Maryland Health Benefit Exchange
State Benchmark Plan Work Group
Friday, April 12, 2019
10AM-1PM

MHBE Office's
750 East Pratt Street
Baltimore MD, 21202
6th Floor, Training Room

Staff: John-Pierre Cardenas, Jess Grau, Michele Eberle

Members: Leni Preston, Kim Cammarata, Stephanie Klapper, Jennifer Storm

Additional Support: Laura Spicer, Brad Boban, Laura Samuels

Renee Vis- phone

Welcome

Comments:

Brad

- Maryland consumers may just have a risker population
    - Only so much that can be done to eliminate costs
    - Premiums are based off of risk, and if the population is risker, premiums will always be higher

Leni

- Leverage the TCC model
    - Shifting utilization towards less costly services, and preventative services
    - Part of the utilization could be due to the catch up period of people being diagnosed with disease too late
        - What are the gaps in utilization

Laura S.

- Remain mindful when limiting access
    - Keeping in mind high utilizers

JP

Discuss process for the MIA and the legislative strategy

- Including the tenants of the recommendations so there are guidelines

Should we be prescriptive for certain diseases?

- Diabetes
- Substance use disorder
- Hypertension

Draft Recommendation Comments

Altered Text	Recommended Change/Comment	Source
Comprehensive, high quality, and tailored to be responsive to the individual needs and unique morbidity profile of Marylanders, and encourages participation in the individual and small group market.	"I would include a statement that the benchmark plan retain the currently covered benefits and all MD insurance mandates. If this isn't a starting premise – I'd be curious as to whether there's been an analysis of benefits that should/shouldn't be included in the mandates."	CHF
1. *Improved health outcomes and near term affordability with consideration of long term cost savings to the health system*	*The population-health perspective of payers and health systems with regard to balancing anticipated health-related improvements and long term cost savings to the health system with near term affordability*	Laura S.
a. *Included benefits should result in maximum improvements in health outcomes including quality adjusted life years, and other health outcomes metrics.*	a. *Included benefits should keep current with medical advances and address gaps in services.*	MD Citizens Health Initiative
b. *The evaluation of benefits for inclusion or restriction should examine both utility (i.e. "a" above) and cost. The below framework prioritizes expansion of benefits that have anticipated high utility and low cost while prioritizing a restriction in benefits with anticipated low utility and high cost.*	"I agree with this framework but are there metrics for deciding which services fall into these buckets for benefit expansion? Picking up on the above comment – I would expect that the current state mandated benefits reflect the benefits that have high utility and address health costs over the long term (if not the short term). That's why I'd look to the mandates for that guidance."	CHF
Low Population Utility / High Population Utility	"I think we need to specify whether this is total population cost/utility or per capita cost/utility. However, I don't know	Laura S.

Low Total Cost in the Population	Consider for restriction	Prioritize for expansion	which one it is! Perhaps we should discuss as a group."	
High Total Cost in the Population	Prioritize for restriction	Consider for either restriction or expansion		
	c. *To the extent reasonable, benefit modifications along the framework established in "b" should result in zero-net premium increases. "Premium impact" in this framework should also include exogenous factors, i.e. State Reinsurance Program, etc., that do not consider benefits.*		*i. exogenous factors (i.e. State Reinsurance Program, new federal policy, new state policy, etc., that do not consider benefits).* *ii. premium costs for consumers who are not subsidized.* *iii. premium costs for consumers who receive subsidies.*	MD Citizens Health Initiative
			c. To the extent reasonable, benefit modifications along the framework established in "b" should result in zero-net premium increases. "Premium impact" in this framework should also reflect exogenous factors related to affordability that do not consider benefits. Examples include current programs,, i.e. State Reinsurance, or potential new programs, such as additional subsidies.	CHF
	new section		*d. Potential unintended impacts of restrictions considered in the framework established in "c" should be contemplated including:* *i. For consumers who receive subsidies, restrictions could result in increased out-of-pocket costs and reduction in access to benefits without resulting in a reduced premium.* *ii. Restricting a high cost/high utility benefit could potentially result in consumers experiencing financial hardship or skipping necessary medical care.*	MD Citizens Health Initiative
	2. *The impact, from a cost, utility, and discretionary perspective, on consumers from populations with/without health disparities across income and geographic areas.*		*2. The impact, from a cost, utility, and discretionary perspective, on individuals from populations with/without health disparities across all demographic factors and geographic areas. In addition to the factors cited above the evaluation of*	CHF

	benefits for inclusion should, as appropriate, reflect the goal to	
	2. The anticipated impact from a cost, utility, and discretionary perspective, on individual consumers *a. The evaluation of benefits for inclusion or restriction should examine individual-level cost and individual-level utility in analyses that are separate from the population-level analyses described in 1.b.* *b. Individual discretion should be considered in addition to a cost vs. utility analyses. Benefits may be prioritized for expansion or continuance if they are valued by individual consumers.*	Laura S.
	2. The impact, from a cost, utility, and discretionary perspective, on consumers from populations with/without health disparities across income and geographic areas, including: *a. Consideration of racial/ethnic disparities and disparities for people with disabilities* *b. Consideration of how the population enrolled in the individual and small group market has changed since the last time the SBP was modified or may change before it is modified again*	MD Citizens Health Initiative

	a. *reduce health disparities among those individuals and populations most impacted by these;* b. *improve population health;* c. *promote preventive care services to improve health outcomes and lower health care costs for individuals and the system; and* d. *ensure that comprehensive and parity-compliant substance use disorder and mental health services are covered to address the State's opioid and suicide epidemics.*	CHF
new section	*3. The anticipated differential impact, from a cost, utility, and discretionary perspective, on consumers from populations who either have (a) disproportionate burden of disease and/or (b) disproportionately worse access to health care based on income status, race and/or geographic areas.* a. *Benefit modifications should not increase existing health disparities in the population. Benefits that may reduce existing health disparities should be prioritized for expansion.* b. *Individual-level values for cost and utility likely differ from the population-level values for some groups.* i. *Cost and utility depend on the underlying burden of disease. Since burden of disease differs across groups in the population, the anticipated cost and utility of benefits will also differ across groups.* ii. *Lack of access to care pose barriers to*	Laura S.

		utility for some individuals; 'real' utility of some benefits are lower than the ideal utility of the benefit. Therefore, benefit modification should consider the 'real' utility for under-served populations.	

Adjournment

The meeting was adjourned at 1PM by the chair, Leni Preston.