State Benchmark Plan Work Group

Meeting 3

March 15, 2019

A service of Maryland Health Benefit Exchange

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

- Welcome
- Discussion of Essential Health Benefits Proposals/Overview of Member Input
- Review of Other State Essential Health Benefits vs Maryland
- Trade-off Considerations and Impacts
- Public Comment
- Adjournment

Overview of Member Input

Which Essential Health Benefits (EHBs) should the work group focus on?

- During the February 22nd meeting, work group members discussed three specific EHBs, including:
  - Diabetes
  - Hypertension
  - Substance abuse and mental health

- Submitted comments cautioned against focusing on one specific population health measure until more information is gathered in terms of what benefits are important to certain types of consumers and the various trade offs
  - More in-depth analysis on how changes could benefit or harm at-risk populations with various health conditions was also proposed

Overview of Member Input

Which Essential Health Benefits (EHBs) should the work group focus on? (continued)

- Other submitted comments suggested that benefits should fill needs for target populations (i.e. Illinois substance use treatment)
  - Certain benefits considered EHBs in other states should also be considered, since specific benefits from other State's Benchmark Plans can be utilized

- Commenters also suggested deferring to physicians to identify any specific gaps in covered benefits
  - Out of the 67 benefit categories, states have chosen to select anywhere from 47 (Utah) to 56 (Maryland and 4 other states), and the focus should be the uncovered benefits

Overview of Member Input

What are important factors to consider when selecting the EHBs to devote resources to?

- During the in person meeting, members noted that better identifying rising costs vs. member utilization increases would be important when considering specific population health measures

- Submitted comments noted that affordability within the context of the State Benchmark plan would be important to consider, specifically:
  - Out-of-pocket costs
  - Premiums
  - Access to coverage

- Additional comments included, balancing the desire to provide the most comprehensive benefits with the desire to provide affordable premiums

Overview of Member Input

How to address the public health need? Premium drivers? Increasing market efficiency?

- Members expressed staying mindful of the opportunities presented by the Total Cost of Care Model and the Primary Care Program that has been newly implemented in the State
- A better focus on health equity and addressing social determinants of health was also addressed in a submitted comment
- Some questions were raised on cost of benefits in relation to premiums, as well as how the current EHB configuration may be boxing in carriers from increasing access and creating barriers to price and quality
- Commenters cautioned that only ~7.5% of the state population is covered under Individual or Small Group policies that must cover EHB
  - Fundamental goal of EHB is to ensure that Ind/small group benefits are approximately equal in generosity to the average employer/state government/federal government plan
  - Decisions to add/remove services from the EHB definition should be driven by balancing the desire to minimize Ind/Small group premiums without sacrificing the comprehensiveness of coverage.

Overview of Member Input

How should the selected EHBs be evaluated for "meeting the needs of the individual market?

- Discussion during in person meeting included comparing disease burden in the state to utilization of services
- Submitted comments suggested including gold standard medical guidelines for specific conditions, and determining whether the SBP covers the recommended treatments
- Concerns were also raised about the cost benefit analysis

Overview of Member Input

How do we encourage efficient utilization? And how do we improve access to treatment methods?

- A submitted comment included a number of questions to consider in relation to members:
  - What is the perspective of consumers currently enrolled in the individual market on the “value” of health insurance and the specific benefits afforded to them?
    - What benefits/services do they prioritize?
    - And does it differ for difference ages and populations?

- Another comment noted that the goal should be to simultaneously improve health outcomes and lower total health care spending
  - And any service that does both should be considered an EHB

Overview of Member Input

Additional Comments

- Members expressed a desire to see more data, specifically on:
  - Health disparities across the state
  - Premium drivers
  - Case management data and multi-morbidity
  - Consumer understanding of EHBs

- Submitted questions included:
  - What impacts do the carriers current benefit plans have on health outcomes and population health more broadly?
  - What specific services are providing the most and/or least efficient and efficacious in advancing the optimal health outcomes?
  - What is (are) the impact(s) of the benefits, both specifically, and globally on premiums and out-of-pocket costs?

- A submitted comment noted that considerations of product cost-sharing design, medical or pharmacy policy, and incentives are outside the scope of EHBs, and should not be the focus of the work group

Maryland Insurance Administration Guidance

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Insurance Article § 31.116 (c)(1), Annotated Code of Maryland

- "The State benchmark plan, for 2017 ***and until the Secretary requires that a new benchmark plan be selected***, shall be selected by the Commissioner, in consultation with the Exchange"
    - Maryland would need to modify the statutory authority to select a new benchmark plan, since it is not allowed under current statue, and the federal guidance is not requiring the state to select a new plan
    - Legislation would need to be passed to implement any changes

Essential Health Benefits

MD vs Other States

EHB Categories

1. Ambulatory 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

Benchmark Benefit Categories

- When selecting a benchmark plan, there are 67 standardized categories of benefits which must be identified as either EHB or non-EHB.
- 37 categories are considered EHB by all 51 jurisdictions
- 7 categories are considered non-EHB in all 51 jurisdictions
- 23 categories are sometimes considered EHB, sometimes considered non-EHB

37 Categories all states consider EHB

- 4 Office Visit categories (PCP, Specialist, Other Practitioners (e.g. RN, PA), and preventive care)
- 7 Hospital categories (OP Facility/physician, IP facility/physician, hospice, ER, ambulance)
- 2 maternity categories (pre/post-natal and delivery)
- 4 MHSA categories (MH IP/OP and SA IP/OP)
- 3 Drug categories (Generic, preferred, and brand)
- 9 Rehabilitative categories (PT/ST/OT , habilitative, DME, transplants, chemotherapy, radiation, reconstructive surgery)
- 2 Laboratory categories (Lab & X-rays)
- 6 Pediatric categories (Well baby visits, Eye exams, eye glasses, dental exams, basic and major dental care)

11 Categories considered EHB by majority of states(including MD)

- Home Health Care (50 out of 51 jurisdictions)
- Non-Preferred Brand Drugs (50/51)
- Imaging (CT/PETs/MRIs) (50/51)
- Dialysis (50/51)
- Prosthetic Devices (50/51)
- Urgent Care Facilities (49/51)
- Skilled Nursing Facilities (48/51)
- Pediatric Orthodontia (48/51)
- Allergy Testing (47/51)
- Diabetes Education (47/51)
- Infusion Therapy (46/51)
- Chiropractic Care (45/51)
- Accidental Dental (44/51)
- Nutritional Counseling (40/51)
- Treatment for TMJ (36/51)

8 Categories considered EHB by a minority of states

- Bariatric Surgery (22/51, including MD)
- Hearing Aids (22/51, including MD)
- Private-Duty Nursing (21/51, not in MD)
- Infertility Treatment (18/51, including MD)
- Routine Foot Care (10/51, not in MD)
- Acupuncture (6/51, including MD)
- Cosmetic Surgery (4/51, not in MD)
- Weight Loss Programs (3/51, not in MD)

7 Categories all states consider non-EHB

- Long Term/Custodial Nursing Home Care
- Adult Vision
- 4 categories of Adult Dental (Routine, Basic, Major, Orthodonia)
- Abortion for which public funding is prohibited

State Comparison Excel File

Microsoft Excel
Worksheet

Federal Flexibility

- New federal flexibility allows 3 things:

1) Use an entire benchmark plan from another state
2) Pick and choose the specific benchmark categories from another state to replace the your state's benchmark categories
3) "Otherwise select benefits to become part of the benchmark"

Only one state (Illinois) has taken advantage of flexibility, under option 3. They did so by adding five additional (much more detailed) categories to the standard 67 categories on the CMS template. Even though their new benefits could have fit under existing categories (generic/brand drug and substance abuse ip/op).

Workgroup Focus

- If there are specific known clinical gaps to be filled like in Illinois, then taking approach 3 to add on those specific benefits might make sense.
- But in absence of known gaps of coverage to correct, recommend that the workgroup focuses on considering the 8 categories which only a minority of states cover and whether MD should consider selecting another state's benchmark (under the second approach) for one of these categories
- Should MD add Private-Duty Nursing, Routine Foot Care, Cosmetic Surgery or Weight Loss Programs to the EHB package?
- Should MD consider removing coverage and/or adding treatment limitations to Bariatric Surgery, Hearing Aids, Infertility Treatment, or Acupuncture from the EHB package?

Acupuncture

- Not a MD mandate, and not in the 3rd most popular small group plan as of 2017 (UHC).
- MD is only state covering acupuncture with no treatment limitations.
- Alaska, Montana, and Washington cover 12 visits per year
- New Mexico covers 20 combined acupuncture/chiropractic visits per year
- California restricts coverage to nausea or chronic pain management
- CA mandate study had a cost estimate of $0.07 to $0.30 PMPM. However, the study states that the CA utilization of acupuncture is 2.4% vs national average of 1.1%, and that uninsured and insured use acupuncture at the same rate, implying that the high utilization in CA is due to cultural acceptance and not induced utilization.
- If MD utilization is at national average, would be in the $0.03 to $0.14 range.
- May make sense to impose reasonable visit limits to discourage abuse and over-utilization, but the premium impact would be negligible.

Infertility/Hearing Aids/Bariatric Surgery

- Infertility Treatment, Hearing Aid coverage, and Bariatric surgery are all MD mandates.
- MHCC estimated the cost of these mandates at 1.3% to 1.5% for infertility and 0.3% to 0.4% for bariatric surgery as of 2012 (pre-ACA)
- The MHCC estimate for hearing aids at the time was 0.0% to 0.1%. However, pre-ACA was limited to <18 and ACA has expanded coverage to all ages. Incidence for hearing aids in the 60-64 age bracket significantly higher. Believe total costs would be in the 0.5% to 1.0% range now.
- Combined, these represent a potential 2 to 3% premium savings for direct costs.
- Bariatric surgery is a treatment for a non-chronic medical condition (morbid obesity). A successful treatment has the potential to reduce expected medical costs for a variety of co-morbid conditions (diabetes, hypertension, high cholesterol, etc). The savings from avoided complications should be netted against the direct costs of surgery, and the net cost is likely to be close to $0 and/or a net savings.
- In Vitro is a treatment for a chronic medical condition (infertility). Successful treatment leads to additional costs (the maternity coverage and the newborn). Duration of treatment is generally limited to 5 to 10 years at maximum.
- Hearing Aids are a treatment for a chronic medical condition. Successful treatment neither generates savings or additional costs, it just improves quality of life. Duration can be lifelong.
- Should In Vitro and Hearing Aids be reconsidered as MD mandates? Including these coverages raise premiums, causing insurance to be more unaffordable (pushing the most marginal members to be uninsured and pushing all members to take on higher cost-shares to maintain affordable premiums). How many members are benefitting from these services? Is their quality of life improvement worth the adverse health outcomes that comes with other members receiving less medically necessary care (either because of cost-shares serving as barriers or because of being uninsured)?

Private-Duty Nursing

- Some states cover in an inpatient setting only. Some cover in a home setting only.
- In either case, most have either visit or hour limitations
- In the home setting, home health care is already covered in 50 states, and involves nurses giving wound care/injections/illness monitoring. Home based private-duty nursing involves assisting with personal care (bathing/dressing/cooking, etc).
- In the hospital setting, private-duty nurses seem to be used when a patient needs more intense nursing services than the general nursing staff can accommodate.
- Is the lack of private-duty nursing coverage a gap that needs to be filled? How many Marylanders are currently paying for private-duty nursing out-of-pocket and what is their average annual spending?

Routine Foot Care

- Routine Foot Care, in the states that provide it, is provided for diabetics only.
- Major cost associated with diabetic care is lower limb amputation. Routine foot care is intended to prevent this.
- Modest cost to pay podiatrist for routine care could potentially yield high savings, due to high cost of amputations.
  - "A study by APMA found that among patients with commercial insurance, each $1 invested in care by a podiatrist results in $27 to $51 of savings for the health-care system. Among Medicare-eligible patients, each $1 invested in care by a podiatrist results in $9 to $13 of savings."

Cosmetic Surgery

- Federal template with 67 categories does not define each category. There are separate “Reconstructive surgery” and “Cosmetic Surgery” categories.
- Most states seems to interpret “Reconstructive surgery” as “a surgery to correct the cosmetic appearances of someone suffering from a congenital birth defect or accidental injury or damage resulting from a disease”. And “cosmetic surgery” is any cosmetic surgery that doesn’t meet one of the medically-necessary criteria to be considered reconstructive.
- Illinois, Montana, and Oregon all said “Yes” to Cosmetic Surgery being covered but then note in the exclusion that it’s only covered in medically necessary cases. That’s the same as MD and most other states, so they’re really just covering reconstructive surgery.
- Georgia is the only state that says cosmetic surgeries must be covered without any limitations or exclusions.

Weight Loss Programs

- 3 states indicated that they cover “Weight Loss programs” as an EHB.
- However, Georgia limits the coverage to Nutritional Counseling. Which is its own category on the CMS template.
- California and Massachusetts are two states that actually cover weight loss programs. MA pays for “up to 3 months” of a “qualified weight loss program” while CA has no limitations or exclusions.
- Does it make sense that MD requires carriers to cover surgical interventions for morbid obesity but does not cover non-surgical weight loss programs? Could money be saved by covering weight loss programs for obese (BMI >30) but not yet morbidly obese (MI >40) members? Given the number of high-cost diseases which are co-morbid with obesity, it seems worth considering weight loss programs as a preventive measure.

Prescription Drug

- For drug, the benchmark defines how many drug must be covered in each of ~160 drug category/class combinations.
- “An (2013) Avalere study of formulary generosity in EHB benchmark plans suggests patient access to prescription drugs will vary based on their state of residence; benchmark plan formularies cover anywhere from under 600 drugs in some states to 1,023 drugs in others. “
- Number of covered drugs ranges from 0 to 83 per category/class for MD benchmark plan as of 2017. Total number of covered drugs across all categories is approximately 1,069, putting MD at the most generous end of the formulary range.
- Worth studying whether the formulary could be reduced. Would require collaboration between doctors/pharmacists (to identify classes that could reduce number of drugs covered without sacrificing patient health) and actuarial consultants (to identify which classes are both a) a significant portion of total rx claims and b) have a meaningful variation in drug costs within the class)

Recommendations

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Discussion on structure of recommendations

- Benefits to consider for clinical gaps?
- Important considerations for inclusion/modfication of benefits?
- Process recommendations for State Benchmark Plan re-evaluation?
- Should the State seek to leverage this flexibility?

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Public Comment