State Benchmark Plan Work Group

Meeting 2

February 22, 2019

A service of Maryland Health Benefit Exchange

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

- Welcome & Introductions
- Charter Overview & Ratification
- *Getting to Know You*
- State Flexibility for Essential Health Benefits
- Morbidity in the Individual Market
- Benchmark Plan Walkthrough/ Establish Focus Areas
- Public Comment
- Adjournment

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Background

- **Section 1302(b)(1):** The Secretary shall define the EHB, except that such benefits shall include at least the following general categories and the items and services covered with the categories:
  1. Ambulatory patient services
  2. Emergency services
  3. Hospitalization
  4. Maternity and newborn care
  5. Mental health and substance use disorder services, including behavioral health treatment
  6. Prescription drugs
  7. Rehabilitative and habilitative services and devices
  8. Laboratory services
  9. Preventive and wellness services and chronic disease management
  10. Pediatric services, including oral and vision care

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Background (cont'd)

- **Section 1302(b)(2) and (3):**
  - The Secretary shall:
  - ❑ Ensure the scope of EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.
  - ❑ Submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of CMS that EHB meets the above limitation.
  - ❑ Provide notice and an opportunity for public comment.

- **Section 1302(b)(4):**
  - The Secretary shall:
  - ❑ Ensure that such EHB reflect an appropriate balance among the 10 categories, so that benefits are not unduly weighted toward any category.
  - ❑ Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.
  - ❑ Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Background (cont'd)

- **Section 1302(b)(4):**
  - The Secretary shall:
  - ❑ . Ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or the individuals' present or predicted disability, degree of medical dependency, or quality of life.
  - ❑ Provide that a QHP shall not be treated a providing coverage for the EHB described unless the plan provides that coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have contractual relation ship with the plan for the providing of services that is more restrictive that the requirements or limitations that apply to emergency department services received from providers provided out-of-network, the cos-sharing requirement (expressed as a copayment amount or a coinsurance rate) is the same requirement that would apply if such services were provided in-network

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Previous EHB-Benchmark Plan Policy

- **Federal EHB Rule** (78 FR 12834): Allows states to determine EHB bases on a base-benchmark plan.

- States may select among
  - The largest plan by enrollment within one of the State's three largest small group insurance products by enrollment;
  - One of the State's three largest State employee health benefit plans by enrollment;
  - One of the three largest federal employee health benefit plans by enrollment; or
  - The largest HMO plan by enrollment offered in the State's non-Medicaid commercial market.

- Default option for states that did not select a benchmark plan was the largest small group market plan by enrollment in the largest product by enrollment in the State.

State Benchmark Plan

Previous EHB-Benchmark Plan Policy

- **State Benchmark Plans must cover all 10 statutory benefit categories:**
  - A base-benchmark plan that does not cover all statutory benefit categories must be supplements by adding the omitted benefit categories in their entirety, generally from another benchmark plan option in the State, to become the EHB-benchmark plan.
  - The EHB-benchmark plan serves as a reference plan for issuers designing their own plans.
  - Plans providing EHB must be “substantially equal” to the EHB-benchmark plan, including both the covered benefits and limits on coverage of the EHB-benchmark plan.

- **State defrayal:**
  - States are responsible to determine additional State-required benefits are in excess of EHB, requiring the State to defray the costs of these benefits to the issuers on behalf of consumers or to the consumers directly.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

New EHB-Benchmark Plan Policy

- **Effective Plan Year:** 2020 and future years
  - Option 1 (45 CFR § 156.111(a)(1)): Selecting the EHB-benchmark plan that another State used for the 2017 plan year under § 156.100 and § 156.110
  - Option 2 (§156.111(a)(2)): Replacing one or more categories of EHB under § 156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another States used for the 2017 plan year under § 156.100 and § 156.110.
  - Option 3 (§ 156.111(a)(3)): Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan, provided certain conditions, including scope benefits requirements, are met.
  - Option 4: States may retain their current EHB-benchmark plans

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

State Mandate Policy at § 155.170

- Section 1311(d)(3)(B) of the ACA permits a State to require QHPs to cover above-EHB benefits.
- The defrayal rule continues to apply in such instances.
- § 155.170(a)(2):
  - A benefit required by State action taking place on or before December 31, 2011 is considered an EHB – and does not need to be defrayed by the State.
  - A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered above-EHB – and is subject to defrayal by the State.
- Applicability to EHB-benchmark plan modifications:
  - States that select an EHB-benchmark plan from another State must defray the cost of any benefits included in the other State's benchmark plan that are benefits mandated by the selecting State after December 31, 2011.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

New EHB-benchmark plan requirements

- Provide coverage of items and services for at least the 10 EHB categories of benefits.
- Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan.
- Not exceed the generosity of the most generous among a set of comparison plans.
- Not have benefits unduly weighted towards any of the categories of benefits.
- Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.
- Not include discriminatory benefit designs.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Definition of typical employer plan at § 156.111(b)(2)

- One of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or
- The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103 provided that:
  - The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;
  - The plan provides minimum value;
  - The benefits are not excepted benefits
  - The benefits in the plan are from a plan year beginning after December 31, 2013

Requirements for a State Benchmark Plan

- The State's EHB-benchmark plan must not exceed the generosity of the most generous plan among a set of comparison plans:
  - The State's EHB-benchmark plan used for the 2017 plan year; and
  - Any of the State's base-benchmark plan option for the 2017 plan year.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

State EHB-benchmark plan selection requirements

- Provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan (including posting on the appropriate State Web site)
- Notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.
- Submit documents in a format and manner specified by HHS by a date determined by HHS.
  - A document confirming the State's EHB-benchmark plan selection complies with the requirements under § 156.111 (a), (b), and (c), including information on which selection option under paragraph (a) the State is using, and whether the State is using another State's EHB-benchmark plan.
  - The State's EHB-benchmark plan document that reflects the benefits and limitation, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using Option 3, a formulary drug list in a format specified by HHS.
  - Other documentation specified by HHS

State Benchmark Plan

State EHB-benchmark plan selection requirements (cont'd)

- ❑ An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with general accepted actuarial principles and methodologies

1. That the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, the extent of any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan; and
2. That the new EHB-benchmark plan does not exceed the generosity of the most generous amount the following list of plans:
   - The State's 2017 benchmark plan, and
   - Any of the available State benchmark plan options in 2017.

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Example Methodology

- **Step 1:** Select a “Typical Employer Plan” or a “Comparison Plan.”
- **Step 2:** Calculate the expected value of covering all of the benefits at 100% actuarial values in EHB category in the proposed EHB-benchmark plan and in the “Typical Employer Plan” or “Comparison Plan.”
- **Step 3:** Compare the expected value of covering all of the benefits in each EHB category between the proposed State’s EHB-benchmark plan and the selected plan.

Important Considerations

- Impact on premium tax credits and subsidies,
- Spillover effect to other benefits in making benefit changes, and
- Need for consumer education on benefit changes

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Illinois Example

- Illinois used Option 3 to modify its existing State EHB-benchmark plan to help address the opioid crisis and improve access to mental health and substance use disorder resources
- Overall goal was to identify additional benefits that could be added to the EHB with minimal premium impact.
- Approach:
  - Use medical experts to develop a list of benefits
  - Use an actuarial firm to estimate the potential premium impact
- Important considerations:
  - Public was not involved in development process due to timeline constraints, but proposal did have a two-week comment period.

State Benchmark Plan

Illinois Example

- Benefit changes:

1. Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.

2. Limiting opioid prescriptions for acute pain to no more than seven days.

3. Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder

4. At least on intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher

5. Telepsychiatry visits

maryland health connection

Morbidity of the Individual Market Risk Pool

A service of Maryland Health Benefit Exchange

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 patters in health care spending and utilization for consumers enrolled on the Individual Market

Highlights

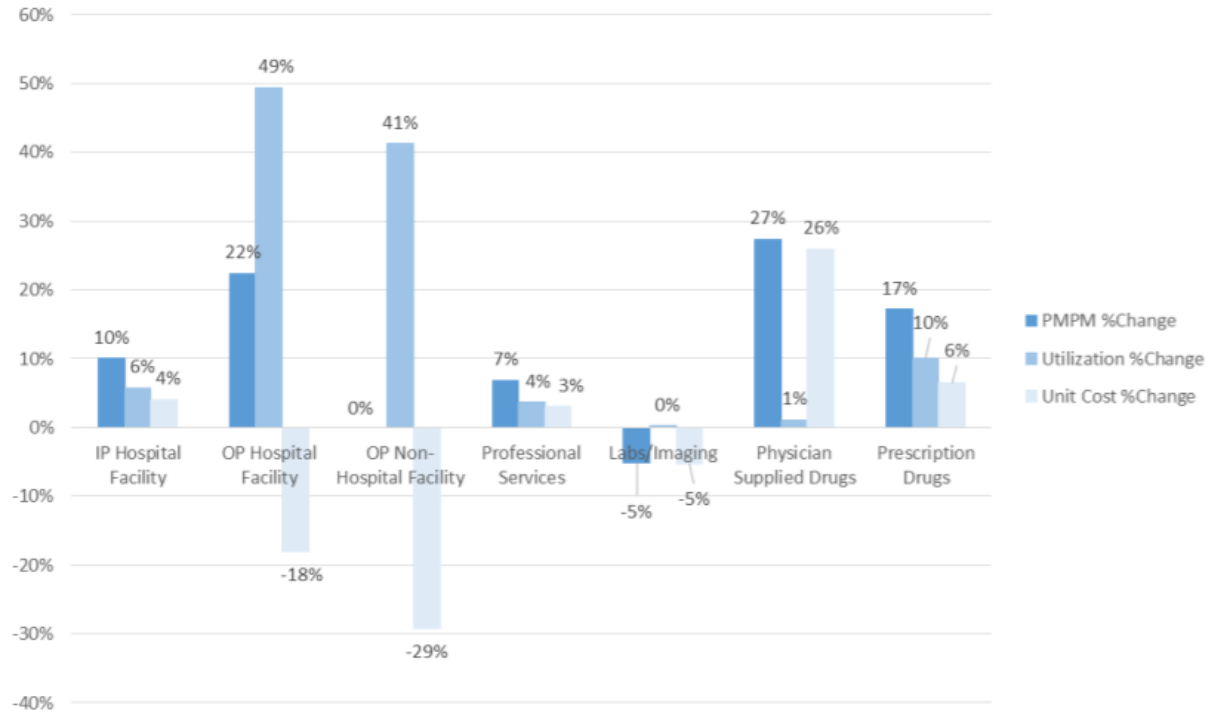
- **Spending grew:** Per member per month (PMPM) expenditures for health care for privately-insured members in Maryland increased each year from 2014-2016

- **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 until costs (20%) of physician supplied drugs also contributed to PMPM growth

Exhibit 2: Annual Changes in PMPM Spending

MARYLAND HEALTHBENEFIT EXCHANGE

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/imagining decreased by 3%. Both decreases are attributable to decreased until 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

MARYLAND HEALTHBENEFIT EXCHANGE

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

MARYLAND HEALTHBENEFIT EXCHANGE

- 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

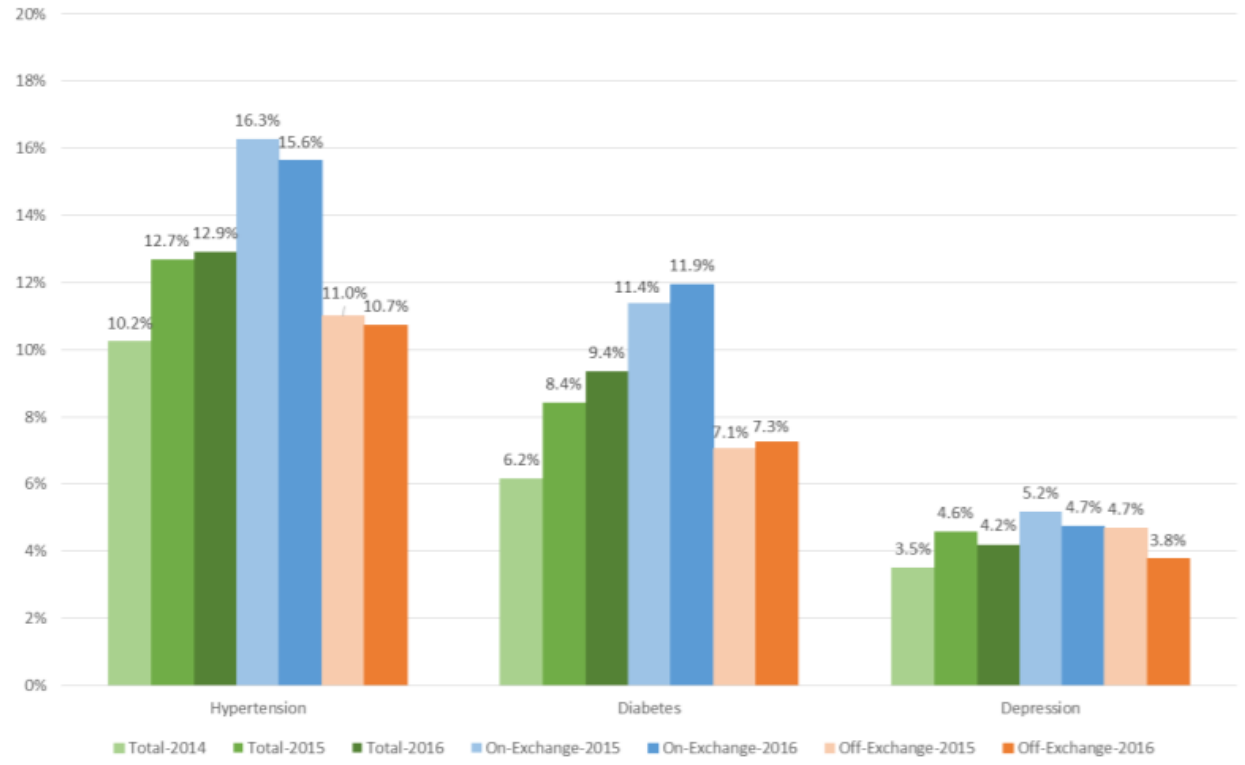
- In the entire individual market, prevalence of hypertension and depression was stable from 2015 to 2016, but diabetes prevalence rose from 8.4% to 9.4%, continuing an upward trend from 6.2% in 2014 (See **Exhibit 4**)

- 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

MARYLAND HEALTHBENEFIT EXCHANGE

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.

maryland health connection

State Benchmark Plan Walkthrough/ Establish Focus Areas

A service of Maryland Health Benefit Exchange

State Benchmark Plan Walkthrough

MARYLAND HEALTHBENEFIT EXCHANGE

Summary
yland Benchmark I

Establish Focus Areas

MARYLAND HEALTHBENEFIT EXCHANGE

Select EHBs to focus on

- Which EHBs should the work group focus on?
- What are important factors to consider when selecting the EHBs to devote resources to?
- Addressing public health need? Premium drivers? Increasing market efficiency?

Develop framework for EHB analysis

- How should the selected EHBs be evaluated for “meeting the needs of the individual market?”
- Benefits compared with best treatment practices? Current treatment practices? Encourage inefficient utilization? Access to treatment methods?
- Improve health outcomes? Create incentives for positive health outcomes?