Preferred Provider Organization Plans Participating in Maryland Health Connection

Introduction

The Maryland Health Benefit Exchange (MHBE) is considering implementing a qualified health plan (QHP) certification standard that would bar preferred provider organization (PPO) plans from participating in Maryland Health Connection (MHC) without an exclusive provider organization (EPO) product offered as an alternative. A PPO is a type of health insurance plan that typically covers services from both in-network and out-of-network providers, allows for primary care and specialist visits without a referral, does not require the selection of a primary care provider to coordinate care, and is more expensive than other plan types.[1] An EPO plan typically only covers services by in-network providers and does not typically require referrals for specialists.[2] Currently, only health maintenance organization (HMO)[3] and PPO products are offered on MHC; there are no EPOs. HMOs typically only cover services from in-network or contracted providers, usually require members to have a primary care doctor, typically require referrals for specialists, and are less expensive than other plan types. The purpose of this document is to provide policy, financial, and other considerations if this change were to be implemented.

Background and National Trends

While the Affordable Care Act (ACA) and accompanying regulations set out minimum standards for QHP certification, state-based marketplaces have the flexibility to create additional requirements, including requirements about the types of products offered. In reviewing the literature about plan offerings in other states, there is evidence to suggest a decrease in PPO plans and an increase in the prevalence of plans that include narrow networks, such as HMOs and EPOs. The decrease in prevalence of PPO plans on exchanges is cited as being driven by consumer behavior, carriers exiting the market, or carriers discontinuing PPO plans.[4] Examples from three studies are presented below:

- A study of the federally-facilitated marketplaces (FFMs) from 2015 to 2018 compared plans with restrictive networks (HMO and EPO) with plans that are less restrictive (PPO and point of service [POS]).[5] The analysis found that the proportion of FFM plans with more restrictive networks increased gradually from 54 percent in 2015 to 73 percent in

[1] Maryland Health Connection Glossary. Retrieved from https://www.marylandhealthconnection.gov/glossary/preferred-provider-organization-ppo/
[2] Maryland Health Connection Glossary. Retrieved from https://www.marylandhealthconnection.gov/glossary/exclusive-provider-organization-epo/
[3] Maryland Health Connection Glossary. Retrieved from https://www.marylandhealthconnection.gov/glossary/health-maintenance-organization/
[4] Katherine Hempstead, PhD. (2015, November 3). Burnt Offerings? PPOs DECLINE in Marketplace Plans. Retrieved from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf424457
[5] Caroline Pearson and Elizabeth Carpenter. (2017, November 30). Plans with More Restrictive Networks Comprise 73% of Exchange Market. Retrieved from http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market

2018. The findings suggested that this increase was driven by insurers aiming to offer competitive premiums, while managing medical costs.

- A study of exchange plans in all 50 states and D.C. analyzed trends in plan type and compared restricted network plans (HMO and EPO) with less restrictive plans (PPO and POS) from 2014 to 2017.[6] The analysis found that the percentage of restrictive plans increased from 42 percent in 2014 to 63 percent in 2017.
- Another study of exchange plans in all 50 states and D.C. collected participating provider information and classified silver plans by physician network size.[7] The study found that the percentage of narrow networks decreased from 31 percent in 2014 to 21 percent in 2017 for silver plans. The analysis also compared physician network size by marketplace type and found that narrow networks were more prevalent in state-based marketplaces (42 percent of plans) than FFMs (10 percent of plans) in 2017.

Policy Considerations

Current PPO Participants

There are currently two carriers in Maryland's individual market—Kaiser Permanente and CareFirst. CareFirst is the only statewide carrier and the only carrier offering a PPO product. Maryland law does not allow carriers to offer individual market plans off the exchange unless they also offer individual QHPs on the exchange.[8] Further, a carrier who participates in the individual market must offer at least a single QHP at the bronze, silver, and gold metal levels on the exchange, and if the carrier wants to offer products off-exchange, they must include options at least at the silver and gold levels.[9] To evaluate the potential impact of the proposed policy, the MHBE first examined current QHP enrollment data (as of November 2018).

Table 1 presents enrollment by plan type and shows that 96 percent of participants were enrolled in a non-PPO plan. Thus, the proposed policy change would impact the plan choice for only a small percentage of MHC consumers. Of those who were enrolled in the PPO product, 71.2 received advanced premium tax credits (APTCs). APTCs help lower premiums for people with household incomes between 100 and 400 percent of the federal poverty level (FPL) who buy insurance through an exchange.[10] Consumers can only access APTCs on the exchange. If the policy were implemented, and CareFirst added an EPO product on the exchange, but maintained a PPO product off-exchange, the unsubsidized members currently purchasing a PPO product on the exchange may choose to purchase the PPO off the exchange, or they may choose to purchase the cheaper EPO product on exchange.

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[6] McKinsey Center for U.S. Health System Reform. (2016 November 3). 2017 exchange market: Plan type trends. Retrieved from http://healthcare.mckinsey.com/sites/default/files/2017-OEP-Plan-Type-Trends-Infographic_VF.pdf

[7] Daniel Polsky, Janet Weiner, and Yuehan Zhang. (2016 December). Narrow Networks on the Individual Marketplace in 2017. Retrieved from https://ldi.upenn.edu/sites/default/files/pdf/2017_Narrow_Network_Issue_Brief_Vol-21-8.pdf

[8] Ins. Art. § 31-1303(b)(1), MD Code Ann.

[9] Ins. Art. § 31-115(b)(5)(iii), MD Code Ann.

[10] Kaiser Family Foundation. *Health Insurance Marketplace Calculator FAQ*. Retrieved from https://www.kff.org/interactive/subsidy-calculator/.

It should also be noted that CareFirst is encouraging PPO participants to closely examine their coverage options during this current open enrollment period, as its HMO product is cheaper and has a similarly sized network, so the share of PPO enrollment may decline even further in 2019.[11]

Table 1. MHC PPO Enrollment by Financial Assistance Status, as of November 2018

Plan Type	Number of Participants	Percentage of Participants
PPO	5,136	4.0%
Non-PPO	122,511	96.0%
Total	**127,647**	**100%**
PPO	**Number of Participants**	**Percentage of Participants**
No APTC	1,477	28.8%
APTC	3,659	71.2%
Total	**5,136**	**100%**

The following tables present demographic characteristics of the PPO participants to show whether the proposed policy would have a disparate impact on sub-populations. Table 2 presents information about the 3,659 PPO participants receiving financial assistance. The majority are female and in the older age groups. Racial information was missing for 26 percent; 57 percent were White; and the remaining 17 percent were racial/ethnic minorities. The majority also purchased silver or gold products. Table 3 presents information about 1,477 PPO participants who are not receiving APTC. The majority are female and White. Compared with those receiving APTC, this group has a higher percentage of children and participants purchasing gold plans.

Table 2. Demographic Characteristics of MHC PPO Participants receiving APTC, as of November 2018

Demographic	Number of Participants	Percentage of Participants
Sex		
Male	1,586	43.3%
Female	2,073	56.7%
Total	**3,659**	**100%**
Age Group (Years)		
0-17	105	2.9%
18-25	296	8.1%
26-34	615	16.8%
35-44	504	13.8%

[11] Eichenser, Morgan. (2018, November). Why CareFirst is Targeting PPO Members to Get Them Even Cheaper ACA Coverage this Year. *Baltimore Business Journal*. Retrieved from https://www.marylandhealthconnection.gov/glossary/exclusive-provider-organization-epo/

Demographic	Number of Participants	Percentage of Participants
45-54	731	20.0%
55-64	1,322	36.1%
65+	86	2.4%
Total	**3,659**	**100%**
Race		
Missing	956	26.1%
White	2084	57.0%
Black or African American	359	9.8%
Asian/Pacific Islander	141	3.9%
Other, American Indian, Alaska Native	119	3.3%
Total	**3,659**	**100%**
Metal Level		
Bronze	472	12.9%
Silver	1,595	43.6%
Gold	1,592	43.5%
Total	**3,659**	**100%**

Table 3. Demographic Characteristics of MHC PPO Participants not receiving APTC, as of November 2018

Demographic	Number of Participants	Percentage of Participants
Sex		
Male	671	45.4%
Female	806	54.6%
Total	**1,477**	**100%**
Age Group (Years)		
0-17	224	15.2%
18-25	86	5.8%
26-34	278	18.8%
35-44	273	18.5%
45-54	242	16.4%
55+	374	25.3%
Total	**1,477**	**100%**
Race		
Missing	473	32.0%
White	735	49.8%
Black or African American	148	10.0%
Asian/Pacific Islander	75	5.1%
Other, American Indian, Alaska Native	46	3.1%
Total	**1,477**	**100%**

Demographic	Number of Participants	Percentage of Participants
Metal Level		
Bronze	317	21.5%
Silver	988	66.9%
Gold	172	11.6%
Total	**1,477**	**100%**

Table 4 presents the geographic distribution of MHC PPO participants receiving financial assistance. Of these participants, 1,900 (51.9 percent) reside in counties in which CareFirst is the only carrier, which are largely rural. Due to small cell sizes, the county distribution of PPO participants who are not receiving APTC cannot be presented. The majority of the unsubsidized PPO participants, however, (87.9 percent) reside in counties that have the choice of both CareFirst and Kaiser Permanente.

Table 4. Geographic Distribution of MHC PPO Participants receiving APTC, as of November 2018

County	Number of Participants	Percentage of Participants	Rating Area	Region	Kaiser Permanente County?
Allegany	158	4.3%	4	Western	N
Anne Arundel	162	4.4%	1	Baltimore	Y
Baltimore City	198	5.4%	1	Baltimore	Y
Baltimore County	210	5.7%	1	Baltimore	Y
Calvert	60	1.6%	2	Southern	Y
Caroline	68	1.9%	2	Eastern	N
Carroll	65	1.8%	4	Baltimore	Y
Cecil	270	7.4%	2	Eastern	N
Charles	45	1.2%	2	Southern	Y
Dorchester	38	1.0%	2	Eastern	N
Frederick	119	3.3%	4	Washington Suburban	Y
Garrett	155	4.2%	4	Western	N
Harford	69	1.9%	1	Baltimore	Y
Howard	125	3.4%	1	Baltimore	Y
Kent	75	2.0%	2	Eastern	N
Missing	178	4.9%	N/A	N/A	N
Montgomery	535	14.6%	3	Washington Suburban	Y
Prince George's	171	4.7%	3	Washington Suburban	Y
Queen Anne's	111	3.0%	2	Eastern	N
Somerset	18	0.5%	2	Eastern	N

County	Number of Participants	Percentage of Participants	Rating Area	Region	Kaiser Permanente County?
St. Mary's	134	3.7%	2	Southern	N
Talbot	112	3.1%	2	Eastern	N
Washington	306	8.4%	4	Western	N
Wicomico	147	4.0%	2	Eastern	N
Worcester	130	3.6%	2	Eastern	N
Total	**3,659**	**100%**			

APTC Impact

In addition to impacting consumers who are currently enrolled in the PPO product, the proposed policy change could also impact the APTC available to consumers in the CareFirst-only counties. The APTC amount is based on the second lowest cost silver plan (also referred to as the standard plan). In the CareFirst-only counties, the PPO, which is a more expensive product, is the standard plan. Currently, 16,529 consumers (12.9 percent of all MHC consumers) are receiving APTC in the CareFirst-only counties, and the proposed policy change would decrease the APTC amounts available to these consumers.

The analysis below presents examples of how the APTC would decrease for three hypothetical consumers residing in Care-First only counties. The analysis assumes a scenario where CareFirst would offer an HMO, EPO, and PPO product, thus making the EPO the standard plan in these areas and the basis for the APTC calculation. However, if the policy is implemented, CareFirst could potentially also respond by eliminating the PPO product, thus making the HMO the standard plan, which would also decrease the APTC available to consumers.

The amount of the APTC is generally equal to the premium for the second lowest cost silver plan in the individual's geographic area, minus a certain percentage of the individual's household income.[12] An eligible individuals' premium contribution is set on a sliding scale; they will not pay more than 2.08 percent to 9.86 percent of their incomes for a silver plan. Those with lower incomes get a larger credit.

In order to conduct the analysis, the MHBE first needed an estimate of the premium price for an EPO product on the individual market. Because there are currently no EPO products offered on MHC, the MHBE assumed that the difference in premium prices between EPO and PPO products offered for state employees[13] is due to network/referral policies. Table 5 presents the monthly premiums for the two carriers offering PPO and EPO products to state employees in 2019. The price difference is 12.4 percent for CareFirst, and 9.9 percent for United. In the

[12] IRS. *Questions and Answers on the Premium Tax Credit*. Retrieved from https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.
[13] Maryland Department of Budget and Management. Retrieved from https://dbm.maryland.gov/benefits/Documents/CY19%20Employee%20and%20Retiree%20Rates%20with%20Subsidy.pdf

analyses below, the MHBE assumes that the EPO product on the individual market would be 10 percent cheaper than the PPO product.

Table 5. Price Difference in 2019 Monthly Premiums between EPO and PPO Products offered to State Employees

Product	Monthly Premium	Difference
CareFirst BCBS - PPO	509.98	12.4%
CareFirst BCBS - EPO	453.84	
UnitedHealthCare - PPO	501.66	9.9%
UnitedHealthCare - EPO	456.56	

Next, the MHBE identified the CareFirst MHC silver plan PPO rates for the different rating regions in the state and for three different ages. Ages 29, 40, and 60 were selected as examples because premium rates may vary based on an individual's age. APTC is a function of household income, household size, required contribution, and the premium for the second lowest-cost silver plan. The federal poverty guidelines for 2018, based on household size and income, determine the household's FPL. The household's FPL and the thresholds provided by the Internal Revenue Service (IRS) then determine the household's required contribution amount toward their premiums.[14] Table 6 below presents the required contribution percentages by FPL.

Table 6. 2019 Required Contribution Percentages

% FPL	Initial Percentage	Final Percentage
Less than 133%	2.08%	2.08%
133% - 150%	3.11%	4.15%
150% - 200%	4.15%	6.54%
200% - 250%	6.54%	8.36%
250% - 300%	8.36%	9.86%
300% - 400%	9.86%	9.86%

The monthly APTC for a household is the monthly premium for the standard plan *minus* the required contribution (which is the required percentage multiplied by the household income). The required contribution is only a function of income and the FPL, so it does not change with age or location; standard plan premiums, however, can change significantly with age and location, meaning that the amount of the APTC can differ significantly among individuals with the same income. Three example scenarios are presented below.

Example 1

- 29 year-old on the Eastern Shore with no dependents, a household size of 1, and an annual income of $18,210 (150 percent of the FPL).
- The required contribution at this income level is 4.15 percent. This translates to a required annual contribution of $18,210 * .0415 = $755.72, or $62.98 per month.

[14] https://www.irs.gov/pub/irs-drop/rp-18-34.pdf

- Without the EPO plan, the standard (PPO) plan premium is $607.15. This implies a monthly APTC of $607.15 - $62.98 = $544.17.
- With the addition of the EPO plan, the new standard plan premium is $546.44. This implies a new monthly APTC of $546.44 - $62.98 = $483.46. This is a reduction in the APTC of $60.71 per month.

Example 2

- 60 year-old in Western Maryland with no dependents, a household size of 1, and an annual income of $30,350 (250 percent of the FPL).
- The required contribution at this income level is 8.36 percent. This translates to a maximum annual contribution of $30,350 * .0836 = $2,537.26, or $211.44 per month.
- Without the EPO plan, the standard (PPO) plan premium is $1,472.56. This implies a monthly APTC of $1,472.56 - $211.44 = $1,261.12.
- With the addition of the EPO plan, the new standard plan premium is $1,325.30. This implies a new monthly APTC of $1,325.30 - $211.44 = $1,113.86. This is a reduction in APTC of $147.26 per month.

Example 3

- 40 year-old on the Eastern Shore, with no dependents, household size of 1, and an annual income of $36,420 in annual income (300 percent of the FPL).
- The required contribution at this income level is 9.86 percent. This translates to a maximum annual contribution of $36,420 * .0986 = $3,591.01, or $299.25 per month.
- Without the EPO plan, the standard (PPO) premium is $693.42. This implies a monthly APTC of $693.42 - $299.25 = $394.17.
- With the addition of the EPO plan, the new standard plan premium is $624.08. This implies a new monthly APTC of $624.08 - $299.25 = $324.83. This is a reduction in APTC of $69.34 per month.

Stakeholder Concerns

Another policy consideration is stakeholder perspectives. During the 1332 waiver and regulations public hearing process, some, but not all, stakeholders expressed concern that the reinsurance program payments could favor issuers with less managed provider networks and utilization controls, such as the PPO product.[15], [16] To address this concern, the MHBE Board

[15] *Maryland 1332 State Innovation Waiver Application to Establish a State Reinsurance Program.* (2018, August 15) .Retrieved from https://www.marylandhbe.com/wp-content/uploads/2018/08/Maryland_1332_State_Innovation_Waiver_to_Establish_a_State_Reinsurance_Program_UPDATED_August_15_2018.pdf

[16] *State Reinsurance Program Regulations: Summary of Public Hearings and Comments*. (2018, September 17). Retrieved from https://www.marylandhbe.com/wp-content/uploads/2018/09/State%20Reinsurance%20Program%20Regulations%20Hearing%20Testimony%20and%20Written%20Comments.pdf

approved a resolution allowing the MHBE to adopt regulations to apply a dampening factor to mitigate potential duplicate payments between the risk adjustment and reinsurance programs.

Summary

In summary, the MHBE is weighing the option of barring PPO products from MHC unless an EPO product is offered as an alternative.

- Nationally, there has been a decrease in the prevalence of PPO products within marketplaces.
- Some stakeholders in Maryland have expressed concern that the PPO is an unmanaged product that will accrue more favorable reinsurance payouts.
- Currently, PPO participants comprise only 4 percent of the MHC market, and just under one-third of those participants do not receive APTCs..
- Of the 3,659 current PPO enrollees receiving subsidies, the majority are female, in older age groups, purchase higher metal level products, and live in rural areas of the state, suggesting that this population may anticipate greater health care use and prefer more comprehensive coverage.
- Adding the EPO product could result in decreased APTC for residents in the 13 counties where CareFirst is the only carrier, and the PPO is currently the second lowest cost silver plan. Currently, about 13 percent of MHC enrollees reside in these counties and receive subsidies based on the PPO premium.