



Affordability Work Group

Meeting 2

March 15, 2019

A service of Maryland Health Benefit Exchange

Agenda

- Welcome and Introductions
- Charter Ratification
- Member Welcome and *Getting to Know You* Activity
- Status of Affordability in 2019
- Other State and MHBE Action
- Affordability Policy Levers
- Morbidity in the Individual Market
- Public Comment
- Adjournment

Changes in Consumer Experience

- Premiums:
 - The State Reinsurance Program (SRP)
 - Cost sharing reduction (CSR) payments “Silver-loading”
 - Advanced Premium Tax Credits (APTC)
- Out-of-pocket costs:
 - Before deductible services
 - Deductible
 - Plan generosity (Actuarial Value, AV)
 - Health Savings Account (HSA)

2018 to 2019 Premiums without APTC¹

Carrier (Network)	Enrollment ² (on/off MHC)	2019 Rates (w/o Reinsurance)	2019 Rates (w/ Reinsurance)
CareFirst (HMO)	109,368	18.5%	-17%
CareFirst (PPO)	13,074	91.4%	-11.1%
Kaiser Permanente (HMO)	69,837	37.4%	-7.4%
Total	192,279	30.2%	-13.2%

¹As of January 31, 2019, 21,977 enrollees do not receive APTC on Maryland Health Connection.

²Enrollment as of June 30, 2018.

2018 to 2019 Premiums with APTC³

- Consumers will receive less APTC in 2019 than in 2018, but still more than otherwise due to “silver-loading”:
 - The SRP reduced premiums for silver plans from -7.2% to -14.5%.
 - Silver plan premiums on Maryland Health Connection are 11% to 28% higher than off-Exchange premiums.
- Depending on their plan and carrier, assuming no change in income, some consumers will pay more in 2019 than in 2018, others will pay less.
 - The SRP reduced premiums differently depending on metal level and carrier
 - Bronze plans -4.4% to -19.1%
 - Silver plans -7.2% to -14.5%
 - Gold plans -9.3% to -15.3%
- Consumers will pay less in 2019 if their premium decrease was greater than their APTC decrease and vice versa.

³As of January 31, 2019, 124, 539 enrollees receive APTC.

2018 to 2019 Premiums with APTC

- Consumers enrolled in the lowest cost gold plan will experience a premium decrease.
- Consumers enrolled in the lowest cost bronze plan may experience a premium increase, or decrease, depending on family composition and income.
- Consumers enrolled in the lowest cost silver plan will experience a premium increase, the amount depends on family composition and income.
- Consumers enrolled in CareFirst-only areas will experience a premium decrease. The impact of “silver-loading” is most pronounced in these areas.
- Scenarios may be found in the Appendix of this presentation.

Market Trends

- All premiums are going down, but some out of pocket costs are rising
- Different experience depending on the carrier and plan
- Even more important to shop

Top 5 Plans: 2018 to 2019 Deductible and Actuarial Value (AV) Changes.*

2018 Plan	2019 Plan	Deductible Change	AV Change
KP MD Silver 6000/35/Dental	KP MD Silver 6000/35/Dental	\$0	+ .47% (67.08% → 67.55)
BlueChoice HMO Silver \$3500 VisionPlus	BlueChoice HMO HSA Silver \$3000 VisionPlus	- \$500	-4.4% (70.70% → 66.30%)
HealthyBlue HMO Gold \$1000	HealthyBlue HMO Gold \$1750	+ \$750	- .63% (78.54% → 77.91%)
BlueChoice HMO Bronze \$6550	BlueChoice HMO Bronze \$7900	+ \$1350	-1.96% (60.49% → 58.53%)
KP MD Bronze 6200/20%/HSA/Dental	KP MD Bronze 6200/20%/HSA/Dental	\$0	+ .44% (60.59% → 61.03%)

*Top 5 Plans account for 80% of enrollments on Maryland Health Connection.

QHP Characteristics

- One bronze option with first-dollar coverage (Kaiser Permanente)
- Two silver options with first-dollar coverage (Kaiser Permanente)
- Two options, gold and platinum, with \$0 deductibles (Kaiser Permanente)
- Three gold options with deductibles from \$1000 to \$1750 (CareFirst PPO & HMO; Kaiser Permanente)

Carrier (Network)	Plans Offered	Metal Levels Offered (#)	HSA Offerings
CareFirst (HMO)	4	Bronze (1), Silver (1), Gold (1), Catastrophic (1)	Silver (1)
CareFirst (PPO)	3	Bronze (1), Silver (1), Gold (1)	Silver (1)
Kaiser Permanente (HMO)	10	Bronze (2), Silver (3), Gold (3), Platinum (1), Catastrophic (1)	Bronze (1) Silver (1)

Out of Pocket Costs

Premiums have decreased in 2019, but the deductible for many plans continued to increase. For example, for a 42 year-old consumer living in rating area 2, deductibles for bronze plans increased by as much as \$1,350, depending upon the plan option selected.

Actuarial Value

When benefit requirements are added, the plan must still maintain the actuarial value, although “de minimis” variation is allowed. De minimis variation generally allows actuarial value thresholds to vary by a range of -4 to +2 percentage points. There is an exception to this rule for bronze plans covering a major service before deductible. In these cases, the threshold may vary from -5 to +5 percentage points.

State Examples: Covered California

Patient-Centered Benefit Designs⁶

- Outpatient services in Covered California’s Silver, Gold and Platinum plans are not subject to a deductible (primary care visits, specialist visits, urgent care, lab tests, X-rays, imaging and other services). Bronze plan enrollees can have three primary care or specialist visits without needing to satisfy a deductible.
- By having common benefits, copays and deductibles across health plans — both in Covered California and “off exchange” in the individual market — consumers are able to make apples-to-apples comparisons on the things that matter most, including the cost of the premium and the doctors and hospitals that are in the plan’s network.
- Combining patient-centered benefit designs with the law’s essential health benefits means consumers are getting real coverage and are not subject to surprise “gaps” in their benefits

State Examples: Access Health Connecticut (AHCT)

Standardized Plan Designs⁷

- AHCT developed individual standardized plan designs for each metal tier which defined deductible, co-payment and/or co-insurance cost sharing on an in-network and out-of-network basis
- The AHCT standardized plan designs are not “gatekeeper” plans and were designed to provide enrollees with direct access to specialists.
- Accordingly, AHCT will not certify the standardized plan designs offered by an Issuer at any coverage level if the Issuer requires a referral from a Primary Care Provider (PCP) in order for an enrollee to be able to access a specialist. Should an Issuer impose the “gatekeeper” requirement in its non-standardized plans, AHCT will require an Issuer to identify this requirement in the Schedule of Benefits and/or the Issuer’s Plan Marketing Name(s). Additionally, such requirement must be described explicitly and prominently in the Issuer’s Evidence of Coverage.

7. Connecticut Health Insurance Exchange, *Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplaces*, http://agency.accesshealthct.com/wp-content/uploads/2018/05/2019-QHP-Solicitation_Amended.pdf

State Examples: New York State of Health

Standard Products w/ 3 PCP Visits⁸

- QHP may offer a standard product with 3 visits to a primary care provider that are not subject to the deductible. Co-payments will apply
 - For these purposes, primary care visits are defined as visits to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, outpatient mental health, or outpatient substance use
 - The additional products will not count towards the number of non-standard products offered by the carrier
- If the carrier opts to offer this product, it must:
 - Be offered at the Gold, Silver, Silver CSR 73% AV, and, Silver CSR 87% AV metal levels, in every county of its QHP service

MHBE 2020 Plan Certification Standards

Value Plans⁹

- In response to public feedback on the increasing consumer cost-sharing and rising out-of-pocket costs in QHPs offered through Maryland Health Connection, MHBE will require that issuers offer “Value” plans, that meet certain cost sharing and branding requirements, at the bronze, silver, and gold coverage metal levels

Value Bronze Plan Office Visits Requirements

- Under the “Value” Bronze three office visits requirement issuers may allocate, at minimum, any three office visits across the Primary, Urgent, and Specialist Care Visits. Issuers are encouraged to allow maximum consumer flexibility to the extent possible under existing technical/operational limitations. To incentivize appropriate utilization of lower cost sites of care MHBE strongly recommends the inclusion of at least one urgent care visit in the selected allocation
- MHBE understands that “Value” plan requirements will increase QHP actuarial value and potentially premiums. MHBE encourages issuers to offer additional QHPs with lower actuarial value to support premium affordability for unsubsidized consumers and provide distinct options within each metal level.

“Value” plan offering requirements for the 2020 plan year.

Requirements	Bronze	Silver	Gold
Minimum offering	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.
Branding	Required for 2020.	Optional.	Optional.
Deductible ceiling	No requirement. Lower deductibles are encouraged.	\$2500 or less.	\$1000 or less.
Set Office Visits Before Deductible	<p>Issuer may allocate no less than three office visits across the following settings:</p> <ul style="list-style-type: none"> • Primary Care Visit (not including preventive care) • Urgent Care Visit • Specialist Visit 	No requirement.	No requirement.
Services Before Deductible	See ‘Office Visits Before Deductible’ above.	<p>The following services must be offered as copays before deductible:</p> <ul style="list-style-type: none"> • Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging 	<p>The following services must be offered as copays before deductible:</p> <ul style="list-style-type: none"> • Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging • Generic Drugs
Encouraged Services Before Deductible		<p>The following services are strongly encouraged to be offered as copays before deductible:</p> <ul style="list-style-type: none"> • Generic Drugs 	
Limitations & Exceptions	No requirement.	No requirement.	No requirement.
Facility Fees	No requirement.	No requirement.	No requirement.

Discussion



Affordability Indicators

- Premiums:
 - The State Reinsurance Program (SRP)
 - Reduce Base Premiums → Differential Impact
 - Reduces Premium Tax Credits → Based on Reduction in Silver Premiums
 - Cost sharing reduction (CSR) payments “Silver-loading”
 - Inflates Premiums for Silver QHPs
 - Advanced Premium Tax Credits (APTC)
 - Dependent on Silver QHP Premiums
 - Actuarial Value (de minimis variation)
 - -4%/+2% for Silver (70% AV), Gold (80% AV), and Platinum (90% AV) QHPs
 - -5%/+5% for Expanded Bronze (60% AV) QHPs if one major service offered before deductible

Affordability Indicators

- Out-of-pocket costs:
 - Before deductible services
 - Increases Actuarial Value
 - Deductible
 - Tool to control utilization by service category
 - May be used to create incentives for utilization of certain services
 - Cost-sharing
 - Co-payments (greater certainty of consumer expenditures)
 - Coinsurance (defrays costs but increases uncertainty of consumer expenditures)
 - Health Savings Account (HSA)
 - 100% of expenditure paid by consumer until deductible is met (no-first dollar coverage)
 - If consumer has an HSA consumers may pay for services with pre-tax dollars
 - Reduces AV, often the QHPs with lowest premiums

QHP Offering Requirements

- Low AV/High AV QHP Rules
- Product Offering Requirements (EPO/PPO proposal)
 - Premium variation across products
 - Premium tax credit changes with QHP offerings
 - Impact on Risk Adjustment

Priorities for Action

- Population Health (specific morbidities)/Total Cost of Care Waiver
- Create a more efficient health care service market through cost sharing
- Specific sources of cost, i.e. prescription drugs, out-patient facilities, etc.



Morbidity of the Individual Market Risk Pool

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Morbidity of the Individual Market Risk Pool

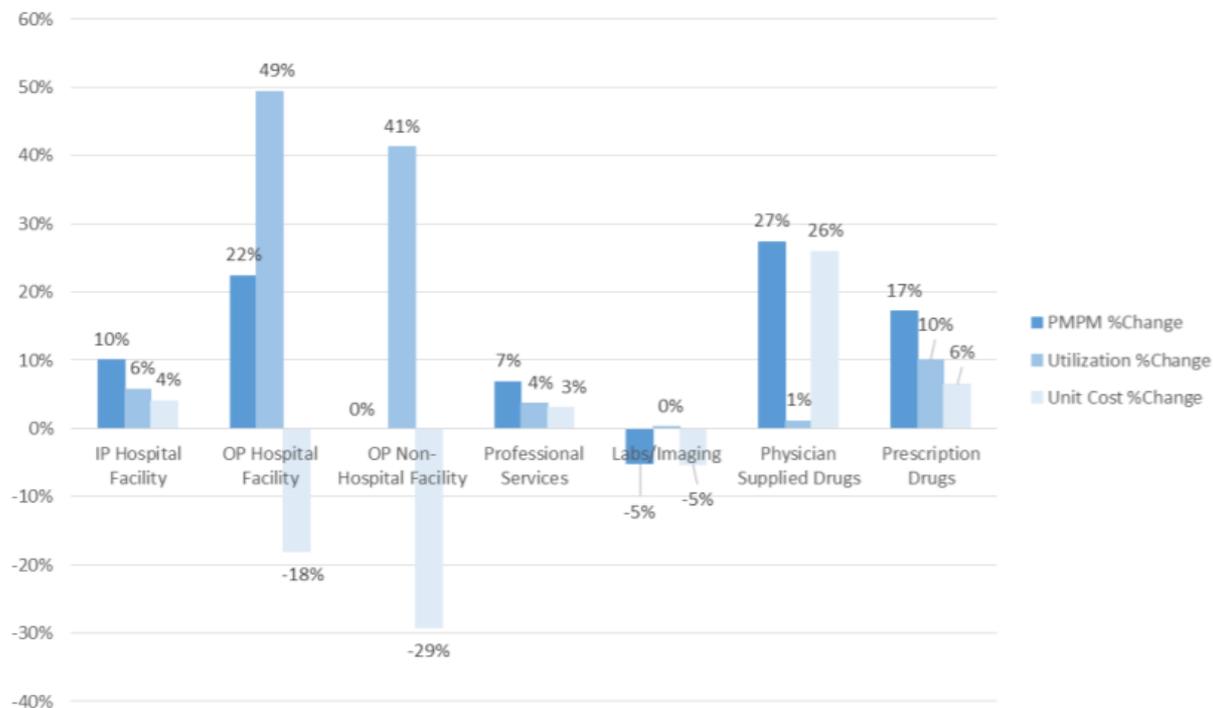
Data from Maryland's Medical Care Database (MCDB) from 2014, 2015, and 2016 was examined by the Maryland Health Care Commission (MHCC) to determine patterns in health care spending and utilization for consumers enrolled on the Individual Market

Highlights

- **Spending grew:** Per member per month (PMPM) expenditures for health care for privately-insured members in Maryland increased each year from 2014-2016
- **Outpatient Hospital and Prescription Drug utilization drove the increase in PMPM spending across all markets in 2016:**
 - Increases in service use for outpatient hospital facility (22%) and prescription drugs (5%) were the main contributors to the increase in total PMPM spending across all markets in 2016
 - Increased unit costs (20%) of physician supplied drugs also contributed to PMPM growth

Exhibit 2: Annual Changes in PMPM Spending

Exhibit 2. Annual Changes in PMPM Spending, Utilization per 1,000 Members, and Cost per Unit by Service Category, Individual Market, 2015 to 2016



- Notes: (i) Kaiser HMO plans are excluded from this report except for membership at the end of the year, as shown in Exhibits 1 and 3.
- (ii) Individuals can have multiple types of coverage during the year but are counted only once in the total.
- (iii) Outpatient non-hospital facility primarily includes ambulatory surgery centers, critical access hospitals, clinics and home health outpatient and inpatient non-hospital facility as it primarily includes home health.
- (iv) Physician supplied drugs are now broken out from professional services.
- (v) Annual changes are for the individual market as a whole (including ACA-compliant and noncompliant plans).

Morbidity of the Individual Market Risk Pool

Highlights continued

- **Some service categories saw PMPM decreases:** In 2016, the PMPM for inpatient hospital facilities decreased by 2%, and the PMPM for labs/imaging decreased by 3%. Both decreases are attributable to decreased unit costs, as utilization remained unchanged
- **Population Health Risk scores (median expenditure risk scores) were virtually stable from 2015-2016** for the large employer and small employer markets but increased for the individual market.
 - Median population health risk was highest in the large employer and individual markets
- **Individual market participants faced the highest out-of-pocket costs in 2016:** PMPM out-of-pocket costs for members in the individual market was \$120, compared to \$58 for members in the large employer market and \$84 for members in the small employer market

Exhibit 3: Spending Among MD's Younger-Than-65 Population

Exhibit 3. On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only) Spending Among Maryland's Younger-Than-65 Population, Privately Insured, Individual Market, 2015 to 2016

	2015		2016		% Change (2015/2016)	
	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange
Members as of 12/31						
Total members (w/o Kaiser)	95,603	114,646	95,388	107,502	0%	-6%
Kaiser members	16,136	10,191	25,717	10,712	59%	5%
Total members (w/ Kaiser)	111,739	124,837	121,105	118,214	8%	-5%
Distribution (w/o Kaiser)	45%	55%	47%	53%		
Distribution (w/ Kaiser)	47%	53%	51%	49%		
Member Months						
Total member months	1,137,678	1,400,012	1,185,127	1,357,993	4%	-3%
Distribution	45%	55%	47%	53%		
Spending						
PMPM spending, all services combined	\$447	\$432	\$478	\$476	7%	10%
PMPM OOP, all services combined	\$92	\$121	\$89	\$145	-3%	20%
PMPM OOP, Medical Only	\$75	\$103	\$74	\$128	-1%	24%
PMPM OOP, Prescription Drugs	\$17	\$19	\$15	\$17	-12%	-11%
PMPM Spending By Service Category						
Inpatient Hospital Facility	\$79	\$73	\$83	\$73	5%	0%
Outpatient Hospital Facility	\$83	\$95	\$88	\$126	6%	33%
Outpatient Non-Hospital Facility	\$11	\$11	\$10	\$10	-9%	-9%
Professional Services	\$105	\$107	\$110	\$112	5%	5%
Labs/Imaging	\$41	\$40	\$39	\$36	-5%	-10%
Physician Supplied Drugs	\$12	\$10	\$15	\$13	25%	30%
SubTotal (Medical Only)	\$331	\$336	\$345	\$370	4%	10%
Prescription Drugs	\$116	\$96	\$133	\$106	15%	10%

Notes: (i) Kaiser HMO plans are excluded from this report except for membership at the end of the year, as shown in Exhibits 1 and 3.

(ii) This exhibit includes Individual market **ACA-compliant plans only**. On the other hand, Exhibit 1 includes both ACA-compliant and non-compliant plans. As such, some figures in the exhibits differ.

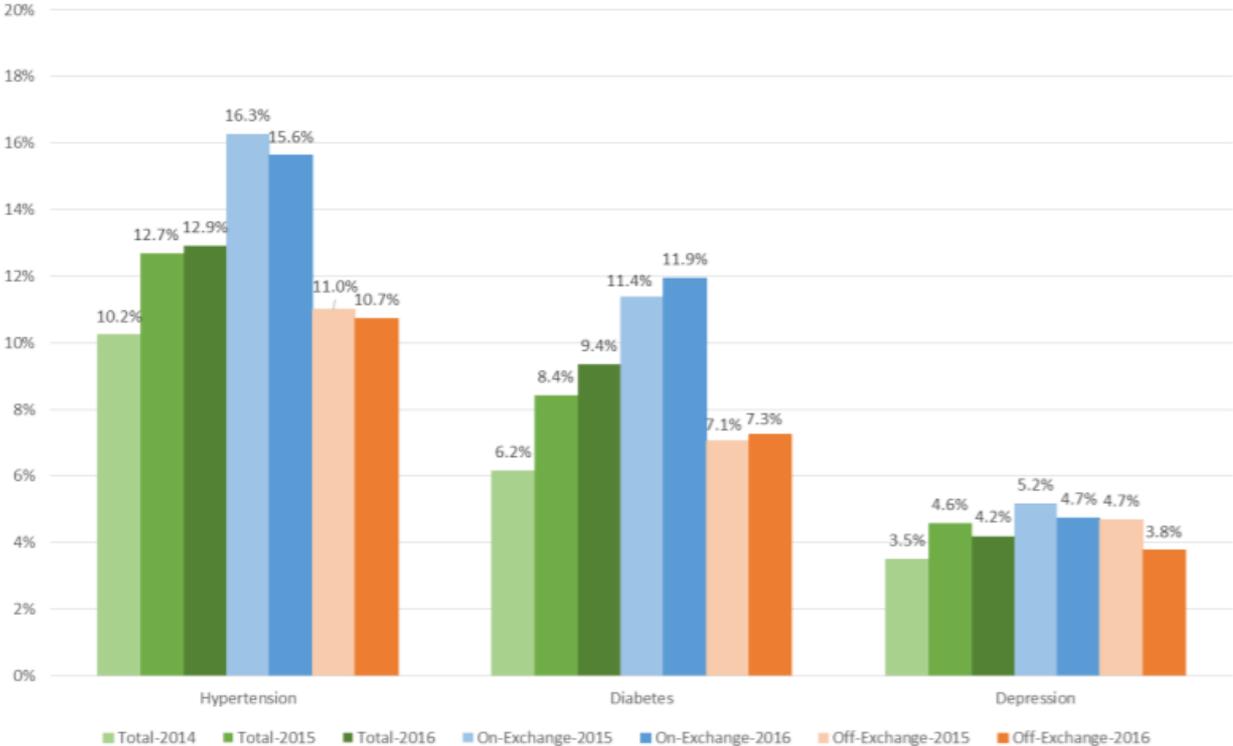
(iii) Some calculations in the above exhibit might not be exact due to rounding.

Morbidity of the Individual Market Risk Pool

- Among three chronic conditions—hypertension, diabetes, depression—both hypertension and diabetes were more prevalent among on-Exchange members than among off-Exchange members in 2016
 - 15.6% vs. 10.7% for hypertension
 - 11.9% vs. 7.3% for diabetes
- In the entire individual market, prevalence of hypertension and depression was stable from 2015 to 2016, but diabetes prevalence rose from 8.4% to 9.4%, continuing an upward trend from 6.2% in 2014 (See **Exhibit 4**)
- Although the total medical out-of-pocket (OOP) spending increased by 17%, the prescription drug OOP spending declined by 6%--constraining the total OOP increase to 13% in the individual market overall in 2016

Exhibit 4: Prevalence of Select Chronic Conditions

Exhibit 4. Total (ACA-Compliant & Noncompliant Plans), and On-Exchange vs. Off Exchange (ACA-Compliant Plans Only): Prevalence of Select Chronic Conditions, Individual Market, 2015 to 2016



Notes: (i) On v. off-Exchange data splits were not available in the MCDB until 2015.
(ii) Total includes both grandfathered and non-grandfathered plans.