Maryland Health Benefit Exchange
Board of Trustees

September 16, 2024
2 p.m. – 4 p.m.
Meeting Held via Video Conference

Members Present:
Laura Herrera Scott, M.D., Chair
Aika Aluc
Laura Crandon
Joy Hatchette
Maria Pilar Rodriguez
K. Singh Taneja
Dana Weckesser

Members Absent:
Ben Steffen, Vice Chair

Also in Attendance:
Michele Eberle, Executive Director, MHBE
Andrew Ratner, Chief of Staff, MHBE
Venkat Koshanam, Chief Information Officer, MHBE
Becca Lane, Senior Health Policy Analyst, MHBE

Meeting Call to Order

Ms. Eberle introduced the newest Board member, Katherine Rodgers, Director of Community Health Initiatives at TidalHealth in Salisbury, Maryland. Ms. Rodgers brings to the Board a wealth of experience in public health. Ms. Rodgers introduced herself.

Sec. Herrera Scott called the meeting to order.

Approval of Minutes

Ms. Weckesser moved to approve the minutes of the August 19, 2024, meeting. Ms. Crandon seconded the motion.

Mr. Taneja commented that on the second page of the minutes regarding his Finance Committee report that the minutes did not capture the entire Committee discussion regarding the indefinite delivery, indefinite quantity (IDIQ) contract. Specifically, that cancelling the contracts for the four new contractor positions before the end of the three-year term would not result in an additional cost. Mr.

Taneja requested that this information be added to the minutes. Blake Barron, the general counsel for the Maryland Health Benefit Exchange (MHBE), stated that he will review the recording of the August Board meeting and revise the minutes. Mr. Blake recommended moving to defer the approval of the meeting minutes and approve the minutes as amended at the next Board meeting.

Sec. Herrera Scott moved to rescind the previous motion to approve the minutes, Ms. Crandon seconded. All approved except for Ms. Rodgers who abstained.

Sec. Herrera Scott moved to defer approval of the August 19, 2024, meeting to the next Board meeting in October. Mr. Taneja seconded. The motion was approved unanimously.

Executive Update

Ms. Eberle began her remarks by explaining that Congress is in the second week of their three-week September schedule and the MHBE is hoping that Congress will confirm continued funding for the federal government beyond September 30. She noted that a federal government shutdown will not impact the MHBE's work. The MHBE is continuing to advocate with their federal delegation and national stakeholders about the importance of continuing the expanded tax credits under the Inflation Reduction Act, which are set to expire in December 2025. Ms. Eberle explained that if the expanded tax credits are discontinued then enrollments in 2026 would be impacted.

Ms. Eberle then noted that the August enrollment report is now available. Private plan enrollment is roughly 217,000, which is a 14% increase over the prior year. Income-based Medicaid enrollment is at 1.2 million, which is almost at 2021 levels after the year long process of returning to the pre-pandemic eligibility rules. New enrollments through Maryland Health Connection (MHC) continue to increase and currently make up 35% of total enrollment in the individual market. The MHBE's efforts to focus outreach on certain populations continues to be successful, with Black consumer enrollment increasing by 24%; Hispanic consumer enrollment increasing by 23%; and young adult enrollment increasing by 46%. Among young adults receiving a subsidy, enrollment has increased by 56% over the prior year. Ms. Eberle noted that there should be movement during the next legislative session to continue the young adult subsidy program beyond the pilot phase. Special enrollment for consumers with incomes below 150% of the federal poverty level (FPL) were twice the enrollment in August 2024 compared to the previous year. The MHBE is now focused on the upcoming 12th open enrollment, which starts November 1 with plan shopping beginning on October 1. Health plans and rates have been approved, training materials have been updated, the targeted marketing plans are underway, and the system updates are being finalized.

Ms. Eberle noted that the American Surgeon published a paper in June on the impact of the Affordable Care Act (ACA) on revascularization versus amputation in patients with chronic limb-threatening ischemia in Maryland. The paper compared amputation rates pre- and post-ACA implementation and found that amputation rates dropped from 56% to 23%, while revascularization rates increased from 44% to 77%. The paper concluded that broader insurance coverage enabled more people to obtain basic, routine care, which led to better preventive care for people with diabetes. Ms. Eberle summarized that this paper confirms what the MHBE has been seeing in the state reinsurance program with claim dollars declining for the number one condition which is diabetes. Ms. Eberle suggested that the Maryland Department of Health's (the Department's) focus work and the MHBE's benefit design has helped people with diabetes access needed care. Ms. Eberle noted that this study highlights the MHBE's efforts to make Marylanders healthier and drive down costs.

Board Committee Report, Standing Advisory Committee (SAC)

Aika Aluc, SAC Board Liaison

Ms. Aluc provided a summary of the July and September SAC meetings. She reported that during the July meeting, the Prescription Drug Affordability Board (PDAB) provided a presentation on prescription drug availability, cost reviews, and upper payment limits. The MHBE provided an overview of the open enrollment consumer user experience key findings report and plan certification standards.

During the September meeting, the MHBE provided a value plan preview for 2026, and most of the meeting focused on maternal health and coverage for pregnancy and postpartum care. Pregnancy is among the top five hierarchical condition categories reported for the reinsurance population, so the SAC discussed how the MHBE can address pregnancy and postpartum care within their authority, specifically affordability, cost containment, and health equity. Lastly, the SAC expressed interest in learning more about health reimbursement accounts (HRAs), and how the marketplace can communicate important information regarding HRAs.

Annual Compliance Report

Scott Brennan, Director of Compliance & Privacy, MHBE

Mr. Brennan presented the compliance and privacy annual report to the Board. He explained that the report focused on four main topics: Board oversight of compliance and privacy; MHBE policy update and revision initiative; the annual fraud, waste, and abuse report; and privacy program metrics and audits. Mr. Brennan reported that the Director of Compliance and Privacy has the ability to directly report to the Board Finance and Audit Committee and does so on a quarterly basis. The MHBE has an established protocol for escalation of significant compliance events. In the past year, the MHBE updated their policy to formally outline the ability and method by which the Director of Compliance and Privacy would report independently to the Board when necessary. Mr. Brennan highlighted the established independence of the Director of Compliance and Privacy and the necessity of direct communications with the Board.

Mr. Brennan provided an overview of the MHBE's initiatives to update policies. MHBE's policies and procedures serve as the cornerstone of a good compliance program. Mr. Brennan explained that updated policies and detailed procedures help the MHBE meet its objectives in a consistent manner while helping control identified risks. The initiative began in the beginning of fiscal year (FY) 2024 and is projected to be completed by December 31, 2024. Policies are updated and then reviewed during the Compliance Committee meetings, undergo legal sufficiency review, and lastly are signed by the Executive Director. After the policies are executed, they are distributed to employees and stakeholders as appropriate. There are 89 policies that govern the MHBE but not all require an update. Mr. Brennan provided a snapshot of finalized policies and policies currently under final review as of June 30. He noted that, as of today, 27 policies have been executed and a total of 49 out of 89 policies are complete or near completion. Moving forward, the compliance team will have a process to keep the policies up-to-date.

Mr. Brennan then provided an overview of the fraud, waste, and abuse report for FY 2024. He explained that 15 allegations were reported through the compliance hotline, which were mostly

consumer-related complaints. Of the 15 complaints, 1 was substantiated and forwarded to the Department for investigation, 1 was deemed unfounded and forwarded to MDH for update, and the remaining 13 were found to be unsubstantiated and closed. The MHBE performs a monthly debarment and sanctions screening of all employees, contractors, and vendors to ensure that none of them are listed on the Health and Human Services (HHS) Office of Inspector General's (OIH) List of Excluded Individuals/Entities. Mr. Brennan reported that they did not find any excluded individuals or entities in FY 2024.

Mr. Brennan provided an overview of the privacy program metrics, external audits, corrective actions, and internal reviews. He noted that the MHBE executed four agreements to establish privacy controls with stakeholder partner organizations that handle sensitive information for the MHBE, including consumer personally identifiable information (PII). The MHBE conducts an annual internal comprehensive assessment through the privacy impact assessment and MARS-E self-assessment and privacy attestation. The MHBE partnered with Cybersecurity to develop a robust cross-functional annual training that is required for all employees and contractors. Mr. Brennan then presented the privacy numbers for FY 2024. There were 194 incidents with 78 being misloads and 72 being producer errors. He noted that there has been an increase in the number of producer errors in FY 2024 compared to FY 2023, which may be correlated with an increased number of brokers working with the MHC and MHBE.

Lastly, Mr. Brennan presented a timeline for the external audits during FY 2024. Three audits are currently in progress, including the improper payment pre-testing and assessment audit with the Centers for Medicare & Medicaid Services (CMS) and the Payment Error Rate Measurement (PERM) audit with the Department. Five external audits have been completed. The independent external financial audit and the independent external programmatic audit are requirements for the SMART audit of financial and programmatic controls conducted by CMS. The financial audit did not have any findings. The independent external audit yielded one result with a limited impact on consumers, and a corrective action is underway. Mr. Brennan noted that the results of the CMS SMART audit are usually released around this time. Mr. Brennan reported that the Office of Legislative Affairs (OLA) is officially near the end of their audit and while he cannot discuss the audit findings until the OLA publishes their official report, the findings were not surprising. Mr. Brennan added the DBM-RED human resources audit and the PERM audit with the Department had findings and corrective action is in progress. Mr. Brennan explained that internal reviews were paused for FY 2024 due to the intensive commitment required for the OLA Audit and departmental resource issues and are scheduled to resume in September 2024 after OLA has concluded their triennial audit.

Ms. Weckesser asked about the subject of the complaint that was substantiated and forwarded to the Department for investigation. Mr. Brennan responded that the complaint was from a consumer regarding an allegation that an individual was using another address to falsely qualify as a Maryland resident. He explained that often in these situations the address problem is the result of a mistake rather than fraud but, in this particular case, it could not be ruled out as a mistake, so it was forwarded to the Department.

Sec. Herrea Scott asked about where the complaint was forwarded to within the Department and the final resolution of the complaint. Mr. Brennan responded that the complaint was forward to the OIG and that the complaint has not been resolved yet. Sec. Herrea Scott explained that the OIG is an independent body and is no longer part of the Department.

2025 Health Plan Landscape

Nicole Edge, Plan Management, MHBE

Ms. Edge provided an overview of the approved medical and dental plans for plan year 2025. She noted that Wellpoint is entering the individual market statewide for the first time and is now one of four carriers offering plans statewide in addition to CareFirst, Aetna, and United. Kaiser continues to offer plans in select counties. Ms. Edge reported that there is one less silver plan each from Kaiser, United, and Aetna, and one less gold plan from Kaiser and United in 2025 compared to 2024 because of a new requirement limiting carriers to three plans for each metal level. This requirement was the result of a recommendation from the 2022 Affordability Workgroup to limit the number of plans to prevent consumers from being overwhelmed with choices. She noted that there are five more qualified health plans (QHPs) available in 2025 bringing the total number of QHPs to 49, a slight increase from 2024 due to the addition of Wellpoint.

Ms. Edge then presented a comparison of the deductible and actuarial value (AV) for plans in 2024 and 2025 by carrier and metal level. She noted that there were not any significant changes from 2024 to 2025, explaining that the AV is set at 60% for bronze plans, 70% for silver plans, and 80% for gold plans. While there is some variation allowed for the lower and upper ranges of the AVs, all the offered plans meet the required AVs.

Ms. Eberle asked Ms. Edge to explain AVs. Ms. Edge explained that the AV for the plan depicts how generous the plan is in its offered benefits and services and those values are set each year. Carriers are generally allowed to have a variation of two percentage points above or below and expanded bronze plans may have a variation of 4 percentage points above the AV. The MHBE ensures that the plans a carrier is offering meets the required AV and that allows the MHBE to explain to consumers how much a plan will be paying for services compared to the consumer.

Sec. Herrera Scott asked whether the value has nothing to do with the membership in that plan but only the plan itself. Ms. Edge responded in the affirmative.

Ms. Eberle added that, for a gold plan, the carrier would pay for 80% of every dollar spent on out-of-pocket costs, while the consumer would pay 20%.

Sec. Herrera Scott expressed concern that the lower AV for bronze plans could lead consumers to defer care because the delta is so big and that the utilization and health outcomes for consumers in bronze plans could differ from consumers in gold plans.

Ms. Edge then presented on the dental plans offered in 2025. She reported that the dental plan offerings in 2025 are the same as in 2024 except for the addition of one preferred provider organization (PPO) under Dominion, and all dental plans are available statewide.

Ms. Eberle asked Ms. Edge to talk about vision plans, which are offered through the exchange but are not approved by the MHBE. Ms. Edge explained that stand-alone vision plans are available through the exchange and the current participating carrier for vision plans is VSP. While the exchange does not offer direct enrollment for vision plans, the consumers are provided a link that will direct them to VSP to enroll in a vision plan. The vision plans offered by VSP are available year-

round. Ms. Edge reported that a recent enrollment update showed that enrollment has increased and is higher than expected. She expressed that the MHBE is hopeful that enrollment will continue to increase.

Sec. Herrera Scott asked why the MHBE does not monitor vision plans the same way they monitor medical and dental plans. Ms. Eberle responded that the ACA has different rules for vision plans and while the MHBE has the option of offering vision plans they are not required to certify vision plans. Ms. Edge added that the MHBE does not certify vision plans in the same manner as medical and dental plans. The MHBE does have internal discussions with the vision plan carrier regarding requirements, but the requirements are less robust than those for medical and dental carriers.

Ms. Weckesser commended the MHBE for doubling the number of carriers participating in the exchange since she joined the Board, which also leads to decreased rates due to the increased competition. She asked if the MHBE can determine how much the increased competition decreased rates and increased enrollment using available data. Ms. Edge responded that the MHBE can look into this issue, but it may take time because Aetna just completed their first year participating in the exchange and Wellpoint is entering the exchange in 2025. Ms. Eberle added that Brad Boban with the Maryland Insurance Administration (MIA) will be presenting on approved rates next and may be able to speak to this issue.

2025 Approved Rates with Trend and Medical Loss Ratio Discussion

Brad Boban, Chief Actuary, MIA

Mr. Boban started by explained that MIA must ensure that rates are not excessive, inadequate, or unfairly discriminatory and must be reasonable in relation to benefits. The MIA begins the rate review process by reviewing 2023 experience period claims and comparing it to past years and to what the carriers had previously projected when setting 2023 rates. The MIA then reviews assumptions used to project experience period claims from 2023 to the 2025 projection period and ensures that each assumption is reasonable individually and in aggregate. Key assumptions used by the MIA include claims trend, morbidity, operating expenses, profit margin/contribution to reserve, risk adjustment transfers, reinsurance recoveries, and the impact of the Medicaid unwinding on enrollment and morbidity. Mr. Boban noted that rate filings were submitted on May 20, 2024, and were approved on September 5, 2024.

Mr. Boban then presented a summary of the rate approvals for ACA individual plans. The carriers initially filed for a 6.7% rate increase, but the MIA approved a 6.2% rate increase. The initial filed rate increase varied by carrier ranging from 4.7% to 14.2% and the final rates approved by MIA ranged from 5.1% to 8.6%. The CareFirst BlueChoice HMO filed for a 4.7% rate increase, but the approved rate increase was 5.1% because CareFirst received a risk adjustment payment in 2023 for the first time due to their shrinking population becoming riskier than the rest of the pool, so CareFirst made an adjustment to their rates. Mr. Boban reported that as of July 31, total enrollment both on and off the exchange was 270,897, which is an 18% increase year over year compared to a 14% increase for enrollment on the exchange. He noted that Optimum Choice from United Health Care increased their enrollment from 23,019 in 2023 to 63,355 in 2024, an increase of 175%. This increase is driven by United's competitive pricing. Mr. Boban explained that while he does not have an exact percentage of the rate decrease caused by increased competition, United has had the second lowest cost silver plan since their second year of joining the market which has helped drive down rates in the

marketplace. The large increase in enrollment in United is showing the dividends of their competitive pricing because this market is very price sensitive.

Mr. Taneja commented that the 6.2% increase appears to be a significant because there has been a large increase in enrollment since 2023. Mr. Boban responded that the average rate increase nationwide is 7% so Maryland's rate increase is below the average. Also, Maryland has the cheapest bronze and gold plans in the country, so the 6.2% increase is on top of the lowest rates in the country. Mr. Boban would not characterize the 6.2% increase as significant because it is a trend-level increase that is slightly below the national average.

Mr. Taneja commented that inflation was high at 17% the past three years but now that inflation is decreasing to 2.5%, the 6.2% rate increase this year appears very high compared to the 4.7% increase last year. Mr. Boban responded that while the rate increase is higher than last year, he would still not characterize it as high because the increase is below the national average and Maryland has the lowest cost bronze and gold plans in the country.

Mr. Boban presented Maryland's premium rates relative to the rest of country in 2024 for a 40-year-old, weighted by zip code, according to a report by the Kaiser Family Foundation. For bronze plans Maryland has the lowest premium in the country at $256, which is 30% lower than the national average of $364. Mr. Boban noted that a 6% increase would bring the bronze premium to $271, and Maryland would have the second lowest bronze plan. Maryland has the cheapest gold plan and the third cheapest silver plan in the nation.

Mr. Boban provided an overview of claim trends in the individual market by service category. Hospital services make up the largest portion of total claims at 37% for inpatient and outpatient claims combined. The cost trend carriers are using on average is 4.3% or 1.043, which is in line with the Health Services Cost Review Commission (HSCRC) update factor of 1.045. Other service categories have higher cost trends such as professional services, which have a cost trend of 4.4% and a utilization trend of 3.9% which combines to a total of 8.5% cost trend. Prescription drugs have a 10.3% total cost trend, with a 5.5% cost trend and 4.5% utilization trend. These are the major service categories driving the costs. Mr. Boban noted that the claims trends are increasing at a rate that is above general inflation after four years of claims trends below general inflation.

Mr. Boban then presented on the impact of risk adjustment and the reinsurance program on costs by carrier in 2023. There were roughly $1.8 billion in allowed claims with an average claims cost per member per month (PMPM) of $654 with large variation among the carriers ranging from $421 to $1,651. Risk adjustment is a federal program to even out the costs for carriers by transferring money from carriers with lower cost members to carriers with higher cost members. Optum Choice and Kaiser transferred money into the risk adjustment program while BlueChoice, CFMI, and GHMSI received money from the risk adjustment program. The risk adjustment program narrowed the gap between the carriers' average PMPM with the average PMPM for carriers ranging from $497 to $1,181. The risk adjustment program also helped even out the premiums in the market. The reinsurance program which is funded by the state paid out roughly $567 million, which lowered the total average PMPM for all carriers from $654 to $452. After reinsurance is applied the average PMPM for carriers ranged from $358 to $600, narrowing the gap between carriers even further.

Mr. Boban provided an overview of the history of the medical loss ratio (MLR) in the Maryland individual market. He noted that, from 2011 to 2018, there were no rebates to enrollees in the individual market. After the reinsurance program was implemented in 2019, faster-than expected decreases in claims costs required carriers to provide a rebate to enrollees because they over-projected costs. They had to provide rebates in 2020 and 2021 as well. In 2022, the size of the rebate decreased dramatically from $45 million, or 4.5% of total premiums, in 2021 to $2 million, or .2% of total premiums, in 2022. In 2022, most of the rebates were paid by Optimum Choice, which attracted a healthier population than expected for their first year in the individual market. Mr. Boban then presented the details of the MLR calculation for 2022 rebates. Under the MLR, carriers are required to spend at least 80% of premium dollars on medical care and quality improvement. Mr. Boban explained that, in 2022, the three-year MLR average for the CareFirst PPO (CFMI) was slightly below 80%, but, due to the credibility adjustment, they were deemed not credible enough to owe a rebate. Optimum Choice had an MLR of 73.3% in 2022, but, after a 2.7% credibility adjustment, they only owed 4% of premiums back in rebates.

Sec. Herrera Scott asked about the criteria for a credibility adjustment. Mr. Boban responded that the main criterion is the number of member months. He explained that the basic theory behind the credibility adjustment is that the smaller a carrier is, the more likely that the variation from the mean is due to statistical variation and not underpricing. The credibility adjustment is meant to prevent over-penalizing small carriers for normal statistical variation due to a smaller population.

Mr. Boban presented a comparison of the premiums for the value plans in 2025 for consumers of three different ages: 21 years old, 40 years old, and 60 years old. He noted that the market is competitive, with the CareFirst PPO priced significantly higher than the other companies because it still has a riskier population, even after risk adjustment. The four HMO companies have similar prices, and Optimum Choice has the cheapest premiums in every metal level.

Ms. Eberle explained that value plans are standardized plans, so all carriers have to offer the same benefit design.

Mr. Boban showed a sample of individual premiums for the cheapest bronze, silver, and gold plans for each carrier for a 40-year-old living in the Baltimore Metro region. The cheapest bronze plan in 2025 is offered by Optimum Choice and has a $261 monthly premium, and the most expensive is a CareFirst GHMSI plan with a $456 premium. Mr. Boban noted that Optimum Choice introduced a new off-exchange silver plan with a premium 11.6% lower than their on-exchange silver plan. He explained that several carriers have off-exchange-only plans, particularly silver plans, because they don’t have the cost sharing reduction (CSR) load. He noted that the monthly premium for Optimum Choice’s cheapest gold plan is only increasing by 1.2% in 2025, to $340.

Mr. Boban presented the approved rates for individual dental plans. Originally the carriers requested a 2.4% rate increase on average, but the MIA approved a .3% rate increase. The large difference between the requested and approved rate increase is mostly due to Delta Dental, which originally requested a 18% rate increase but was approved for a 9.7% rate increase. He noted that CareFirst is lowering premiums for their two plans by 5%. This is the second year in a row where enrollment in dental plans has remained basically flat at around 96,000, indicating that enrollment has peaked, but it is still much higher than five years ago.

Ms. Eberle added that Medicaid incorporated adult dental as a Medicaid benefit, so the MHBE expected a larger drop in dental plan enrollment and is happy with the current enrollment.

Mr. Boban showed a sample of individual premiums for the most popular dental plan for each of the five dental carriers for a 40-year-old living in the Baltimore Metro region in 2024 and 2025. He noted that CareFirst is decreasing rates, while the other carriers are increasing rates. In general, the PMPMs for dental plans are much lower than the PMPMs for medical plans.

Mr. Boban presented the approved rates for small group carriers. He reported that the carriers filed for an average rate increase of 6.1%, and the MIA approved an average rate increase of 4.5%. The average rate increase varies by quarter, with increases of 3.2% and 2.4%, respectively, in the first two quarters. There were larger average rate increases of 5% and 5.1%, respectively, in the third and fourth quarters of 2025. Mr. Boban explained that the mid-year rate decreases that occurred last year went into effect for the third and fourth quarter enrollees, but the first and second quarter enrollees will get the mid-year decrease on top of the approved rate increase. This is the third year in a row where multiple carriers filed for mid-year rate decreases, so the MIA is trying to push the carriers' rates down more during the rate filing process to avoid the mid-year rate decreases. Mr. Boban reported that the average small group rate increase nationwide is 7.5%, so the below-average trend increase is attributable to a favorable claims experience during the 2023 experience period. Small group enrollment has decreased by 5.2%, from 239,226 in 2023 to 227,226 in 2024, which continues several years of declining enrollment. Mr. Boban noted that this is the first year where the individual market had considerably more enrollment than the small group market, with the former's enrollment increasing and the latter's declining.

Mr. Boban showed a sample of small group premiums for the lowest-cost silver plan for each carrier for a 40-year-old. He explained that there are more choices in the small group market than the individual market. He also showed a sample of small group premiums for the lowest-cost gold plan for each carrier.

Mr. Taneja commented that the ACA implementation has led to a lower uninsured rate and increased access to health care and asked if there is any evidence or data showing that Marylanders are healthier today than ten years ago. Mr. Boban responded that this is beyond his scope of expertise, and he cannot speak to the general health of Marylanders.

Mr. Taneja suggested spending time in the future examining how the MHBE has contributed to the health of Marylanders, such as by improving life expectancy. Sec. Herrera Scott responded that the COVID-19 pandemic was an unforeseen factor that delayed people's access to care from 2020 through 2023, so the last four years have been volatile. She noted that the opioid epidemic and other factors, such as gun violence, have also contributed to a decline in Marylanders' overall life expectancy, which may make if more difficult to isolate the impact of the ACA on Marylander's health. She recommended looking at a specific cohort and examining data before and after COVID as an example, adding that there is geographic variation in health care access as well.

Procurement Items – Amazon Web Services Option Year One

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

Mr. Koshanam provided an overview of the Amazon Web Services (AWS) infrastructure for the MHBE, which is distinct from the AWS platform used for MDTHINK. He reported that the MHBE currently uses AWS for marylandhbe.com, the MHC for Small Business web and mobile apps, Broker Connect, live agent chat, the internal WordPress site, and the enrollment dashboard. AWS is also used for innovative technologies, such as the robotic process automation (RPA) used to automate Medicaid documentation verification processes. Mr. Koshanam explained that the FY 2025 information technology (IT) strategy includes expanding the MHBE AWS infrastructure footprint. The MHBE has completed the migration of three lower environments to the MHBE AWS from MDTHINK, and the remaining six environments will complete migration by December 2024. Mr. Koshanam noted that the cost after the environments are migrated from MDTHINK to the MHBE AWS is net neutral. The IT team is also building a health benefit exchange (HBX) disaster recovery capability for business continuity with the intention of going live in March 2025.

Mr. Koshanam then presented a timeline of the AWS infrastructure expansion from 2023 through 2025. The AWS infrastructure expansion is intended to improve efficiency in operations and reduce dependency on one platform in MDTHINK. Mr. Koshanam reported that, in 2024, the IT team is migrating the nine lower environments from MDTHINK and building a proof-of-concept environment to foster security, agility, and innovation needs. In early 2025, the IT team will build a disaster recovery capability for the HBX to ensure business continuity and is already working on expanding business intelligence capabilities to allow stakeholders to examine consumer data at a granular level for policy development. The IT team will also build microservice architecture for the exchange in 2025 and is in the early stages of implementing Kubernetes, an automation deployment process. Mr. Koshanam noted that all these initiatives have been vetted by CMS.

Ms. Gamble started with a summary of the AWS procurement. The Board approved the original award in October 2022, and the AWS license started in November 2022, for a base period of two years and one option year. MHBE staff are requesting the Board's approval to exercise the option year for the period of November 1, 2024, through October 31, 2025. Initially, the procurement was done through a request for quote through General Services Administration Schedule 70, and the successful vendor was A&T Systems, Inc. The annual cost varies based on utilization, and Board approval for a Not-to-Exceed (NTE) amount will be requested annually. In FY 2023, the actual cost was $382,037.55, and in FY 2024, it was $555,965.29. The projected cost for FY 2025 is $1.5 million. Ms. Gamble reported that, in FY 2025, the federal government is paying for 75% of the cost, or $990,000, and the state is paying for the remaining $510,000.

Sec. Herrera Scott asked if the increased cost of $1.5 million is due to new initiatives using AWS for 2025. Mr. Koshanam responded in the affirmative, explaining that the lower environment migration and building a large disaster recovery capability are responsible for the bulk of the costs. The cloud costs have increased by 25% over the past couple of years. Mr. Koshanam stated that the costs are within the IT budget and are expected to stay within the IT budget for FY 2024 and FY 2025.

Sec. Herrera asked if the MHBE has the $510,000 in the general funds for option year one. Mr. Koshanam responded that the MHBE does not need additional funding because the cost is within the approved FY 2025 budget for IT.

Mr. Taneja asked about the difference between FY 2024 and FY 2025 that is contributing to the increase in budget from $555,965 for AWS in FY 2024 to $1.5 million AWS in FY 2025. Mr.

Koshanam responded that, in FY 2024, the MHBE requested a total NTE amount of $2 million for the AWS platform, but the environment migration did not follow the original schedule. The expected FY 2026 budget for AWS is roughly $2 million, and the MHBE's goal is still to contain the costs within the IT budget due to the cost savings on migrating the environments from MDTHINK and improved efficiencies.

Sec. Herrera Scott moved to approve to exercise Option Year 1 from November 2024 to October 2025, to procure the Amazon Web Services Subscription from A&T Systems, Inc. as presented. Mr. Taneja seconded the motion. The motion was approved unanimously.

Sec. Herrera Scott moved to approve a Not-to-Exceed amount of $1.5 million for FY 2025 for the Amazon Web Services Subscription, with Federal Participation amount of $990,000 and State Participation amount of $510,000 as presented. Ms. Weckesser and Mr. Taneja seconded the motion. The Board approved the motion unanimously.

Policy Items – 2026 Plan Certification Standards Preview and Regulation Updates

Becca Lane, Senior Health Policy Analyst, MHBE

Ms. Lane began with an overview of the draft value plan designs for plan year 2026 that the Value Plan Workgroup recently voted unanimously to recommend. The only plan certification standards for 2026 are for the value plan designs. The value plan designs may need adjustments in January 2025 to remain within the federal AV ranges after the release of the 2026 federal AV calculator later in 2024, after which the value plan designs will go before the Board for a vote to be finalized.

Ms. Lane explained that the MHBE sets plan certification standards for individual market plans sold through MHC, which can encompass plan design, operations, and other requirements. Value plan standards are approved on an annual basis. The value plan designs are used as a policy tool to work towards several goals, including affordability and access to care; for example, value plans prioritize pre-deductible coverage as one of their features. The standardized designs of value plans are intended to make consumers' plan selection process easier by allowing for direct comparisons between plans. Another goal of value plans is to promote health equity: for example, by making diabetes care in value plans free.

Ms. Lane presented a history of value plans, which were first implemented in 2019. She noted that the main change over the past few years is the standardization of the value plans, which means the value plan designs are the same for all carriers. The changes to the value plans have been driven by the Workgroups, which always consist of a broad range of stakeholders, including consumer assistance workers, consumer advocates, carriers, providers, and state agency representatives. The most recent Value Plan Workgroup met six times over the summer of 2024, and, moving forward, the Workgroup will be reconvened annually to discuss the value plan standards and recommendations.

Ms. Lane showed a summary of the updates the recent Workgroup voted unanimously to recommend for 2026. The value plan designs are the same as the designs in 2025 except for a couple of key changes. Lab copays were reduced from $80 to $55 for bronze plans and to $45 for silver 73 and base silver plans. The Workgroup chose to make this recommendation to further health equity: expensive lab co-pays can be difficult for people with chronic conditions or co-morbidities, which disproportionately affect people of color. Another, more technical change was to align pediatric dental

coinsurance across the two major service classes to align Maryland with other states, and the coinsurance was lowered for plans with lower-income enrollees and increased for plans with higher-income enrollees. All other elements remain unchanged from 2025 designs.

Ms. Lane then presented a timeline for the finalization of the value plan designs. The drafted proposed 2026 standards were presented to the Standing Advisory Committee on September 12. After the federal AV calculator is released in the Fall or Winter, MHBE staff will adjust the value plan designs and reconvene the workgroup as necessary. The Board will vote on the final proposed 2026 value plan standards on January 21, 2025, and then, after the month-long public comment period, the Board will vote on the final 2026 standards during the February 18, 2025, meeting.

Mr. Taneja asked when the costs will be available. Ms. Lane responded that the federal AV calculator is released in the Fall, which is not related to costs but will determine whether the plan designs are too generous or not based on the federal AV restrictions. If the plan designs are too generous, then the designs will have to be modified, possibly by increasing some copays.

Mr. Taneja asked how a decision can be made without knowing about the financial burden that will be placed on the state. Ms. Lane responded that there is not an associated burden to the state because these are the plan designs for 2026 so the rates for 2025 will not impact the 2026 plan designs.

Ms. Eberle added that carriers will have to submit their rates for plan year 2026 by May 2025, and, in order for them to determine what they will charge for premiums, they need to know about the required benefit designs. The MHBE must work within the AV parameters for the plans, so they must wait for the release of the federal calculator, which may be released before the end of the year, before ensuring the plan designs will fit within the federal AV parameters, and, if not, then the designs will need to be modified.

Mr. Taneja expressed concern that the state may be burdened with additional funding if the AV calculator requires changes to the plan designs. Ms. Eberle responded that there will not be any additional funding demands on the state; instead, the results will determine how much the carrier has to pay for services versus how much the consumer has to pay.

Ms. Lane then provided an overview of the regulation updates that need to be made to conform with federal regulations. She presented a slide listing the regulation updates and referred the Board to the memo for more details. The MHBE is proposing to clarify the effective date for a change to the failure to file and reconcile policy, eliminate the 15th of the month rule for special enrollment periods, and remove the expected contribution requirement for the below 150% FPL special enrollment period. Other updates include allowing retroactive termination of private plans when enrollees enroll in Medicare Part A or B with a retroactive effective date and a technical update to COMAR 11.35.07.11 to remove redundant subsections.

Ms. Lane presented a timeline for the finalization of the regulation updates. If the Board approves the proposed regulation updates today, then the MHBE will submit the updates to the Joint Committee on Administrative, Executive, and Legislative Review, after which the draft regulations will be published on the Maryland Register in November, and, after the 30-day public comment period, MHBE staff will bring the final regulations update to the Board for a final vote on January 21, 2025.

Sec. Herrera Scott asked for a motion 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. Ms. Weckesser motioned to do so, and Ms. Rodgers seconded. All members present voted to approve the motion, except for Mr. Taneja and Ms. Aluc, who abstained.

Sec. Herrera Scott asked why Mr. Taneja and Ms. Aluc abstained. Ms. Aluc responded that her concerns are similar to Mr. Taneja and that she wants more clarity on the cost sharing for consumers versus what the carrier pays. Sec. Herrera clarified that this motion is related to modifying the Maryland regulations to confirm with federal regulations and is not related to value plan designs. Ms. Eberle added that a Board vote was not needed for the first policy item on the proposed value plan standards for 2026.

Mr. Taneja stated that he abstained for the same reason as Ms. Aluc. Sec. Herrera Scott gave Mr. Taneja and Ms. Aluc time to read through the proposed federal conformity regulation updates.

Sec. Herrera Scott 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.

Before votes were cast, Mr. Taneja asked about the difference between the authorization of the MHBE to submit the regulations versus their publication. Sec. Herrera Scott referred to the timeline showing the regulatory framework for all Maryland regulations. After the regulations are submitted to the Joint Committee on Administrative, Executive, and Legislative Review for review, they must be published for a 30-day public comment period. Regulations cannot be released without giving the public an opportunity to provide feedback. The Board will have a formal vote for final action on January 21, but the publication allows the public to see the proposed changes to the regulation and provide comment.

Mr. Taneja asked for confirmation that, in a way, the MHBE is proceeding with what has been proposed here, but, after the public provides comments during the 30-day public comment period, the MHBE will seek to address those comments. Sec. Herrera Scott clarified that the MHBE is trying to align the current state regulations with the proposed changes from the federal government and that those changes must be handled through regulation. She explained that Ms. Lane provided the language for the proposed changes and that the regulation changes have to be published for public comment. If there are no comments during the 30-day public comment period, then the regulations will still be brought before the Board for a final vote. If there are public comments, then the MHBE's legal department will review the public comments and decide if any changes should be made to the proposed regulations, after which the Board will vote on the new versions of the proposed regulations that incorporate public comments. The final Board vote will not occur until January 21.

Ms. Lane added that some of the federal regulatory updates are requirements for state exchanges that must be implemented, while others are optional and subject to public comment. Ms. Lane noted that the regulations would become effective on February 17, assuming the Board votes on the regulations on January 21.

Sec. Herrera Scott called for a vote on the motion 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 Board approved the motion unanimously.

Adjournment

Sec. Herrera Scott closed the meeting. Ms. Rodriguez seconded. The meeting was adjourned at 4:04 PM.