



MARYLAND
HEALTHBENEFIT
EXCHANGE

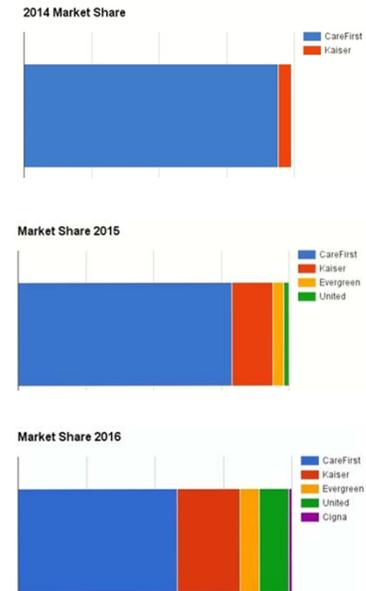
LEGISLATIVE BUDGET HEARINGS

House: FEB. 4, 2016
Senate: FEB. 8, 2016

2016 HIGHLIGHTS

1. Enrollment up 35% to 165,600+
2. 325,000+ enrolled in Medicaid this enrollment
3. System processed more than twice as many total enrollments as a year ago: 490,000 vs. 210,000
4. A more competitive marketplace:

Carrier	2014	2015	2016
CareFirst 	94%	79%	58%
Kaiser 	5%	15%	23%
Evergreen 	-	4%	7%
United 	-	2%	11%
Cigna 	-	-	1%
All Savers 	-	-	-



African-American enrollments up 40%

- Self-identified: 32,000; Up from 23,000 for all of prior open enrollment

Hispanic enrollments up 215%

- Self-identified: 19,000; Up from 6,000 for all of prior open enrollment
- In 2015, uninsured rates for non-elderly in Maryland were whites-5%, blacks-7% and Hispanics-15%. Since ACA took effect, rates of uninsured African-Americans and Latinos reduced by 7%; whites reduced by 3%.

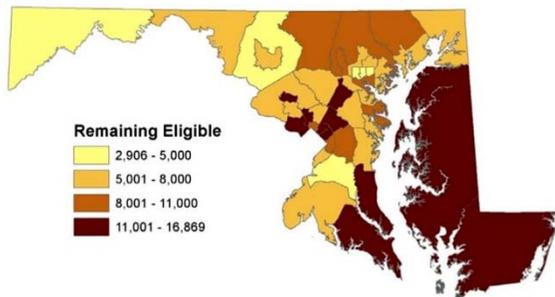
(Sources: Kaiser Family Foundation, Census Bureau, University of Maryland [School of Public Health](#))

“Young Invincible” (18-34) enrollment tied for 5th in US

- 29% of total private plan enrollments. National average is 27%
- Up from 27% in Maryland in prior open enrollment.
- Participation is vital to sustainable mix of “risk pool”

1. Reach the Hard To Reach Uninsured

- Continue to use resources such as SHADAC -- State Health Access Data Assistance Center (SHADAC) at the University of Minnesota -- to analyze data of remaining eligible uninsured, as used in 2015.
- Find innovative ways to leverage “trusted messengers” such as Md. Assoc. of Public Library Administrators (“Library Enrollment Day”), NAACP, Faith Institutions (“Super Health Sunday”), BGE; CVS; Merritt Athletic; M&T Bank; Maryland Retailers Assoc.; Education Based Latino Outreach; The Center of Help/Centro de Ayuda; DLLR; Maryland Workforce Exchange; Md. Dept. of Veterans Affairs



Source: SHADAC analysis of the 2013 American Community Survey and data from the Maryland Health Benefit Exchange. Error! Bookmark not defined.

2. Continue to Improve the Website

- **Website enhancements** to increase efficiencies and reduce operational supports.
- **User Experience Testing** recently concluded by UX firm gotoresearch. Live look-ins as consumers sought to enroll in private health plans or Medicaid during the final two weeks. Report due next month. Findings will help inform improvements in advance of OE4.
- **Continue to grow @MarylandConnect Twitter, Facebook** audiences, which doubled in past year. Our **YouTube video** on how to complete an online application has 18,000+ views since Sept.

3. Enhance Consumer Support

- **Established a constituent services unit** in early 2015 to provide additional support for escalated cases.
- **Successful first year of “BATPhone” pilot** -- Broker Assistance Transfer. Authorized brokers were integrated “virtually” in our call center, resulting in 1,400 enrollments. Brokers spent 740 hours talking to consumers, reducing added volume on call center.
- **Improve consumer information to support plan selection:** Increase accuracy of provider directories and disclosure of metrics on provider network adequacy and plan quality.

Items for Comment



Given the discontinuation of this dedicated funding stream, the agency should comment on efforts to ensure affordable premiums after funding for the reinsurance program ends.

Affordability and the rates are impacted by many factors. While the MHBE is not directly responsible for setting or approving rates, MHBE helps keep premiums low by lowering the rate of uninsured in the State and by improving the insurance market risk pool.

As of March 2015, Maryland's rate of uninsured was 6% -- tied for 4th in the nation with five other states, according to the Kaiser Family Foundation and U.S. Census. Maryland's enrollment of African-Americans (self-identified in application) grew from 23,000 for 2015 to 32,000 for 2016. Maryland's enrollment of Hispanics grew from 6,000 for 2015 to 19,000 for 2016. This reduces the cost of care by lowering the amount of uncompensated care in the State and, ultimately, makes premiums more affordable.

The MHBE tied for 5th in the country for enrolling young people (ages 18-34) with 29% of the total in our State enrolled between Nov. 1 and Dec. 26, 2015, according to the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services. This improves the risk pool by enrolling more young people into Qualified Health Plans and is an ongoing priority for MHBE.

In consultation with the General Assembly and the Administration, the MHBE could also exercise its statutory authority to use alternative contracting options and active purchasing strategies. These strategies would allow the MHBE to work with carriers and other stakeholders to encourage new health care delivery models aimed at reducing the cost of care.

Items for Comment



The agency should comment on whether or not they have set a specific deadline for the development of quantitative standards and what that deadline may be.

The MHBE convened a stakeholder workgroup on network adequacy to address this issue with carriers, consumer advocates, and other industry stakeholders. Building on that work, the MHBE Board adopted 2017 plan certification standards that require carriers to disclose network adequacy metrics to the MHBE and consumers. The MHBE Board will consider formalizing quantitative standards for plan year 2018 following analysis of the required metrics and additional stakeholder input. In addition, a number of proposals may be presented in this Session about network adequacy quantitative standards.

The agency should comment on the potential payout of claims if CMS requires these funds to be returned.

During the period of this audit, the MHBE was acting in good faith by following the cost allocation plan approved by CMS. If CMS were to require these funds to be returned, there is a process by which MHBE can appeal the decision. The MHBE continues to work with CMS to implement a cost allocation plan per CMS approval and guidance.

Response to Recommendation



Reduce 3 vacant positions. Two of these positions have never been filled. One has been vacant for longer than four months. \$ 205,889 SF 3.0 PINs

The MHBE respectfully disagrees with this recommendation.

In a year's time, the MHBE reduced turnover by 66% (from 24% to 8%). This was made possible by the ongoing development of the MHBE, and our ability to transition from a start-up phase to steady-state operations.

Details about the 3 positions (PINS) recommended for reduction:

The MHBE has made an offer, which has been accepted, on PIN 088539 which is our consumer assistance training coordinator position. The hire is expected to start 2/17/16.

PIN 088561, which will be posted soon, is a position that is needed to oversee key work processes to ensure that we continue to refine the quality, efficiency, and effectiveness of our service delivery programs.

PIN 088791 is an OAG staff Attorney position. Given the numbers, size, and complexity of our procurements, the MHBE would like to be able to hire an additional attorney to support procurement efforts.