MHBE

Standing Advisory Committee

July 18, 2024
2:00PM – 4:00PM
Via Google Meets

Members:
Aika Aluc, MHBE Board Liaison
Mark Meiselbach, Co-Chair
Diana-Lynne Hsu, Co-Chair
Matthew Celentano
Emily Hodson
Scott London
Allison Mangiaracino
Yvette Oquendo-Berruz
Marie-Therese Oyalowo
Aryn Phillips
Mark Romaninsky
Douglas Spotts
JoAnn Volk
Rick Weldon

MHBE Staff
Maggie Church
Michele Eberle
Makeda Hailegeberel
Amelia Marcus
Betsy Plunkett
Pooja Singh

Members of the Public
Brad Boban
Kimberly Cammarata
Maya Greifer
Kimberly Robinson
Andrew York

Welcome and Agenda
Co-Chair Diana-Lynne Hsu welcomed everyone to the meeting and briefed the Standing Advisory Committee (SAC) on the agenda. Emily Hodson made a motion to approve the May meeting minutes. Matthew Celentano seconded, and the May meeting minutes were approved.

Executive Update
Michele Eberle, Executive Director of the MHBE, started with the executive update. Ms. Eberle discussed the possible expiration of expanded tax credits at the end of December 2025, explaining that state-based marketplaces coordinate on messaging to federal legislators on how the tax credits protect consumers. They are especially valuable in combatting uncontrollable premium rises based on cost factors, which prevail because state marketplaces lack the reference-based pricing present in Medicaid and Medicare,

Ms. Eberle then reported that on July 2nd, the Centers for Medicare & Medicaid Services (CMS) announced that Maryland was one of the first three states selected to participate in the state's Advancing All-Payer Health Equity Approaches and Development model called, 'AHEAD.' Under this model, CMS will collaborate with states to curb the growth

of healthcare costs, improve population health, and advance health equity through reducing disparities in health outcomes. Ms. Eberle discussed how the MHBE plans to accomplish this through reviewing the design of the benefits structure and outreach efforts.

Ms. Eberle then provided an update on state-based marketplaces. There are currently 20 state-based marketplaces, and Georgia is the most recent to join the network. CMS continues to emphasize the three M's (Medicaid, Marketplace, and Medicare) to ensure the full continuum of health coverage. Ms. Eberle then reported that Governor Moore announced the appointment of Joy Hatchette as the Acting Commissioner for the Maryland Insurance Administration (MIA). Ms. Hatchette will be serving as an ex-officio voting board member on the MHBE Board of Trustees until a permanent Commissioner is selected.

Ms. Eberle also noted that the June enrollment data report has been posted and that all information is current through June. The dashboard provides data by county and state legislative districts. The MHBE is working on adding federal legislative districts to support efforts around the expanded tax credits. Ms. Eberle reported that the exchange has an all-time high enrollment, up year-over-year by 22%. Typically, enrollment goes down through the year, but the end of the public health emergency (PHE) unwinding has resulted in an increase in enrollment through June.

Ms. Eberle then discussed updates on the board and the MHBE. She noted that the Board is awaiting an appointment to replace Dr. Rondall Allen. The Board approved its 2025 meeting schedule during its annual meeting. Two Board appointments are ending on May 31st of 2025, meaning the Board will be looking for two new members at the beginning of June 2025.

Ms. Eberle concluded providing a few agency updates. A team at the call center dedicated to escalated cases was moved in-house at MHBE to streamline response time and improve consistency of responses. Ms. Eberle noted that the agency is focused on getting ready for the next open enrollment, including plan certification and marketing. The agency is also working with the Maryland Department of Health (MDH) to submit a planning document to CMS to get approval for Medicaid work in the next federal fiscal year.

Maryland Prescription Drug Affordability Board Presentation

Andrew York, Executive Director of the Maryland Prescription Drug Affordability Board (PDAB), started with an overview of his agency. The PDAB was created as an independent agency during the 2019 Session when the General Assembly enacted the HB768/SB759. There are five board members, supported by a 26-member stakeholder council. Its stated purpose in the legislation is to "protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the state, and other stakeholders within the healthcare system from the high cost of prescription drug products."

Mr. York discussed PDAB's priority projects. Cost reviews are in-depth reviews of select drugs to determine if they're causing affordability challenges. Upper payment limits are a novel policy tool that is available to make prescription drugs more affordable. The PDAB is also always looking for other ways to leverage its subject matter expertise for policies that the state can implement to make prescription drugs more affordable.

Mr. York introduced the PDAB's members. The five-member board consists of Van Mitchell (Chair), Joe Levy, Stephen Rockower, Ebere Onukwugha, and Jerry Anderson. There is a unique appointment structure, with one governor appointee and the rest as legislative appointees. Mr. York continued by giving an overview on the Stakeholder Council. The Council consists of 26 members who provide expertise and representation of different perspectives throughout the supply chain.

Mr. York further discussed the cost review study process. The PDAB can select drugs to undergo this cost review study process. They must select from a list of eligible drugs based on statutory metrics, which includes name-brand drugs that are over $30,000 per year, name-brand drugs that increase in price by more than $3,000 over a course of a year, biosimilars that are not at least 15% less costly than the reference biologic, and generic drugs that cost more than $100 per month and have a price increase of at least 200% or more in a year. The PDAB's legislation also allows the addition of other metrics during the regulatory process that can make a drug eligible for this study. Examples of these metrics can include drugs with the highest overall spend, the highest out-of-pocket patient cost, the highest per-patient spend, or the highest overall patient cost. The PDAB must select the drugs for the cost review study during an open meeting.

Mr. York stated that the cost review study process is a tool for the PDAB to get more information on these drugs and understand if they're causing affordability challenges. One of the defining features is a very high gross spend, which is the amount of money that the insurer will pay to the pharmacy. There's a lot of information that's not available that may better explain the impact of a drug to the health system and high out-of-pocket costs for patients, so the cost review process is a tool to collect this information and better understand the issue. The ultimate outcome of the cost review is for the PDAB to determine whether use of the drugs has led or will lead to affordability challenges for Maryland or high out-of-pocket costs to patients.

Mr. York then discussed the five steps of a cost review study: Identify eligible drugs; Select drugs; Collect information on the drugs; Analyze the drugs; Provide the results. During the identification process, the public can notify the PDAB of affordability problems with drugs, and the PDAB also has their own opportunity to make drugs eligible for the list. The PDAB also receives a dashboard with different metrics that are outlined in regulations that they may use to identify drugs for study. Next, these drugs are referred to the Stakeholder Council and published for public comment. The Stakeholder Council reviews and discusses the prescription drugs at an open meeting, and the PDAB selects prescription drug products for cost review.

Mr. York stated that, once drugs are selected for the cost review, there is a written comment period. Then begins the data collection, with the PDAB requesting information from manufacturers, health insurance carriers, pharmacy benefit managers (PBMs), and wholesale distributors. PDAB staff may assemble a dossier of data and analyses for consideration in the cost review study as outlined in COMAR 14.01.04.05. Then, the PDAB may determine whether the prescription drug has led to or will lead to affordability challenges to the state health care system. Ultimately, the PDAB creates and adopts a report of the cost review study that summarizes the information considered by the Board in conducting the cost review study, and the Board's determination.

Mr. York identified the six drugs selected for the cost review study the PDAB is currently undertaking. The drugs are as follows: Farxiga (dapagliflozin), Jardiance (empagliflozin), Ozempic (semaglutide), Trulicity (dulaglutide), Dupixent (dupilumab), Skyrizi (risankizumab).

Ms. Hsu asked about the conditions that the selected drugs are primarily intended to treat. Mr. York answered that the first four drugs (Farxiga, Jardiance, Ozempic, Trulicity) are primarily for diabetes, and Dupixent and Skyrizi are immunomodulators or autoimmune biologics.

Ms. Eberle asked why these six drugs were selected. She acknowledged the diabetes drugs but wanted to know about the others. Mr. York noted that the PDAB utilized a dashboard showing all the eligible drugs with all the factors they are allowed to consider, such as therapeutic class, total gross spending, average payer cost per patient, patient out-of-pocket cost, etc. The way that each member weighs each factor may be different and each does their own analysis. All this information then feeds into the Board Chair, who curates the list of drugs Mr. York noted that Maryland's is one of only five such Boards that currently exist in the U.S.

Mr. York then discussed upper payment limits. The PDAB may set upper payment limits for prescription drug products that are purchased or paid for by a unit of state or local government or an organization on behalf of a unit of state or local government; paid for through a health benefit on behalf of a unit of state or local government, including a county, bi-county, or municipal employee health benefit plan; or purchased for or paid for by the Maryland State Medical Assistance Program (Medicaid). Mr. York noted that the PDAB must draft an Upper Payment Limit Action Plan to be approved by the General Assembly Legislative Policy Committee. This would inlcude which drugs would be subject to upper payment limits, how the PDAB would set the Upper Payment Limits, and how the Upper Payment Limits would be implemented. The PDAB will also draft a report in 2026 on whether or not to expand the scope of upper payment limits to the entire state.

Mr. York discussed recommended additional policies. The Insulin Affordability Program is a new program that has not yet been implemented, but it will feed into the Patient Navigator Program. There currently are many resources available to patients to help with drug affordability. The Transparency Program is important because one of the

defining features of the prescription drug market is not knowing how the money flows, so there is a need for access to this information. Lastly, the Annual Report summarizes price trends and recommends policies.

Mr. York concluded with opportunities for collaboration. The PDAB continues to build out their Patient Navigator Program to provide patient support and wants to continue coordinating on Cost Reviews by working with MHBE carriers and enrollees to identify drugs that may cause affordability challenges. Lastly, the PDAB can serve as a resource for drug access and pricing issues.

JoAnn Volk asked how the PDAB anticipates implementing upper payment limits. Mr. York acknowledged that this is a key issue. The PDAB identified that their priority is ensuring that patients can afford their medicine. The issue is that the plans that the PDAB regulates are often very generous when looking at co-pays. By contrast, patients would see the PDAB's work the most in co-insurance. The PDAB would be implementing upper payment limits through negotiated rebates. The supply chain itself would remain the same, but the PDAB would identify what the cost of the drug should be to the health plan and then have the PBM and health plan work directly with the manufacturer to get to the target upper payment limit.

Ms. Volk asked if commercial payers will have a role in the upper payment limits. Mr. York said this would have to be done through legislation and needs additional analysis.

Ms. Hsu asked if all six drugs in the affordability study are on the formularies. Mr. York said the cost reviews look at affordability across the entire state: across the commercial sector, Medicare, and Medicaid. The PDAB asks if a drug causes affordability issues for all Marylanders, and if this is the case, they look at all their tools to make the drug more affordable. One of those tools is setting upper payment limits.

2023 Open Enrollment Consumer User Experience Testing - Key Findings Report

Betsy Plunkett, Director of Marketing & Web Strategies at the MHBE, started a presentation on the key findings from the Maryland Health Connection (MHC) user experience (UX) testing for Fall 2023 and what is being implemented for the upcoming year. The goals for testing are to understand the real-time usage and behavior of consumers through the enrollment and renewal process, identify difficult areas, gauge the impact, and discuss when and how these high impact areas will be fixed.

Ms. Plunkett discussed the UX testing structure. Testing took place during the first two weeks of the open enrollment period, from November 1-November 15, 2023, so there was a chance to make adjustments that may affect consumers. There were ten sessions in English and five sessions in Spanish. Each session was about 90 minutes, and participants shared their screen while being recorded. Participants were compensated between $125 and $200 for their time. Ms. Plunkett noted that the testing group consisted of current and new enrollees, and there was diversity among the

enrollees by race, ethnicity, and age. There were participants from throughout Maryland, including rural, urban, and suburban areas.

Ms. Plunkett reviewed the positive improvements compared to previous years. Users were successful in creating accounts and logging in. There were no username or password issues, which was an area previously identified for improvement. People did understand the tax filing status, to which clarifying language had been added after it was identified as a stumbling block in the past. Individuals were also able to correctly edit the annual income. One user was able to successfully upload documents. The signature page was reorganized to make it easier to get through. Ms. Plunkett continued with the improvements to the shopping experience. The healthcare usage levels resonated with users, users took the time to read the short disclaimers, coverage examples were practical, the tooltips and glossary were helpful, and specific features such as compare, filter, doctor search, and drug search had positive reviews.

Ms. Plunkett then shared quotes that show users' feelings about the platform overall, which are included in full in the presentation for this meeting.

Ms. Plunkett summarized key findings that represent areas of significant concern, including that returning users aren't sure how to get started, some users decline financial assistance by mistake, the layout of the eligibility selection page is confusing, and users rarely know the details of employer coverage. Ms. Plunkett stated that changes will be implemented to the first three concerns before open enrollment this year. Additional insights on the account home page include that users expect to see a list of only documents when clicking "View My Documents" but instead they see options that do not include documents. Users are often not ready to change their plans but want to explore options, and most users don't think they need to change their information. Insights on health care savings include that some users still misinterpret financial assistance in the application. Some users misread the question or automatically disqualify themselves, and some users do not understand the question. Lastly, the income questions and phrasing layout led to a miscalculation of the current year's income, and the system's calculations and carry-over of current and future income seemed incorrect to users.

Ms. Plunkett then discussed Flora, the chatbot. Users found that the chatbot experience is nice to have but often unhelpful. In most cases, Flora had difficulty interpreting the users' questions, often providing generic information that was not useful. Users preferred the option to chat with an expert and found it was most helpful. The MHBE has implemented artificial intelligence (AI) into the chatbot with gates around the knowledge base so it doesn't pull from the federal site or other states. The MHBE spends a lot of time making sure the website is accurate and up to date.

Allison Mangiaracino asked whether any of these findings will be used in the upcoming Consumer Decision Support Workgroup or if this was just to inform the SAC of changes for this upcoming open enrollment. Amelia Marcus stated that the Consumer Decision

Support Workgroup will focus more on the plan shopping process vs. the entire application process. The MHBE will provide updates to the SAC on the Workgroup.

Ms. Volk asked if there is an overall message of updating your information due to changes in health or income and the effect on financial help an individual is eligible for. Betsy Plunkett answered that when an individual clicks renew or change plan, there is an opportunity to review the whole application, and now consumers can edit at different points in the application which will force an individual to go through the whole application, reviewing their information in the process.

Ms. Volk asked whether the UX testing participants were current marketplace enrollees renewing their coverage and whether the testing panel included anyone previously enrolled in Medicaid before the PHE unwinding. Ms. Plunkett answered that the testing panel included eight current enrollees and six new enrollees.

Ms. Volk stated that her next two questions are more related to the upcoming Consumer Decision Support Workgroup, and she asked how aware participants are of the cost sharing reduction plans and their exclusivity to silver plans. Ms. Plunkett answered that the agency generates a list of enrollees who would be eligible for a different plan with the same or lower cost and better benefits, to whom they send targeted emails encouraging them to make the change.

Ms. Volk asked if there are resources to help participants find the value plans and understand the differences from other plan options. Ms. Plunkett answered that there is a lot of information and many fact sheets available on the value plans. Flora is able to pull information on the value plans if someone wants to know more. Amelia Marcus also stated that value plans are listed on MHC with a distinctive flag and pop-up information about them.

Ms. Hsu asked why none of the UX testers were from the Eastern Shore. Betsy Plunkett replied that time constraints and the nature of working through various research firms limited their ability to secure full geographic diversity on the testing panel.

Ms. Hsu asked who runs Flora. Ms. Eberle stated that the MHBE information technology (IT) department created Flora using information drafted by the MHBE marketing team and has begun using a small amount of AI.

SAC Discussion - Plan Certification Standards

Ms. Eberle led the discussion on plan certification standards. Plan certification standards are the only lever of authority available to the MHBE to make benefit designs most meaningful for the state, for consumers, and for the agency. She noted that MHBE workgroup deliberations help determine the largest health care cost drivers to the state, informing the plan certification standards. She asked SAC members to discuss what can be done in the plan certification standards with regard to affordability, cost containment, and health equity.

Mark Romaninsky asked whether plan certification standards consider provider network adequacy, noting that it is sometimes a stumbling block for new plans that are otherwise attractive to consumers. Michele Eberle replied that, while this is not part of MHBE's plan certification standards, plans must demonstrate that they meet the network adequacy standards defined by MIA.

In response to Mr. Romaninsky, Ms. Volk distinguished network breadth from network adequacy, stating that all plans must meet network adequacy standards but that this does not ensure that a plan has a broad network. Ms. Volk also discussed affordability and noted that Maryland has the NCQA Health Equity accreditation, but she is not sure if this requires self-reported data as opposed to demographic data from other data sources, such as zip code. She stated that the gold standard is self-reported data. She also noted that, under the Federal No Surprises Act, carriers and providers need to regularly update their provider directories for accuracy so that participants are able to select from current plans. When it comes to affordability, she discussed the need for transparency around facility fees so that consumers know what to expect.

Matthew Celentano stated that it is not always the case that "broader is better." Each carrier has to submit a plan on July 1st of every year to MIA to demonstrate that they have an adequate network, and every one of the carriers has fulfilled those obligations the past couple of years, but this can vary from person to person depending on factors such as geography.

In response to Ms. Volk on faciility fees, Ms. Hsu commented that HSCRC has a facility fees workgroup and that facility fee issues involve more than just hospitals and consumers.

Ms. Hsu asked what aspects of plan affordability can be adjusted. Ms. Eberle answered that the MHBE can look at anything that falls under the benefit structure, with the biggest limitation being the federal actuarial value calculator, which sets limits on plan generosity.

Maya Greifer recommended caution when considering updates to the plan certification standards to address health equity concerns of particular sub-populations and encouraged the MHBE to think of updates for the full population.

Public Comment
No comments offered.

Adjournment
The meeting adjourned at 3:43 PM.