Maryland Health Benefit Exchange
State Benchmark Plan Work Group
Friday, March 15, 2019
10AM-12PM

Maryland Health Benefit Exchange Offices
750 East Pratt Street
Baltimore MD 21202
6th Floor, MHBE Training Room

Members Present
Leni Preston
Brad Boban
Stephanie Klapper
Laura Pimentel
Laura Samuel

Those Calling In
David Cooney

Others Present
John Pierre Cardenas
Michele Eberle
Jessica Grau
Robert Metz
Tiffinnie Severin
Laura Spicer

Welcome & Introductions
John Pierre-Cardenas (JP) welcomed the members to the second meeting of the State Benchmark Plan work group, and provided a summary of the group's last meeting.

Discussion of Essential Health Benefit Proposals/Overview of Member Input
JP provided an overview of the member input from the prompts received on February 222nd (Summary of comments provided below)

Comment
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
• Other submitted comments suggested specific benefits needed to 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 SBP can be utilized
• Commenters 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
What are important factors to consider when selecting the EHBs to devote resources to?
• During 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
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.
How the selected EHBs should 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
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
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

Discussion of Current State Statute

JP noted that current Maryland state statute dictates that the State Benchmark Plan may only be modified if the Secretary of Health and Human Services must require a new benchmark plan to be

selected. Legislation would need to be passed by the Maryland General Assembly to alter to the statute to allow state agencies to alter the benchmark plan.

Review of Other State Essential Health Benefits vs. Maryland

Brad Boban from the Maryland Insurance Administration provided an overview of the essential health benefits (EHBs) offered in other states, as well as the EHBs that Maryland currently covers under its SBP.

He noted that there are currently 37 categories that all states consider EHBs, 11 categories of benefits considered EHBs by a majority of the states, including Maryland, 8 categories considered EHBs by a minority of states, and 7 categories all state consider non-EHBs.

Brad noted that the work group could focus its work in a number of different ways utilizing this information, including filling known clinical gaps such as Illinois did. Or in lieu of those known gaps, to focus on the 8 categories in which only a minority of states cover.

He then provided an overview of the trade-offs of covering any/all of the 8 categories, including acupuncture, infertility treatment, hearing aids, bariatric surgery, private duty nursing, routine foot care, cosmetic surgery, and weight loss programs. Brad also noted that the benchmark plan defines how many drugs must be covered in each of the ~160 category/class combinations, with Maryland covering 1,069 drugs, placing it on the higher end of number of formularies covered by the state. Brad suggested that the state could take a closer look at these formularies to see if the numbers could be reduced.

Tradeoff Considerations and Impact

JP asked that the group consider the prompts for next session:

1. Goals of the State Benchmark Plan
    a. Balance cost/benefit
        i. Health outcomes vs. immediate need
        ii. Not just premiums drivers but also QALYs, etc.
    b. Premium affordability
        i. Should we add a limitation to how much we want to increase premiums (1%-3%? Etc.)
    c. Public health, more broadly
        i. Long term impacts of preventative care
    d. Reduce health disparities
    e. Premium savings by editing benefits
2. Process
    a. Claims based studies to determine spend
    b. Claims that did not happen (Include small groups)
        i. To determine which services are highly utilized, and providing the most value
    c. Population health metrics for longitudinal
    d. Physician input (scope of practice)
    e. Mandate study (premiums QALYs)
    f. Include benefit reduction as a part of that
3. Statute modifications
    a. Timeline
    b. Limitations

    c. Priorities
4. Given the information
    a. Benefits to consider
    b. Items to be put in the study
5. Diabetes as a focal point

Other considerations:

- Briefing for Health Insurance Coverage Protection Commission

Adjournment

The chair of the work group adjourned the meeting at 12:15PM. The next meeting will take place on March 22, 2019 at 100 Community Place, Crownsville MD 21202 First Floor Conference Room, Side A.