew Salesforce licenses for the period of March 2, 2023 - March 1, 2024 as presented. Ms. Herron seconded. The motion was approved.

2024 Final Value Plan Certification Standards

Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE

Ms. Fabian-Marks presented on the final 2024 Value Plan certification standards. She began with a timeline of plan certification activities for 2024, which started with the presentation of proposed standards during the October 2022 Board meeting and will end at today's final recommendation and Board vote. She described the history of Value Plans at the MHBE and the work of the 2022 Affordability Workgroup, noting that carriers must offer standard plans on the federal HealthCare.gov marketplace for plan year 2023. She explained that the Affordability Workgroup recommended retiring the existing Value Plans, replacing them in 2024 with new Value Plans that standardize cost sharing, and limiting each carrier to one Value Plan at each of the Bronze, Silver, and Gold levels.

Next, Ms. Fabian-Marks described the policy goals underlying the standardization of cost sharing in Value Plans: to improve health care access and affordability, to promote insurer competition, and to simplify plan shopping. She shared the guiding principles of affordability, simplicity, alignment with state health goals, equity, and minimal market disruption. She explained the concept of actuarial value (AV) and how it is applied to each metal level, adding that plans must fall within certain limits established through the federal AV calculator. To meet the limits, cost sharing tradeoffs must often be made whereby reductions in cost sharing for one service require increases in another.

Ms. Fabian-Marks then showed how the Value Plan designs were modified after the 2024 AV calculator was released. She explained that three of the six plan designs were over the limit, including the Bronze plan and two of the Silver plan variants—the 73% cost sharing reduction (CSR) and 94% CSR plans. To bring the plans into compliance with the AV limits, their maximum out-of-pocket (MOOP) limits were raised by $300, making the new MOOP for each $500. This action, she noted, was sufficient to bring the Sliver 94% CSR plan into compliance, but further changes were necessary for the other two plans.

Ms. Eberle asked how often consumers reach their MOOP. Ms. Fabian-Marks replied that it is very rare for consumers to pay that much out of pocket—roughly 6% of enrollees reach their MOOP.

Next, Ms. Fabian-Marks described the two options developed in cooperation with the MIA to bring the Bronze and Silver 73% CSR plans into compliance. The first option is to increase the specialist copay from $80 to $90 and the generic drug copay from $20 to $25. This is the option recommended by the MHBE staff. The second option is to increase specialist copays for Silver and Silver 73% CSR plans from $80 to $110 and for Bronze plans from $80 to $125. She shared feedback from three carriers, of whom two preferred the first option.

Secretary Herrera Scott characterized the proposed copays as expensive and asked how often consumers utilize specialty services. Ms. Fabian-Marks replied that consumers who have a need to see a specialist more frequently are hopefully picking a more generous plan. Secretary Herrera Scott pointed out that consumers often make their plan choice based on the premium cost rather than the total cost of care and asked how the MHBE supports consumers in making a sound decision on these matters. Ms. Fabian-Marks answered by showing that 75% of the MHBE's enrollees have selected a more generous plan and described the out-of-pocket (OOP) cost calculator tool deployed on MHC to support plan buying decisions by showing potential total costs for consumers. Commissioner Birrane noted that the OOP cost calculator tool is very helpful.

Mr. Steffen asked how many consumers are currently enrolled in Value Plans. Ms. Fabian-Marks replied that roughly 40% of the MHBE's enrollees are in Value Plans.

Mr. Steffen asked what further steps the MHBE can take toward standardization, such as access to an independent assessment for all consumers. Ms. Fabian-Marks answered that the agency has evaluated the value-based insurance design work by the University of Michigan and noted that, while there is some utility, it would not meaningfully affect AV.

Ms. Fabian-Marks then presented the proposed 2024 updated Value Plan designs with all of the cost sharing elements that are considered in the federal AV calculator. She highlighted the specialist and generic drug copay changes reflecting option 1 and pointed out the many benefits whose copays are available before the consumer reaches their deductible. She listed a number of benefits available with $0 cost sharing in all Value Plans, including primary care visits and a suite of services related to diabetes treatment and prevention.

Commissioner Birrane stated that, although the Value Plans do not exactly mirror the work done by the National Association of Insurance Commissioners on value-based insurance design, they broadly align with the goals of this work and reflect national priorities.

Mr. McCann moved to approve the proposed Value Plan certification standards for plan year 2024 as presented. Ms. Herron seconded. The motion was approved.

2024 Estimated Reinsurance Parameters

Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE

Ms. Fabian-Marks presented the proposed parameters for the 2024 State Reinsurance Program (SRP). She began by describing the regulatory requirements that the Board set: an annual attachment point, coinsurance rate, reinsurance cap, and a market-level dampening factor provided by the Insurance Commissioner if necessary. She noted that the regulations require that the Board set the estimated parameters on or before April 1 and the final parameters on or before December 31

of the calendar year preceding the applicable plan year. The timeline for the 2024 parameters will be earlier than is required by the regulation.

Next, Ms. Fabian-Marks stated the MHBE staff recommendation for the 2023 SRP parameters: an attachment point of $19,500, a coinsurance rate of 80%, a cap of $250,000, and a dampening factor provided by the Insurance Commissioner.

Ms. Fabian-Marks then presented projections showing that the SRP will likely run out of funds by FY 2028, based on factors including the removal of SRP funds for other programs, the end of enhanced federal subsidies in FY 2025, and an assumed annual increase in the attachment point of $500. She showed that increasing the annual attachment point from $500 to $1,000 would not significantly extend the time before the SRP runs out of funds. Considerations when determining the estimated parameters included: program solvency, impact on individual market rates, impact on enrollment, and uncertainty over program costs and federal funding. She noted that the MHBE, the MIA, and the Maryland Health Care Commission (MHCC) are collaborating on a report to the legislature on these matters, to be delivered by December 1, 2023.

Next, Ms. Fabian-Marks discussed the SRP carrier accountability reports, a regulatory requirement that carriers submit annual reports describing their activities to manage costs and utilization by those enrollees whose claims were reimbursed by the SRP. She noted that the first annual reports were for plan years 2019 through 2021 and that, while the 2021 reports are still under review, some preliminary findings are available. No carrier reported care management initiatives for asthma or pregnancy, while both CareFirst and Kaiser Permanente described initiatives addressing behavioral health and diabetes. She noted that United was new to the market in 2021 and had no initiatives meeting the threshold of 300 or more enrollees, but that the carrier has programs in place that may have an impact in the future.

Ms. Fabian-Marks concluded her remarks by sharing statistics on the health conditions that triggered the SRP in plan years 2019 through 2021. In all three years, the top three most frequently appearing conditions were various cancers, HIV/AIDS, and diabetes. When evaluating total claims costs, as distinct from most frequent conditions, the most expensive conditions included various cancers as well as septicemia, sepsis, and systemic inflammatory response/shock in all three years. Diabetes and respiratory arrest were in the top five conditions in two out of three years.

Mr. McCann moved to approve the estimated parameters for the 2024 State Reinsurance Program as presented, with an attachment point of $19,500, a coinsurance rate of 80%, a cap at $250,000, and a dampening factor to be provided by the Insurance Commissioner. Mr. Steffen seconded. Mr. McCann stated that the SRP is clearly unsustainable and noted that 2028 is not far in the future. The motion was approved.

1332 Waiver Extension Application

Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE

Ms. Fabian-Marks gave the Board an overview of the application to extend the 1332 waiver governing the SRP. She shared the structure and broadly described the contents of the application, which would allow the SRP to continue through 2028. She demonstrated that the MHBE has maintained compliance with the 1332 guardrails during the first waiver period and shared a comparison of

Maryland to other states: Maryland showed better results than both non-waiver states and other states with 1332 waivers. She noted that premiums are down more than 25% compared to 2018 and that Maryland's lowest-cost plans are 25% to 30% less expensive than U.S. averages. Enrollment in the individual market, both on- and off-exchange, has increased 22% to 25% since the program was adopted in 2019. She concluded by presenting the timeline of the waiver extension application, culminating in the new five-year waiver period beginning on January 1, 2024.

Mr. Steffen asked how the MHBE would modify the application should the Maryland General Assembly pass legislation extending the right to enroll on MHC to undocumented people. Ms. Fabian-Marks replied that the MHBE conferred with the bill's sponsor to ensure that its provisions would not take effect before the application submission. Mr. McCann asked whether the undocumented enrollees would have federal subsidies. Ms. Fabian-Marks answered that, while it is possible that federal subsidies would be available, it is unlikely, and state funding would likely be required.

Mr. McCann moved to approve submission of the 1332 Reinsurance Waiver Extension Application to the U.S. Departments of Health and Human Services and Treasury following the end of the public comment period on March 7, 2023, as presented. Mr. Taneja seconded. The motion was approved.

Adjournment

Mr. McCann adjourned the meeting.