Maryland Health Benefit Exchange
Board of Trustees

September 18, 2023
2 p.m. – 4 p.m.
Meeting Held at the Maryland Health Care Commission and via Video Conference

Members Present:
Laura Herrera Scott, Chair
Ben Steffen, Vice Chair
Kathleen A. Birrane
Dana Weckesser
Maria Pilar Rodriguez
K. Singh Taneja
Laura Crandon
Aika Aluc

Members Absent:
Rondall Allen

Also in Attendance:
Michele Eberle, Executive Director, Maryland Health Benefit Exchange (MHBE)
Johanna Fabian-Marks, Director of Policy and Plan Management, MHBE
Nicole Quigley, Assistant Attorney General, MHBE
Tamara Cannida-Gunter, Director of Consumer Assistance & Eligibility, MHBE
Betsy Plunkett, Director, Marketing and Web Strategies, MHBE
Cynthia Wilson, Executive Office Administrator, MHBE
Ginny Seyler, Connector Program Manager, MHBE
Tishma Delagarde, Deputy Chief Financial Officer, MHBE
JasCiel Stamp, Director, Human Resources & Organizational Effectiveness, MHBE

Meeting Call to Order
Secretary Herrera Scott called the meeting to order.

Approval of Minutes

Secretary Herrera Scott asked for a motion to approve the minutes from the Board's July 17, 2023, meeting. Mr. Steffen moved to approve the minutes from the July 17 meeting as presented. Mr. Taneja seconded. The Board voted unanimously to approve the minutes.

Public Comment

None offered.

Executive Update

Michele Eberle, Executive Director, MHBE

Ms. Eberle began her executive update by explaining that the individual, small group, and dental rates for plan year (PY) 2024 have been approved and released. Individual market rates increased by 4.7%. Among other states, that number ranges from 3% to 15%. Ms. Eberle explained that states took varying strategies to keep rates low and noted that, in Maryland, the State Reinsurance Program (SRP) has helped and that claims expenses and trend have remained low. For most consumers on Maryland Health Connection (MHC), the rate increases will be offset by the tax credits they receive. She noted that the Maryland Health Benefit Exchange (MHBE) will encourage people to come back and shop for new plans because Aetna CVS Health has newly rejoined the marketplace, so there are now three insurance carriers operating statewide. She noted that staff will make sure the rates are loaded into the system, test against what was filed, and execute renewal notices, which must be distributed one month before open enrollment.

Ms. Eberle then described efforts underway to prepare for the upcoming legislative session. These include the House Bill (HB) 413 Workgroup, an effort led by the Maryland Insurance Administration (MIA) and with participation from MHBE and the Maryland Health Care Commission (MHCC). The bill requires an evaluation of the SRP's performance and other benefits that could be provided to Marylanders; the report is due in December. The MHBE is also working with MDH on Senate Bill (SB) 806, which requires the MHBE to develop a report analyzing the cost to the state to offer Medicaid coverage to undocumented immigrants. Finally, the MHBE is working with the Health Services Cost Review Commission (HSCRC), MHCC, and MDH to examine ways to ensure the effectiveness of the health care coverage they are providing to Marylanders.

Next, Ms. Eberle gave miscellaneous updates. She noted that, at the federal level, the Medicaid unwinding is front and center. The MHBE is working on consumer assistance, information technology, and outreach to support the ongoing unwinding. They have implemented continuous coverage for those under age 19 and those whose income is under 100% of the federal poverty level (FPL). The MHBE is implementing automatic, or *ex parte*, renewal at the individual rather than at the household level. The agency has contacted consumers through direct email, chase email, texting, and surveys to gauge where consumers shifting from Medicaid to qualified health plans (QHPs) are going. A chat feature within the MHC application allows consumers to be assisted immediately, which takes pressure off the Call Center. The Healthy Babies Equity Act became effective July 1, 2023, granting Medicaid access to non-citizen pregnant individuals in Maryland. As of July, enrollment in the program was already at 3,800; Ms. Eberle praised MDH's efforts in spreading information about the program.

Ms. Eberle continued by sharing that the MHBE's August data report is now online. She noted that all enrollments are presented by district, which may be helpful for legislators. The report shows overall QHP enrollment continuing to increase as Medicaid numbers are decreasing; enrollment from target populations is up, including Hispanic, Black, and young adult Marylanders. She shared that the small business market has been a focus of the MHBE and that they have hired two new staff members. One recent development is a partnership with the Maryland Business Express website— visitors to the site looking to start a business can get automatically connected with the MHBE for more information on enrolling in health coverage.

Policy Committee Report

Michele Eberle, Executive Director, MHBE

Ms. Eberle explained that Mr. Allen is absent but that no Policy Committee update is necessary because the Board will be given the same presentations during this meeting that the Policy Committee received in their most recent meeting.

Finance Committee Report

Ben Steffen

Mr. Steffen explained that the Finance and Audit Committee met the week of September 11 and covered several agenda items. First was a presentation by Scott Brennan, Director of Compliance and Privacy at the MHBE, who went over recommended policy changes regarding the director's ability to report directly to the Finance and Audit Committee rather than the existing method, in which it must be done through the executive director. The compliance director pointed out how this might be important in some situations. Mr. Brennan provided an update on the Office of Legislative Audits, which has begun its routine three-year audit on the MHBE; all state agencies regularly undergo such audits. The process began in July 2023 and is ongoing. The auditors are particularly interested in the SRP as well as the MHBE fund more broadly. Their draft report is expected to be delivered to staff in late November 2023; Mr. Steffen noted that the audit's findings will be communicated to the Board.

The Finance Committee also received an update on the work that began in Summer 2023 to obtain disclosure information from indefinite delivery indefinite quantity (IDIQ) vendors: the task is nearly complete, with 37 of 39 vendors having submitted their financial disclosure forms. Another presentation given to the Committee was on the privacy impact assessment that the MHBE submitted to the Centers for Medicare & Medicaid Services (CMS) at the end of June 2023: staff are awaiting responses on that information. Finally, Mr. Steffen reported that Mr. Armiger provided the Committee with an update on the preparation of the fiscal year (FY) 2025 budget. He explained that budget documents are not public until they are approved and released by the Governor, so that information is not shared in public session. He praised the MHBE staff's financial responsibility and responsiveness to other agencies, like the Maryland Department of Budget Management, regarding the budget.

Standing Advisory Committee Report

Dana Weckesser

Ms. Weckesser reported on the most recent Standing Advisory Committee (SAC) meeting, which focused on diabetes, a pressing issue given the high cost and prevalence of the disease. During the meeting, the SAC heard presentations on diabetes prevention and medication. They tended to focus

on type 2 diabetes and prediabetes. Providers talked about their in-person and virtual support programs and case management services. The presenters included Pamela Williams from the MDH Bureau for Cancer and Chronic Disease, who presented on Maryland's Diabetes Action Plan; Ms. Fabian-Marks, who reviewed diabetes-related benefits and its impact on reinsurance; Rayva Virginkar and Dr. Mahalia Ashraf from United Healthcare; Stacy Shapiro from Kaiser Permanente; and Tracy Grampp and Ashley Fried from CareFirst. Robust discussion followed the presentations. Ms. Weckesser concluded her report by reminding the Board that the SAC has representation across various stakeholder groups and sectors and encouraging the Board to use the SAC to provide feedback and background information on issues.

Board Hearing Final Regulations

Nicole Quigley, Assistant Attorney General, MHBE

Ms. Quigley began her presentation by explaining that she will request the Board's final votes for implementing hearing procedures. She shared relevant context: in June, by the recommendation of the Policy Committee, the Board implemented a final vote to delegate producer appeals to the Office of Administrative Hearings (OAH). The Board changed the MHBE's regulations to reflect that delegation, with edits including removing hearing procedures from that chapter because OAH has their own hearing procedures. However, hearing procedures are needed for the other types of appeals over which the Board retains the ability to preside. To address this issue, the Board approved the proposed addition of Chapter 20 at the May Board meeting, which moved the language on hearing procedures out of the producer appeals chapter and into their own chapter. Ms. Quigley shared a diagram showing the timeline of the process for updating these regulations, which is included in full in the presentation for this meeting. No comments were submitted during either the stakeholder or the public comment periods, so the regulations proposed at the May Board meeting are unchanged. MHBE staff seek the Board's approval to move forward with their final publication. Ms. Quigley explained that, if the Board votes to adopt the regulations as proposed, the regulations will be published in the October 6, 2023, issue of the Maryland Register and will be effective on October 20, 2023.

Secretary Herrera Scott asked for a motion to approve the adoption of the new regulations. Mr. Steffen moved to approve the adoption of the addition of COMAR 14.35.20, as presented, and to publish the regulations in the Maryland Register October 6 Issue, to go into effect on October 20, 2023, as presented. The motion was seconded. The Board voted unanimously to approve the adoption of the new regulations.

Proposed 2025 Plan Certification Standards

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

Ms. Fabian-Marks presented on the 2025 proposed plan certification standards. Detailed slides are available in the presentation for this meeting. Ms. Fabian-Marks explained that this is the first step in an annual process: after this presentation and a public comment period, the Board will be asked to approve the standards toward the end of the year or in the new year, pursuant to the Maryland state statute and regulations. She explained that there are typically updates to the previous year's standards, sometimes due to feedback from stakeholders, but that there are no proposed changes to the 2024 standards at this time. Staff anticipate that the Value Plans will need adjustments once the 2025 federal actuarial value (AV) calculator is released. The tool is typically updated in December,

after which staff will examine the AVs in the 2024 Value Plan designs and consider whether parameter updates are needed. Staff will bring suggested changes to the Board for approval in December 2023 or January 2024. Ms. Fabian-Marks explained that the SAC was consulted for feedback and had no proposed edits. She stated that there is no motion for the Board today since there are no proposed changes, although staff can consider changes to the standards if the Board has suggestions.

Rafael Lopez, Secretary for the Maryland Department of Human Services, asked about the Young Adult Health Insurance Subsidies Pilot (YAHISP) program's three-year duration. He asked whether options to extend the pilot were available if it was successful. Ms. Fabian-Marks replied that the legislature initially authorized the program as a two-year pilot and extended it this past session for an additional two years, with plans for an assessment of the program's impact to determine whether it continues further. Ms. Fabian-Marks explained that the pilot design was chosen in part because the program's funding came from the SRP fund, resulting in hesitancy to commit funding to the program permanently before seeing its results. She explained that the program has shown great results, with young adult enrollment up year over year and with nearly 7,000 young adults in the market, likely due in part to the program. She referred to the HB 413 Workgroup mentioned in Ms. Eberle's executive update, noting that the group's report will include information for the General Assembly to consider on a variety of potential affordability initiatives. One option that they are exploring is a revised subsidy that is similar to the young adult subsidy but is available to all ages. She acknowledged that funding and other priorities will determine whether such a subsidy is implemented but remarked on the priority Maryland agencies and the legislature are placing on these types of programs.

Federal Conformity/Policy Proposed Regulations

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

Ms. Fabian-Marks explained that she has three regulation updates to share.
The first item is a set of proposed federal conformity and policy updates. Detailed slides are available in the presentation for this meeting.

Ms. Fabian-Marks reviewed the timeline for the process of making these updates: prior to bringing them before the Board, they were shared with stakeholders for an informal comment period and adjusted based on the responses received. Following today's vote, the regulations will be published for a formal 30-day public comment period before a vote by the Board to finalize them in January 2024. She explained that each year, the MHBE assesses the need to update any state regulations to comply with annual changes to the federal regulations governing state health insurance exchanges. The first change is to clarify that dependents stay on their parents' plans until the end of the year in which they turn 26; federal law had previously allowed for carriers to remove dependents at the end of the month of their birthday. All carriers have been covering dependents until the end of the year of their 26th birthday, so there will be no change in coverage, but the Maryland regulations are being edited to clarify the point.

The next change is to give consumers two years (rather than one) to resolve situations where they failed to file and reconcile their taxes and received advance premium tax credits (APTC). Federal law requires that individuals stay up to date on their tax filing to continue receiving APTC. The typical process has been suspended during the pandemic but consists of the MBHE running a check early in the year to assess whether people receiving APTC correctly filed their taxes for the prior year. If they

did not, after some warning periods, APTC are removed from those individuals until the tax filing issues are addressed. The new federal regulations specify that APTC should only be removed if an individual did not reconcile two consecutive years of tax filings. This change is anticipated to go into effect for PY 2025, but for this PY (including this fall and in the new year), these checks will remain suspended, and no APTC will be removed.

The third conformity update increases the number of essential community providers (ECPs) carriers must contract with to 35%: the state standard was at 30% and is now rising to meet the increased federal standard. ECPs are designated under state and federal law, including federally qualified health centers, Indian health providers, and other categories of providers that target low-income and uninsured communities. All Maryland carriers contract with close to 35% of the ECPs in their respective areas.

The fourth conformity change clarified that plan variant marketing names must be correct and not misleading. While Maryland has not experienced this issue, carriers nationally were listing deductible amounts in plan names that were not updated to align with the savings available to low-income individuals under Silver plans.

The fifth conformity update establishes a timeliness standard of "within 10 days" for notices of payment delinquency; carriers were previously required to provide timely notice, but no exact time period was defined.

The last conformity update introduces the consideration of plan network when determining the most similar plan when renewing individuals whose plan is no longer available into a new plan. This process follows a federal hierarchy that previously did not consider plan network as one of its components.

Secretary Herrera Scott asked for clarification on the point regarding marketing names. Ms. Fabian-Marks explained that individuals making below 250% of the FPL qualify for cost-sharing reductions (CSRs) for Silver plans, and carriers must adjust their cost-sharing for each of three plan options. She stated that some carriers were using the base deductible for their Silver-level plan names and that federal regulations will now mandate that the actual deductible, accounting for the CSRs, be used.

Mr. Steffen asked how many people will be affected by the change giving consumers two years to reconcile their tax filings. Ms. Fabian-Marks replied that it is a small number, with the federal regulation citing a proportion of around 10% or lower. She explained that the rationale for the federal change was that the policy of suspending APTC pending tax reconciliation is particularly punitive toward low-income individuals, who may have complex tax filing situations and may be eligible for substantial APTC.

Mr. Steffen agreed that this type of situation can be complicated. He asked whether the MHBE can offer any consumer assistance to individuals in that situation, or if any other organizations are doing so. Ms. Fabian-Marks responded that there are organizations that offer free tax filing, like the CASH Campaign of Maryland. She stated that the MHBE's navigators could not assist with tax filing themselves but could refer consumers to organizations that could help.

Mr. Steffen asked how the proportion of ECPs with which a QHP contracts is calculated, inquiring about whether QHPs must contract with 35% of the ECPs in their county or in the state. Ms. Fabian-Marks replied that they must contract with 35% of the ECPs in their service area.

Mr. Steffen asked if there is a way for the MHBE to track utilization of ECPs. Ms. Fabian-Marks responded that they have not tried to but probably could using data from the All-Payer Claims Data Base, expressing interest in that potential analysis.

Commissioner Birrane asked whether any comments were received about the change defining the timeliness standard. Ms. Fabian-Marks replied in the negative and noted that the standard was finalized in the federal regulations, so there are few changes Maryland could make.

Ms. Fabian-Marks continued her presentation, explaining that the next set of regulatory change are adjustments to special enrollment periods (SEPs). The first change gives consumers more options when they are losing minimum essential coverage: existing regulations allow people to enroll the first of the month after the coverage is lost, which can create a gap in coverage if they happen to lose their coverage mid-month. The new regulation will give consumers the option to enroll the first of the month in the month that they lose coverage, so there may be some weeks of dual enrollment, but no coverage gap will occur. Ms. Fabian-Marks noted that this situation is rare.

The next change adjusts the SEP for the loss of Medicaid and Children's Health Insurance Program (CHIP) coverage. The federal regulations have seen an optional change increasing the SEP from 60 days before and after loss of coverage to 60 days before and 90 days after; Maryland is choosing to follow their lead. There are also minor wording revisions based on stakeholder feedback. Ms. Fabian-Marks pointed out that there is a Medicaid unwinding SEP allowing anyone who loses Medicaid coverage at any time to enroll in a QHP through July 31, 2024; the expansion of the post-coverage-loss SEP to 90 days will take effect after the SEP ends on July 31.

The final proposed regulatory change removes the burden on consumers to demonstrate a plan display error if they may be eligible for a plan display error SEP. A plan display error is a case where MHC displayed the wrong information to consumers in a way that influenced their purchasing decision, and after clarifying the information, a consumer wants to purchase a different plan. Ms. Fabian-Marks explained that this is very rare and stated that the MHBE likely would not have forced a consumer to prove that but that the existing regulatory language suggested they would have done so. The new language clarifies that the MHBE can proactively provide an SEP if they realize that there was a plan display error.

Secretary Herrera Scott asked for confirmation that these regulatory changes pertaining to SEPs are also being done to align with new changes to federal regulation. Ms. Fabian-Marks replied in the affirmative.

Ms. Fabian-Marks explained that the one policy proposal not tied to federal regulation changes is to limit the number of plans per carrier per metal level to three starting in PY 2025 rather than four, which has been the limit for years. The Affordability Workgroup that the MHBE convened in 2022 recommended decreasing the limit to three. This recommendation was made in response to research that found, when consumers have too many plan choices, they face analysis paralysis and are more likely to choose plans that are not the best option for them, financially. She stated that there has been

no pushback on this proposal and that carriers were part of the Workgroup recommending the change.

Secretary Herrera Scott asked for a motion to approve the proposed regulations as presented. Mr. Steffen moved to approve the proposed regulations as presented and authorize MHBE to submit the proposed regulations as presented to the Joint Committee on Administrative, Executive, and Legislative Review for review and to the Department of Legislative Services for publication in the Maryland Register. The motion was seconded. The Board voted unanimously to approve the proposed regulations.

Medicaid to QHP Final Regulations

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

Ms. Fabian-Marks presented on a set of final regulations for the MHBE's Medicaid-to-Private-Plan enrollment program. Detailed slides are available in the presentation for this meeting. The program seeks to simplify the process of transitioning to a private plan for Medicaid enrollees who are no longer Medicaid-eligible and who are now QHP-eligible. If someone is determined QHP-eligible during their redetermination but does not select a plan within seven days, they are automatically enrolled into a plan, with the plan selection done through a hierarchy that was previously shared with the Board. If possible, they are enrolled in a private plan with the same parent company as their previous managed care organization (MCO), but they are otherwise enrolled in the lowest cost silver or gold plan in their region, with the metal level depending on their income. The process was established through emergency regulations that the Board approved in February 2023, but emergency regulations can only be in place for six months; regulations in effect for longer must follow the normal regulatory process. Ms. Fabian-Marks shared the timeline for these regulations: the Board approved the publication of the emergency regulations as proposed standard regulations, and they were published on June 30. No comments were received, so the MHBE asks the Board to finalize these regulations for ongoing operations.

Secretary Herrera Scott moved to approve the Medicaid to Private Plan Enrollment Program final regulations as presented and authorize MHBE to submit them to the Division of State Documents for publication in the Maryland Register as presented. Ms. Weckesser seconded the motion. The Board voted unanimously to approve the final regulations as presented.

Young Adult Subsidy Final Regulations

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

Ms. Fabian-Marks then moved onto a presentation on the final regulatory change. Detailed slides are available in the presentation for this meeting. She explained that current regulations assume that the YAHISP program will only be in effect from 2022 to 2023, but legislation this year extended the pilot program through 2025, so the MHBE proposes a small change to allow the Board to continue setting eligibility and payment parameters for the program beyond 2023. Ms. Fabian-Marks gave an overview of the timeline for these regulations: the Board approved these proposed regulations in June, and no public comment was received following their publication. The MHBE now seeks the Board's approval of the final regulations.

Secretary Herrera Scott asked for a motion to approve the regulatory updates as presented. Secretary Lopez moved to approve the final Young Adult Subsidy regulatory updates as presented and authorize MHBE to submit them to the Division of State Documents for publication in the Maryland Register. Mr. Steffen seconded. The Board voted unanimously to approve the regulatory updates as presented.

2024 Health Plan Landscape

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

Ms. Fabian-Marks gave an overview of the 2024 health plan landscape, a presentation given to the Board annually. Detailed slides are available in the presentation for this meeting. She stated that, with Aetna joining the market statewide, there are now three carriers operating statewide (CareFirst, United, and Aetna), while Kaiser operates in only some counties. She then presented a three-year breakdown of the number of plans that each carrier has offered by metal level. There are nine new Aetna plans on the market in 2024; for the other carriers, the number of plans is the same as in 2023. She then presented a chart showing the deductibles and AVs associated with each carrier's plans for each metal level for the last three years. She noted that the table, which was provided in the slides for this meeting, is misnamed and actually displays data for 2022-2024. She noted that there were no remarkable changes year-over-year, although there has been a slight increase in lower-level Silver plan AVs due to the federal government's change to the *de minimis* range, raising the floor for allowed AVs for that metal level to 70%, which boosts APTC and consumers' buying power.

Secretary Herrera Scott noted that the deductibles shown are high and asked if the MHBE examines healthcare utilization between metal levels. She also asked for confirmation that Gold plan users tend to use primary and secondary prevention care, while consumers with Bronze plans tend to use emergent and urgent care. Ms. Fabian-Marks responded by pointing out that only the base Silver plan deductibles are shown, not the CSR variants. She stated that, when taking those variants into account, around 70% of enrollees are in a plan that is equivalent to at least a Gold plan; most enrollees are not in the high-deductible Silver and Bronze plans shown. She also explained that the MHBE conducted an analysis with The Hilltop Institute a few years ago examining differences in utilization in the Value Plans as well as between metal levels; she noted that this analysis found the differences in utilization that Secretary Herrera Scott described. She pointed out that all plans cover preventive care at no cost, even at the Bronze level, and that, starting in 2024, the Bronze Value Plan covers primary care, specialists, generic drugs, and speech and physical therapy, albeit with copays before the deductibles.

Commissioner Birrane asked for confirmation that the numbers shown represent all individual market participants who purchased through MHC, regardless of whether they receive APTC. Ms. Fabian-Marks responded in the affirmative.

Ms. Crandon asked for clarification on the point regarding the change in the *de minimis* range for some plans, inquiring whether there has been movement in the Gold metal level. Ms. Fabian-Marks replied that the AVs in the Gold metal level did increase but stated that she did not have an explanation. She explained that she was referring to raising the AV floor for Silver-level plans to 70%, which increased the AVs of plans in that metal level. Mr. Boban added that CMS changed the *de minimis* on other metal levels as well, including Gold. He further explained that the new AV floor of

70% for Silver plans only applies to on-exchange plans; off-exchange Silver plans can still have AVs as low as 68%.

Ms. Crandon asked whether the table showing the number of plans by carrier by metal level refers to the total number of plans or the number of new plans. Ms. Fabian-Marks responded that the total number of plans is shown.

Commissioner Birrane asked for confirmation that the plans shown represent only on-exchange plans. Ms. Fabian-Marks responded in the affirmative.

Mr. Steffen asked how QHPs are being counted with regards to the maximum of three plans they may have at each metal level, asking if CareFirst as a whole is counted as one organization or if the CareFirst health maintenance organization (HMO) and each of the CareFirst preferred provider organizations (PPOs) are counted as separate organization that may each have three plans at a given metal level. Ms. Fabian-Marks replied that the HMO is counted as its own organization, and the two PPOs are counted as a single organization, meaning that, if one PPO has a plan and the other has a mirror plan, they are collectively counted as one plan.

Ms. Aluc asked for confirmation that 70% of consumers have Silver and Gold plans rather than Bronze plans. Ms. Fabian-Marks responded in the affirmative, adding that the enrollees in the Silver metal level are in Silver plans that grant CSRs, which brings the value to the level of a Gold plan, making those 70% functionally in a Gold plan or better.

Referring to the point made regarding the literature indicating a connection between an abundance of choices and a tendency for consumers to freeze, Ms. Crandon asked if these 44 plans are the number by which they should be thinking about the benchmark of choice, noting that the number seems low. She expressed a desire to leverage behavioral economics research to think about the tipping point above which consumers become overwhelmed and make poor choices. Ms. Fabian-Marks replied that she would be happy to look into the question but is not aware of research that identifies a specific optimal number of choices. She noted that the MHBE may have conducted a literature review on the topic. She stated that 44 is a large number and said that it is a struggle to limit choice while allowing carriers the opportunity to innovate. Ms. Fabian-Marks explained that one of each carrier's three plans per metal level will now be the primarily MHBE-designed Value Plan. She added that Maryland is among the states with the strictest limits of plans per metal level per carrier, with some states offering consumers as many as 200 plan options, but noted that the federally facilitated marketplace is also moving toward greater restrictions per metal level per carrier. She stated that the MHBE will soon convene a Consumer Decision Support Workgroup with stakeholders, which will discuss how to present information on plan options in a way that avoids overwhelming consumers and helps them identify the best fit for them. Current decision support features include the ability to search for plans covering certain doctors or prescriptions and sort by total projected costs throughout the year given a consumer's expected healthcare utilization. High-value Silver plans with CSRs are shown first since they offer the best value for most eligible consumers.

Ms. Weckesser recommended that MHBE staff get in contact with SAC Co-Chair Mark Meiselbach, who may be able to help answer Ms. Crandon's question.

2024 Approved Rates with Trend and Medical

Bradley Boban, Chief Actuary, Maryland Insurance Administration

Next, Mr. Boban presented on the 2024 approved rates. Detailed slides are available in the presentation for this meeting. He went over the typical rate review process: Maryland regulations require rates to be reviewed to ensure that they are not excessive, inadequate, or unfairly discriminatory and comply with state and federal law. He stated that carriers may not consider the different utilization patterns by metal level when rating Affordable Care Act (ACA) plan rates, which use a single risk pool methodology that sets rates based on the combined experience of all metal levels; this means that rate differences reflect only differences in the actual benefits offered. The first step of the process is to compare the data for the 2022 experience period with the experience carriers expected when they set the 2022 rates and with the 2021 experience. Assumptions are reviewed, with key assumptions in these ACA rate filings including claims trend (both cost and utilization in different service categories), morbidity (the relative health status of the risk pool), carrier operating expenses, profit margins, risk adjustment transfers, reinsurance recoveries, and the impacts of COVID-19; In recent years, COVID-19 cases have now dropped to a very small percentage of claims, but data are still being distorted by a pandemic-related drop in claims in 2020 followed by cost spikes in 2021. The final assumption relates to the uncertain impact of the Medicaid unwinding. He stated that all rate filings were submitted on May 22, 2023, and were approved today, September 18, 2023.

Mr. Boban then moved on to the rates themselves. The average approved rate increase in the individual market is 4.7%, compared with the 5.7% average increase filed in May and with the 6.6% average increase approved last year. This increase is despite the cost of raising the attachment point for the SRP back to $20,000 from $18,500, the number to which it was decreased last year due to the uncertainty around the end of the American Rescue Plan Act. If the attachment point had stayed steady, the rate increase would have been around 8% last year and 3% this year. Even with this increase, rates are, on average, 22% lower on an absolute dollar basis than they were in 2018, the year before the SRP began. Enrollment is down slightly from last year but is rising again due to the Medicaid unwinding; Mr. Boban predicted that the year will end with higher enrollment than last year.

Mr. Boban then showed sample premiums to demonstrate the typical consumer experience and the variation that exists between plans, showing each carrier's lowest-cost Bronze plan in 2023 and 2024: PPO rates are decreasing, while HMO rates are increasing slightly for the off-exchange and unsubsidized on-exchange consumers; 70% of on-exchange consumers will receive subsidies that dampen the impact of these rate changes. The same view was shown for Silver plans next, where more carriers are decreasing rates than raising them. Gold plans were then compared in the same way. Mr. Boban pointed out that Aetna's rates are included on each of these slides as well: in general, Aetna's rates were clustered with the other HMO rates, while CareFirst PPO had meaningfully higher rates, though the gap between PPO and HMO has narrowed this year.

In the next exhibit, Mr. Boban showed sample Value Plan premiums by carrier by metal level for consumers at a few different ages. 2024 is the first year where Value Plans will have the same cost-sharing across the board rather than more general requirements. All carriers must use the federal age factors, meaning carrier's pricing relative to one another is independent of age.

Commissioner Birrane asked for confirmation that the amounts shown are unsubsidized. Mr. Boban responded in the affirmative, adding that the rates are for a consumer in Baltimore County but noting that they should apply for the entire state given that no carrier is geo-rating this year.

Mr. Boban then presented on rates for the individual dental market, where the approved rate change was minus 1.3%, the same amount as what the carriers requested in May. 75% of consumers should see their rates fall, while 25% will see increases in the low single digits after having gotten rate decreases last year. There has been continued rate stability in the ACA dental marketplace. Enrollment here is plateauing after very large enrollment uptakes over the past three years but is still up, unlike medical enrollment. Mr. Boban expressed hope for continued gains in the future.

Next, Mr. Boban shared ACA small group rate approvals: the average approved rate increase was 6.9%, compared with the 7.5% average increase requested in May. He noted that a higher observed trend tends to drive higher rate increases in the small group market. The average approved trend in the ACA individual market is 5.3%, which Mr. Boban noted is low in the history of trend and is supported by the 2022 experience, but small group data show a high average trend of 7.8%, up 6.8% from last year; these numbers are well-supported, but small group trend could be higher than the carriers project. The difference between the respective trends for the individual and small group markets is the largest it has ever been, and it is not fully understood yet. Variation between carriers has narrowed since the initial rate requests from a range of 20 to a range of 14 percentage points. Each carrier-specific rate increase is also an average of all of that carrier's plans. There are 250 small group plans, meaning the number of choices is high compared with the limited choices of the individual market.

Next, Mr. Boban showed sample small group premiums for an individual and a family, respectively, in the lowest-cost plan for each carrier at each metal level besides Bronze, which, Mr. Boban explained, has very low enrollment. He noted that an actual small group would have multiple individuals and families added together. Among the Silver plans, there are decreases occurring, although the carriers are averaging an increase.

Commissioner Birrane asked for confirmation that the numbers being shown represent the whole premium, including both the enrollee and the employer's contribution. Mr. Boban replied in the affirmative.

Mr. Boban stated that all rates are available on MIA's website and noted that the link to the website is available in the press release published the day of the meeting entitled, "Maryland Insurance Administration Approves 2024 Affordable Care Act Premium Rates." Information can be accessed for every plan and every age in the individual market and for every plan in the small group market.

Commissioner Birrane emphasized the impact of the MHBE on Maryland's rates, particularly for the Value Plans. She stated that her national work shows her that Maryland is consistently has some of the lowest pricing with some of the best benefits nationwide, particularly with respect to out-of-pocket minimums. She praised the efforts of the MHBE, the Board, the MIA, and the Connector entities.

Mr. Boban then presented on medical loss ratio (MLR) rebates. The ACA set the calculation to determine this value and set the minimum MLRs for the individual and small group markets at 80% and for the large group market at 85%, respectively. The MLR is calculated by dividing claims by

premiums, with adjustments made for the SRP, quality improvement expenses, taxes, and fees; it is computed at the market and the state level and has been computed since 2011. The MLR is a three-year average: carriers only owe a rebate if the average of their one-year MLRs for the last three years is below the minimum. A credibility-adjustment is applied to carriers with 1,000 to 75,000 life-years to adjust for the disproportionate impact random claims variation has on these smaller carriers' MLRs. If a carrier's MLR is below the minimum, a rebate is owed: the amount is the minimum minus the actual MLR, times the average premium. For members in the individual market receiving APTC, the MLR rebate depends on the unsubsidized premium, meaning it is possible for people with high APTC to receive a rebate higher than the amount they paid in premium. The 2022 MLR report was submitted at the end of July, after which any rebates owed must be issued by September 30 to all policyholders who had a policy during that reporting year.

Mr. Boban then discussed the rebate history for Maryland, showing rebates for the individual market by carrier. From 2011 to 2018, there were no rebates because carriers had high enough MLRs. The rebates in 2019 totaled $26.9 million and were all from CareFirst. This figure rose to $72.5 million in 2020 and fell to $44.8 million in 2021. The 2022 rebate numbers have not yet been published by CMS but are expected to be a great deal lower since they are three-year averages that will incorporate 2019 and 2020 MLRs, which were very low. Mr. Boban then presented a table showing the three-year average calculations that went into determining these rebates: 2018 was when one-year MLRs first dipped below the minimum, and in 2019, all CareFirst entities fell below the minimum due to the SRP. Morbidity had been steeply increasing each year, and, while the expectation was that the SRP would halt that increase, it was expected to take a couple years; instead, the SRP effected this change much faster than expected, causing the low MLRs in 2019. He noted that neither CareFirst CFMI nor GHMSI are fully credible, so they received credibility adjustments. The large rebate in 2020 was due to very low three-year average MLRs from all CareFirst entities, driven by the COVID-19 pandemic.

Secretary Herrera Scott asked about the average rebate an individual would have received that year. Mr. Boban replied that those data are available in the CMS report, but he does not have them at hand. He stated that the rebates can be translated into per-member figures moving forward. Secretary Herrera Scott responded that it would be helpful for making the impact of the rebates more concretely felt.

Mr. Boban continued presenting, noting that the high MLRs in 2021 drove the 2021 three-year average for CareFirst up. Additionally, 2021 was the first year for Optimum Choice, Inc., and they owed a rebate despite receiving the largest credibility adjustment. In 2022, the low MLRs from 2019 will no longer factor into the three-year average calculations and will be replaced by the 2022 one-year MLRs, which are high as well. Financial statements filed in May indicate CareFirst will have some high MLRs, which will bring the three-year averages up meaningfully, causing rebates to drop. CMS typically publishes the finalized MLRs and rebates in Mid-October.

Mr. Boban then shared CMS resources on MLR reports, including a tool to find a specific carrier's MLR reports and a link to more generalized high-level MLR reports from CMS. Mr. Boban showed an example of the latter, starting with the 2021 edition of the first report CMS publishes, which provides the rebate per member. In 2021, total Maryland rebates were $53.4 million, for an average rebate of $234 per person: $44.9 million of these monies was for the individual market, while $1.6 million was for the small group market, and $6.9 million was for the large group market. This report format is available for every year from 2011 to 2021.

A second report is also available, showing rebates by market by carrier by state for each year. Mr. Boban shared information from this report, noting that it only includes carriers that paid a rebate. He then concluded by providing information on rebates in the small and large group markets, which have had nonzero rebates more years than the individual market has but whose rebates have tended to be smaller as a percentage of total premium; carriers did not miss the minimum MLR by the same magnitude in the group markets as they did in the individual market. He stated that, in the small group market, rebate checks are sent to the employer rather than to the individual, and it is the employer's responsibility to distribute the rebate to their employees in proportion to how premiums are divided between employer and employees.

To Secretary Herrera Scott's earlier request for more concrete examples, Commissioner Birrane stated that the MIA can provide more information on what this information means for someone purchasing insurance through MHC or off-exchange through examples such as how MLR rebates interface with APTC in the individual market. Mr. Boban agreed.

Mr. Steffen asked what federal enforcement agency ensures that small and large group rebates given to employers are appropriately distributed to employees. Commissioner Birrane replied that the MIA exercises high-level enforcement authority to ensure that rebates are being paid, noting that the biggest issue is difficulty finding an individual to give them their rebate. Mr. Boban added that premium credits are a more common form of rebate in the group markets than in the individual market because the majority of small groups are stable. He stated that, for any small group that ceases to exist, the carrier is still responsible for finding that employee.

Second Vote on Young Adult Subsidy Final Regulations

Secretary Herrera Scott explained that a second vote would be run for the approval of the young adult subsidy final regulations due to a procedural error the first time. She asked for a motion to approve the regulations as presented. Mr. Steffen moved to approve the final young adult subsidy regulations as presented and authorize MHBE to submit them to the Division of State Documents for publication in the Maryland Register as presented. Ms. Weckesser seconded. The Board voted unanimously to approve the final regulations.

Adjournment

Secretary Herrera Scott adjourned the meeting.