Maryland Health Benefit Exchange
State Benchmark Plan Work Group
Friday, March 22, 2019
10AM-12PM

100 Community Place
Crownsville, MD 21032
First Floor Conference Room

Members Present
Leni Preston (Consumer Health First)
Stephanie Klapper (Maryland Citizens Health Initiative)
Laura Samuel (Johns Hopkins School of Nursing)
Jennifer Storm (Care First)
Renee Vis (Kaiser Permanente)

Those Calling In
Brad Boban (Maryland Insurance Administration)
Kim Cammarata (Health Education and Advocacy Unit – Maryland Attorney General's Office)
Laura Pimentel (University of Maryland School of Medicine)

Others Present
John Pierre Cardenas (MHBE)
Jessica Grau (MHBE)
Laura Spicer (Hilltop Institute)

Welcome & Introductions
John Pierre-Cardenas (JP) welcomed the members to the third meeting of the State Benchmark Plan work group, and provided a summary of the group's last meeting. The minutes from the last meeting were approved with no edits.

Discussion of Essential Health Benefit Proposals/Overview of Member Input
JP provided an overview of the member input from the prompts received on March 18th (Summary of comments provided below)

Topic of Discussion	Member Comments
Goals	
Goals of the work group	• The EHB benchmark should first and foremost meet Marylanders health needs and priorities. The workgroup should also consider updating the EHB benchmark plan to keep current with medical advances and address gaps in access • Perform an analysis of both long and short term impacts on health outcomes, but keep costs and affordability of plans in mind. • The Triple Aim Framework is relevant to this discussion: 1) improve patient satisfaction & quality of care 2) improve population health 3) reduce health care costs. • Social determinants of health are relevant to several of these goals (i.e. public health prevention, reducing health disparities, QALY). Aligned with the Triple Aim Framework, I'm curious about how social determinants of health can be addressed in a cost-effective manner. It seems worthwhile to consider better integration of social services and medical services (consistent with medical home model). For example, since SNAP reduces food insecurity (which is linked with obesity and many chronic diseases), can benefits be used to support a navigator or case manager help families enroll in SNAP? Same story for housing support, etc.
Balancing cost/benefit	• Any cost benefit analysis should address in this order: (1) consumers' immediate needs with positive health outcomes; (2) preventive care and benefits such as wellness programs; and (3) longer-term and/or population health specific benefits. • Quality is an individual issue that can vary enormously. Therefore, while it is a useful economic tool, it may be worth further consideration. • Many consumers enrolled in the individual market receive subsidies, and therefore reducing EHBs would reduce their benefits, and increase their out of pocket costs • Any benefit removed would remove out-of-pocket maximum protections for those benefits • In evaluating metrics like QALYs for benefits which have a non-trivial premium impact, should consider two separate populations. A) The improvement in QALY for the intervention population that will benefit from the new covered service. B) The decreased QALY for the marginal population that gets priced out of the marketplace and becomes uninsured because of the premium increase. • It is important to balance the benefit and cost of potential changes to the Essential Health Benefits. This should include not only premiums, but also positive impacts to population health that reduce cost. However, it is also important to recognize that new benefits may still impact affordability in the near-term as cost savings from improved population health do not appear immediately. We suggest that the workgroup recommend any additional benefits be paired with a corresponding reduction in benefits, such that there is zero net premium impact. This would allow the state to advocate for changes to

	the Essential Health Benefits that will reduce costs in the long-term, while not impacting affordability in the near-term.
Premium affordability	• A cap on increasing premiums would be useful as a decision-making marker. However, that cap should be determined based upon an analysis of what consumers say they can afford and/or the financial subsidies that would allow them to obtain/use reasonable coverage. • Affordability may be better addressed through other mechanisms such as reinsurance program, the legislatively proposed MD Easy Enrollment Health Program, and the legislatively proposed Prescription Drug Affordability Board • Is there a way to link with inflation or some other measure of economic growth that may be more specific to this segment of the population, such as unemployment rate? • The "guard-rails" put in place limit the premium increase to a "de Minimis". Any chosen EHB package can be no more generous than the 15 comparison plans. The current benchmark plan includes all MD mandates + pediatric dental and pediatric vision. It's unlikely that any of the other 14 comparison plans are even more generous. • If we are already at the most generous of the comparison plans, then we will have to show that there's a de minimis premium impact. An impact of under 0.1% is definitely de minimus. Maybe we could argue something under 0.5% is de minimius. But I think something that's closer to 1.0% than 0.5% is definitely not going to be considered de minimus by CMS. • However, based on my reading of the "Acceptable Methodology" we would be able to show that the net costs, accounting for savings from other EHB categories, are di minimus. Illinois did not take advantage of this explicitly. They evaluated the gross cost of the services and concluded it was only 0.07% and noted that there were likely savings that they could net against these costs.
Public health	• There is value to identifying population health measures and applying that lens when analyzing the SBP - taking into account the population(s) covered by QHPs. For example, the addition of routine foot care is one benefit that would align with the diabetes measure while producing better health outcomes for individuals.
Reduce health disparities	• Collection of relevant data, including race and ethnicity, should be a priority. This data can then be used to evaluate the impact of proposed changes and/or additions to the SBP. We would also note the disparities in access to behavioral health services. Therefore, we would underscore the need to ensure that any SBP be in full compliance with the Federal Mental Health Parity and Addiction Equity Act. • Conduct an analysis on whether the current benchmark has disparate impact and/or adequately addresses conditions known to be associated with racial/ethnic disparities and disparities for people with disabilities • A large number of health disparities are highly correlated with income. The combined Ind/Small group market skews significantly lower FPL than the large group market because of the APTC subsidies. So, any new EHBs which targets a disease that correlates with FPL (like diabetes), should help to reduce disparities.

Premium savings by editing current costly benefits	• Obviously, this should be part of analysis but any editing should incorporate evidence-based practices. • Most comparison plans do not cover pediatric vision/pediatric dental. These two services should give at least 1 to 2% of room for removing benefits. There might possibly be more room, depending on how lean the most popular large group plans are with respect to any non-mandated benefits.
Process	
What should the process be in terms of editing the SBP	• Analysis of benefits mandated in other states, but not in Maryland with consideration given to: (1) premium increase, if any; (2) short- and long-term health outcomes; and (3) impacts in different populations and regions. Our view is that a mandate, such as that for routine foot care appears to be advantageous given its value in promoting better health outcomes, while potentially lowering long-term decrease in health spending. It may also be useful to examine the wellness program benefits in other states to see how they align with related programs currently covered by Maryland carriers. Are these equal to and/or do they exceed those in other states and do those yield better outcomes? • Market feedback to assess whether the bench mark plan is meeting the needs of the consumer. The assessment should also consider if the benchmark plan is already generous enough and if it truly needs to change. In addition, if available, the results of the MIA research regarding how the consumers define value should be incorporated in these findings. Reducing benefits (including removing mandated benefits) should be reviewed closely from a public policy, clinical and public relations perspective. Kaiser would also support physician input to outline any notable gaps in coverage. • We agree with the workgroup's approach to recommend the state study particular benefits, rather than recommending particular benefits without appropriate supporting data. These should be structured this as actuarial studies that examine both costs and savings of benefit additions or reductions.
Physician input	• Analysis of current benefits may include analyses of claims data as well as information solicited from physicians. The focus should be on understanding which benefits should be expanded, or limited, based upon their evidence-based outcomes and the premium impact would be. A determination as to whether any rise in premiums would be deemed affordable by consumers should come, in part, from a consumer focus group/survey process. In regards to preparing such an analysis, we would cite the Report provided in August 2012 to the EHB Advisory Committee as a useful model.
Mandate study	• Consumer focus groups and surveys with diverse participants which would then provide a basis for MHBE decision-making. Included in this, or through other information-gathering, it will be important to identify what benefits are important to consumers but which they may not be accessing due to out of pocket costs. Just this week The Hill reported on a CDC study1 which showed that in 2017, 11.4% of adults did not take prescribed medications due to cost. A similar impact has been shown for other health care services. • These should be structured this as actuarial studies that examine both costs and savings of benefit additions or reductions.

Statute modification	• A statutory modification is required in 2020 to ensure that Maryland does not have to wait for federal action to address future changes to the benchmark plan. It is the Insurance Commissioner, in coordination with the Exchange, who should have such authority. There should also be consideration given to amending the reference to 2014 in (c)(1)(I), but no change we feel is necessary regarding (II) and the requirement for an open and transparent process. • As regards the question of whether a limit on premium increases or further listing of benefits is required, it may be more appropriate to leave that with a regulatory process. • MHBE should consider the effects of possible future federal action and/or new state legislation to address affordability in the marketplace and address high costs in the healthcare system • There should be limitations on how often the state can examine such a change. For example, only allowing a review of Essential Health Benefits every 3 years would provide the state appropriate flexibility while minimizing consumer churn and confusion from annual changes. • We are supportive of a statutory change to enable Maryland to take advantage of the Federal flexibility to change the Essential Health Benefits. However, there should be limitations on how often the state can examine such a change. For example, only allowing a review of Essential Health Benefits every 3 years would provide the state appropriate flexibility while minimizing consumer churn and confusion from annual changes.
Items to be included in proposed studies	
Items for studies	• Claims data could be used to identify the most common chronic conditions in the individual market and assess if these are the same on and off exchange by race, ethnicity and other factors as relevant. A by-product of this would be to ascertain if it is time for VBID benefit designs that provide first dollar coverage for services needed to manage these chronic conditions • Potential source of data for is Medical Expenditure Panel Survey (MEPS) https://meps.ahrq.gov/mepsweb/. There's a wealth of data, and healthcare spending is broken down by payer type and includes out-of-pocket costs. Those out-of-pocket costs include both cost-shares for services covered by insurance and direct spending for services that aren't covered. Diseases that have higher than average out of pocket spending might indicate that there's services not being covered by insurance and that could potentially be added. • Prescription drug formulary be included in the study. Prescription drugs are the most significant cost driver – they account for approximately one in every three dollars that carriers spends on claims – and are an area where the science is quickly changing
Benefits to consider	• The IL model for opioid use should be considered for replication here. • Strategies for prevention and management of diabetes are relevant. For example, could nutrition benefits currently already covered for patients with diabetes be extended to patients with hyperglycemia (to better prevent diabetes)? • Routine foot care for patients with diabetes should be considered for several reasons (better align with clinical guidelines for diabetes care, potential health impact, relatively small total cost for care).

	• My 2 cents on the infertility/bariatric surgery/hearing aid discussion:
	  • Agree that restricting infertility is politically problematic. However, is there a way to limit coverage in a clinically meaningful way to contain costs?
	  • There is new research that hearing aids may prevent dementia and improve functional health outcomes, suggesting that there is a public health benefit related to coverage. Also, since a very small segment of the individual/group plan market needs hearing aids, I suspect that they are not premium drivers.
	  • Despite clear clinical benefits from bariatric surgery, it is a very costly procedure. It may be worthwhile to consider imposing restrictions along with parallel improvements in chronic disease prevention and non-surgical weight loss coverage.
	• Prescription drug list should be updated and edited with input from clinicians, pharmacists, etc. Since 2017 new drugs have come to market, other drugs have become generic, new drug warnings have been issued, and new clinical guidelines have been published.

Diabetes as a focal point	• If based on research and analysis, MHBE decides to make diabetes as a focal point, then we suggest considering the gold standard of care and recommend evidence-based treatment to determine whether there are gaps in the current EHB benchmarks and solutions to fill those gaps. • Diabetes is one of the top 10 diseases in MD that are most impactful to population health and there's a known coverage gap that other states are covering, so it makes sense as an initial focus. Other expensive diseases (Hypertension, COPD, high cholesterol, coronary artery disease, depression, substance abuse, alcohol abuse, psychotic disorders) should be surveyed to determine if there are any coverage gaps. • Can we leverage the MD total cost of care model and/or the MD primary care program to offer cost-efficient care management for diabetes and other chronic conditions? If so, how? • While we agree that it is important to consider specific chronic disease states, such as diabetes, we would recommend that the disease specific disease states with the greatest potential to generate savings be included as an item for study – rather than the workgroup recommending specific disease states without supporting data.
Additional Information	
Briefing for Health Insurance Coverage Protection Commission	• Given the synergy between the Affordability and SBP workgroups, we believe that such a briefing would be important. And, the information should also be shared with the Commission's workgroups who are charged with the study of additional subsidies, public option, basic health plan, and consumer protections. • We recommend that MHBE provide a briefing on Maryland's new flexibility to change the EHB benchmark to HICPC and gather input on the process to revise the benchmark
Additional Comments	Use the MHBE's consumer-related (vs. operational) statutory principles for the purpose of defining goals for, and ultimately any proposed changes to, the SBP. Three principles apply:

	• "make health care coverage more accessible to more Marylanders; • Promote affordable coverage; • Address longstanding disparities in health care access and outcomes.“ In addition, the principle to "facilitate flexibility for the Exchange to respond to changes in the insurance market, health care delivery system, and economic conditions while also maintaining sensitivity and responsiveness to consumer needs," should be considered.

Discussion/Draft Recommendations

Members then began drafting the work group's recommendations for modifications to the State Benchmark Plan (SBP). The group crafted a standard for the SBP to meet, and began outlining how the standard should be considered.

- The Workgroup recommends that an ideal state benchmark should meet the following criteria:
    - Jenn and Leni - as close as you can get to zero net premium increase
    - Leni – need for research on what consumers value
    - Laura Samuels – is it just premiums that consumers look at? Or the total cost? Leni – gut is that they focus on the price they pay each month w/o understanding the full impact of cost sharing. JP – 10-15% with chronic conditions who were previously on MHIP really look for health plans to meet their chronic diseases. Others are more price sensitive consumers.
    - Result in long-term cost savings to the health system
    - Brad – premium should not be primary focus – focus needs to be marginal costs of adding the benefit v. the marginal benefit added to members
    - Laura Samuels – old model of expecting a premium burst with adding preventive benefits may not be as relevant now
    - Jenn – should at least do the research on the offset
    - Laura P – has to be consideration of cost constraints
    - Brad – can compare options we have with cost and quality data – could swap something with high value with something that is low value – this would require a lot of data and analysis
- Ideal benchmark plan is comprehensive, high quality, and tailored to be responsive to the individual needs and unique morbidity profile of Marylanders in the individual and small group markets.
- To meet this standard, the following must be considered:
    - Improved health outcomes and near-term affordability with consideration of long-term cost savings to the health system:
        - Included benefits should result in maximal improvement in health outcomes, including quality-adjusted life years and other health outcomes metrics.
        - The evaluation of benefits for inclusion or restriction should examine both utility (i.e., “a” above) and costs. The below framework prioritizes expansion of benefits that have anticipated high utility and low costs, while prioritizing a reduction in benefits with anticipated low utility and high cost.
        - To the extent reasonable, benefit modifications along the established “b” should result in zero net premium increases. “Premium impact” in this

framework should also include exogenous factors, such as reinsurance, that do not consider benefits.

- Brad – feds give us a limit on generosity
- McKinsey report framework – utility and cost decision criteria – added consumer ability to bear the cost
- Leni – question about overlay with affordability workgroup – JP response – yes, goal will be to create a comprehensive framework
- Brad – for this workgroup, consumer costs – if we take away coverage of something, how onerous is it for the consumer to pay for it themselves, e.g., acupuncture v. infertility?
- Laura Samuels – should consider how these benefits are differentially needed by the population
- Stephanie and Renee – Need to consider the small business perspective
- Impact from cost, utility, and discretionary perspective, on consumers from populations with/without health disparities across income and geographic areas

Adjournment

The chair of the work group adjourned the meeting at 12PM. The next meeting will take place on April 5, 2019 at 100 Community Place, Crownsville MD 21202 First Floor Conference Room, Side A and will include two guest speakers.