State Benchmark Plan Work Group

Meeting 4

March 22, 2019

A service of Maryland Health Benefit Exchange

State Benchmark Plan

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

- Welcome
- Overview of Member Input
- CMS Input and Recommendations
- Trade-off Considerations and Impacts
- Public Comment
- Adjournment

Overview of Member Input

What are the goals of the State Benchmark Plan?

i. Balancing the costs/benefits
   i. Health outcomes vs. immediate need
   ii. Not just premium drivers but also QALY, ets.

ii. Premium affordability
   i. Should we add a limitation to how much we ant to increase premiums (1%-3%..etc.)

iii. Public health, more broadly
   i. Long term impacts of preventative care

iv. Reduce health disparities

i. Premium savings by editing current costly benefits
   i. Prescription drug formulary

Overview of Member Input

Member Responses: Goals

Members noted that the triple aim framework should be kept in mind: 1) quality of care 2) improving the health of the population and 3) reducing health care costs, while also keeping considering social determinants of health.

Question	Comment
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.

Overview of Member Input

Member Responses: Goals

Members cautioned that reducing EHBs could increase out-of-pocket costs, and any increase in benefits for one population should consider possible increased costs for the marginal population.

Question	Comment
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.

Overview of Member Input

Member Responses: Goals

Question	Comment
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.

Overview of Member Input

Member Responses: Goals

Question	Comment
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.

Overview of Member Input

Member Responses: Goals

Question	Comment
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.

Overview of Member Input

What should the process be in terms of editing the SBP

i. Claims based studies to determine spend

ii. Understanding claims that didn't happen to assess what services are working well (include small group)

iii. Population health metrics for longitudinal studies

iv. Physician input (scope of practice)

v. Mandate study (premiums and QALYs)

Overview of Member Input

Member Responses: Process

Question	Comment
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.

Overview of Member Input

Member Responses: Process

Question	Comment
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.

Overview of Member Input

Statute Modifications

i. Timeline

ii. Limitations

iii. Priorities

Overview of Member Input

Member Responses: Statute

Question	Comment
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.

Overview of Member Input

Given the information, what benefits should be considered?

- Items to be put in the aforementioned studies
- Benefits to consider

Member Responses: Benefits to Consider

Question	Comment
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

Overview of Member Input

Member Responses: Benefits to Consider

Question	Comment
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.

Overview of Member Input

Other considerations

- Diabetes as a focal point
- Briefing for Health Insurance Coverage Protection Commission

Overview of Member Input

Member Responses

Question	Comment
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?
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

Overview of Member Input

Additional comments

Comment
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.

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Centers for Medicare and Medicaid Services (CMS) Input and Recommendations

CMS Insight and Recommendations

General Note

- States have broad latitude in relation to altering their plans
  - As long as states are adhering to methodology requirements, CMS is happy to hear any and all ideas

Discussion of Value Based Plans

- Advice on implementing Value Based Plans
  - Implement a standardized plan design in addition to the value based plans to provide guardrails

1332 Waiver/State Flexibility Option

- Increasing benefits could lead to increased premiums
- MD could then apply for a 1332 waiver to receive pass through funds to offset premium increases
  - May also be applicable to the existing State Reinsurance Program waiver
- Pass through funds could also be augmented and designed around a incentive payment structure for case management

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Discussion

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Public Comment