MARYLAND HEALTHBENEFIT EXCHANGE

State Benchmark Plan Work Group Report

Recommendations for future modifications to the State Benchmark Plan

MHBE Policy and Plan Management
May 20, 2019

Background

Section 1302 of the Affordable Care Act establishes that plans sold in the individual and small group markets offer coverage for a comprehensive set of benefits. Included within this set of benefits, the Essential Health Benefits (EHBs), are ten categories of services and items that span from emergency services to maternity and newborn care.[1] In 2011, the U.S. Department of Health and Human Services (HHS) established a process through which states can select a "benchmark plan" that covers the EHBs that must be included in the scope of benefits for each plan sold in the individual and small group markets of a given state.

Critically, the EHBs included in these benchmark plans are linked with the applicability of federal funds (i.e. advanced premium tax credits, APTCs) that are used reduce the cost of premiums for enrollees. Restated, APTCs may not be applied to the cost of benefits that are not considered EHBs.

In 2018, HHS modified this process to provide states with greater flexibility to determine, update, or modify their existing benchmark plans.[2,3] The MHBE identified this as an opportunity to address one of its statutory principles - to "facilitate flexibility to enable the Exchange to respond nimbly to changes in the insurance market, health care delivery system, and economic conditions while also maintaining responsiveness to consumer's needs and demands." Of note in this regard are the shifts in Maryland's health system landscape that include the performance and population health metrics required by the CMS Waiver for the Total Cost of Care Model and Primary Care Program.

To address this new opportunity, MHBE convened a work group of stakeholders to develop recommendations for the Board of Trustees and incorporated this approach in its *2020 Letter to Issuers Participating in Maryland Health Connection (Issuer Letter).* That included the following parameters for the report:

1. Determine whether the current benchmark plan meets the needs of the individual market.

[1] For additional information on the Essential Health Benefits please see Attachment A in the Appendix
[2] Final 2019 Notice of Benefits and Payment Parameters
[3] Illinois utilized this new flexibility to help address the State's opioid epidemic. For additional information please see Attachment A in the Appendix.

2. Provide recommendations on whether to leverage new state flexibility to modify the State Benchmark Plan
3. ~~3.~~ Solicit Report must include feedback from the Standing Advisory Committee~~, market impact of the change, and estimated savings/costs of the approach.~~
4. Provide a public comment period of no less than 30 days upon release of the report.[4]

This document details the work of the State Benchmark Plan Work Group (Work Group) to meet each of the requirements under the *Issuer Letter*. Additionally, this document provides the consensus recommendations of the Work Group in subsequent sections.

State Benchmark Plan Work Group Membership
The membership of the Work Group represented stakeholders with specific subject matter expertise to inform the business of the Work Group. To provide additional subject matter expertise from a regulatory, clinical, and research perspective MHBE engaged with the Maryland Insurance Administration, University of Maryland School of Medicine, and Johns Hopkins School of Nursing. Table 1 provides information on the Work Group members.

Table 1. State Benchmark Plan Work Group Membership[5]

Name	Organization	Role
Kim Cammarata	Health Advocacy and Education Unit, Attorney General's Office	Member
Stephanie Klapper	Maryland Citizen's Health Initiative	Member
Leni Preston	Consumer Health First	Chair
Jennifer Storm	CareFirst	Member
Renee Vis	Kaiser Permanente	Member
Brad Boban	Maryland Insurance Administration	Support
Laura Pimentel, MD	University of Maryland School of Medicine	Support
Laura Samuel, Ph.D, CRNP	Johns Hopkins School of Nursing	Support

State Benchmark Plan Work Group Business
The business of the Work Group including meeting minutes, presentations, and background information may be found in the Appendix of this document. The Appendix is organized by meeting date and includes all of the information supporting the business conducted during each session.

[4] Link to *2020 Letter to Issuers Participating in Maryland Health Connection.*
[5] Work Group members noted that the future engagement of employers would be useful.

Requirement 1: Determine whether the current benchmark plan meets the needs of the individual market.

Work Group members received a presentation by Brad Boban (Maryland Insurance Administration) on the 50-state landscape of the Essential Health Benefits included within State Benchmark Plans.[6] The presentation revealed certain characteristics of Maryland's State Benchmark Plan that, when compared with those of other states, open up opportunities for further consideration.

Example 1: Weight Loss Programs and Routine Foot Care
It was found that Maryland's SBP includes neither Weight Loss Programs nor Routine Foot Care as EHBs. In the context of the Total Cost of Care Waiver, where the state will be evaluated by performance on population health metrics for those with diabetes, Work Group members noted that the exclusion of these benefits from the State Benchmark Plan may be a missed opportunity to both increase the wellness of this population and decrease downstream disease burden on the health system.

Example 2: Prescription Drugs
Mr. Boban's research found that there is a high degree of variability across states in the prescription drugs that are included in each state's EHB formulary. For example, some states include fewer than 600 prescription drugs in their formularies while others include up to 1,023 prescription drugs. By comparison Maryland includes 1,069 drugs as a part of the EHB prescription drug formulary, placing Maryland at the most generous end of state formularies. Work Group members noted that Maryland's formulary may be worth analyzing to determine whether or not the formulary might be better tailored to maintain clinical outcomes while reducing premiums.[7]

Example 3: Acupuncture
It was found that Maryland's SBP is the only state covering acupuncture with no limitations. Other states have applied restrictions and limitation to the acupuncture benefit. For example, California limits utilization to treatment for nausea or chronic pain management while Washington, Alaska, and Montana limit acupuncture for up to 12 visits per year.

Several other examples of Maryland's unique characteristics were discussed during the session. These can be found in the Appendix.

Work Group Recommendation 1: Philosophical Approach/Analytical Framework
Work Group members agreed that the scope of Requirement 1 exceeded the data/analytic resources available to the Work Group. Instead, Work Group members sought to inform the process through which the necessary data could be gathered and the framework for how such data might be analyzed.

While the Work Group members did not determine that the current benchmark plan either meets, or exceeds, the needs of those in the individual market, they did determine that the State Benchmark Plan should be reviewed to determine if: 1) new benefits should be included and 2)

[6] Presentation may be viewed in the Appendix under the XX session meeting documents.
[7] Work Group members noted that modifications to the State's EHB formulary should take special precaution to prevent inadvertent discriminatory limitations or exclusions.

existing benefits should be expanded, pared down, or removed subject to appropriate limitation and restriction.[8] To guide the review process, Work Group members crafted a philosophical approach and analytical framework that the state should follow when seeking to determine, update, or modify the State Benchmark Plan (hereafter, "Recommendation 1"). Most of the Work Group's meeting time was focused on the development of Recommendation 1, which s the result of extensive collaboration and consensus building. Among the issues the members considered reflect two of the MHBE's core principles. To: (1) "promote affordable care;" and (2) "address longstanding disparities in health care access and outcomes."

The first section of Recommendation 1 establishes a definition for the ideal State Benchmark Plan. The second section of Recommendation 1 establishes a philosophical approach/analytical framework for how the State should evaluate the SBP. This included consideration of a patient-centered approach and evaluation of how any resulting modifications to the SBP would impact specific populations. It is important to note that the recommendation should be read within the context of the factors affecting Maryland's health system landscape, i.e. the Total Cost of Care Waiver, the State Reinsurance Program, etc.

Recommendation 1 is provided in the highlighted area below.

The State Benchmark Plan Work Group recommends that an ideal State Benchmark Plan is:

> Comprehensive, high quality, non-discriminatory, customized to the individual needs and unique morbidity profile of Marylanders, and encourages participation in the individual and small group markets.

To meet this standard the following must be considered:

1. Improved health outcomes and near-term affordability with consideration of long-term cost savings to the health system:

    a. Included benefits should result in maximum improvements in health outcomes including quality of care, quality-adjusted life years, patient-centered outcomes, and other health outcomes metrics.

    b. Benefits also should reflect medical advances and address gaps in services.

    c. The evaluation of benefits for inclusion or limitation 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 limitation of benefits with anticipated low utility and high cost.

	Low Utility*	**High Utility***
Low Cost	Consider for limitation	Prioritize for expansion
High Cost	Prioritize for limitation	Consider for either limitation or expansion

* Including quality of care, quality adjusted life years, patient-centered outcomes, and other health outcomes metrics.

[8] Work Group members noted that the review of benefit changes should include careful consideration of how such changes will impact members with qualified High Deductible Health Plans due to the rules for first-dollar coverage in these plans under the tax code.

d. The evaluation in "c" should be considered for conditions that are chronic or otherwise have large health or cost burdens for the individual, the population, and employers.

e. The state should evaluate whether the benefits mandated by the state and/or included in the State Benchmark Plan should be limited or expanded based on additional analysis performed by the state. The evaluation ideally should be performed:

    i. In alignment with the state benefit mandate study performed by the Maryland Health Care Commission (every four years); or
    ii. As needed in response to an acute public health crisis as determined by the secretary of the Maryland Department of Health.

f. To the extent reasonable, benefit modifications along the framework established in "c" should result in zero-net or *de-minimis* premium increases. "Premium impact" in this framework also should include exogenous factors that do not consider benefits, i.e. State Reinsurance Program, or other policies/programs that impact premiums.

2. The differential impact from a cost, utility, and discretionary perspective of:

    a. Populations with/without health disparities across all demographic factors, geographic areas, and disability statuses, with particular attention to primary drivers of health disparities, i.e. race, ethnicity, income status, etc.
    b. Populations receiving and not receiving financial assistance, with particular attention to:
        i. Avoid increasing financial burden due to increased out-of-pocket costs and premiums; or
        ii. Consumers forgoing recommended medical care.

Work Group members also noted that the State should be mindful of potential State defrayal of costs for benefit mandates that meet certain criteria under federal rule. Work Group members also noted that it is important to consider consumers with qualified High Deductible Health Plans when modifying the SBP due to potential interactions with IRS rule.

Work Group Recommendation 2: Studies that should inform determination of the State Benchmark Plan.

To support Recommendation 1 the Work Group agreed that the State should conduct studies that would provide additional insights on how the EHBs: (1) within the SBP, are manifest within the marketplace from a unit cost/utilization perspective; (2) are perceived and accessed by marketplace participants; and (3) intersect with social determinants of health, or other factors impacting the use of services and access to care.

The Work Group also determined that effectiveness research on issuers' programs for issuer chronic disease/utilization management warrant further discussion and engagement with stakeholders. It is important to note that the Work Group does not recommend any study that would be duplicative of any ongoing State effort.[9]

Table 2. Recommendation 2 Studies

[9] For example, the Maryland Insurance Administration study on "Access and Use in the Individual Market."

Study	Existing/New	Methods	Recommendation/Research Question
Study of Mandates Services	Required under Insurance Article § 15-1502, Annotated Code of Maryland		Recommendations: 1. The Study should be performed as soon as possible, on schedule, and adequately funded. 2. The Study should be expanded to include all of the benefit categories under the State Benchmark Plan and recommendations for including additional benefits. 3. The Study should consider all of the factors set forth under Insurance Article § 15-1501(C) for the benefit categories under the State Benchmark Plan, in parity with the factors considered for the study of mandated services. 4. The Study should provide information on unit cost/utilization for each of the benefit categories.
Study on Consumer Experience with Benefits	New	Surveys, interviews, & focus groups	Research Questions: 1. What is the perceived value of insurance benefits? Which benefits are considered priorities by consumers? 2. Which benefits should be included based off perceived value/consumer priorities? 3. What are perceived barriers to care, including accessibility, coverage exclusions, etc.? Recommendations: 1. Study should control for financial assistance and sub-populations with health disparities. 2. Study should control for health literacy.
Study on the Intersection of Social Determinants of Health and Benefits	New	Population data, claims data, etc.	Research Questions: 1. Do social determinants of health impact the consumer's ability to access benefits in the package? 2. How can existing benefits be structured/implemented to address social determinants of health, if necessary? 3. What are the exogenous factors that impact the consumer's experience when interacting with the health system outside of benefits? 4. Has the SBP made a difference? For example, has Pediatric Dental & Vision benefit improved outcomes? Has the SBP affected benefit utilization?

Study	Existing/New	Methods	Recommendation/Research Question
Potential research area for further discussion and engagement: Effectiveness review of issuer chronic disease management/utilization review programs across markets with the intent to increase transparency, promote adoption of best practices, and determine outcomes.			

Work Group members also agreed that all studies should consider, as feasible, populations with/without health disparities across all demographic factors, geographic areas, and disability statuses with particular attention to the primary drivers of health disparities, i.e. race, ethnicity, income status, etc. Additionally, all studies should also consider standardization and stratification of disparate data sets to ensure comprehensive insights.

It should be noted somewhere in this Report that the ACA requires states to pay the cost of new mandates beyond the benchmark plan. Further, under the 2019 Notice of Benefit and Payment Parameters, the state is required to pay for any new benefits:

"…State-required benefits mandated by State action taking place after December 31, 2011, other than for purposes of compliance with Federal requirements, would continue to be considered in addition to EHB even if embedded in the State's newly selected EHB-benchmark plan under the proposals at § 156.111. Therefore, their costs would be required to be defrayed by the State."

Additionally, the federal regulations have a "generosity" test to measure any changes to the EHBs since 2017.

Requirement 2: Provide recommendations on whether to leverage new state flexibility to modify the State Benchmark Plan.

The Work Group received a presentation on current EHB policy by John-Pierre Cardenas, MHBE Director of Policy and Plan Management. During the session, the Work Group learned that existing statute concerning the SBP, under Insurance Article § 31-116 (c)(1), precludes the State from determining/modifying the SBP without a directive from the U.S. Secretary of Health and Human Services Given that the new federal rule allows states to modify their State Benchmark Plans at will and without timeline, members agreed that the statute should be modified to:

1. Allow the State to leverage new flexibilities to modify the State Benchmark Plan.
2. Include criteria to ensure study-driven decision making, consideration of special populations, ample public input, and process transparency.

Recommendation 3: Modification to Insurance Article § 31-116, Annotated Code of Maryland.

Md. INSURANCE Code Ann. § 31-116

Annotated Code of Maryland INSURANCE TITLE 31. MARYLAND HEALTH BENEFIT EXCHANGE.

(a) In general. -- The essential health benefits required under § 1302(a) of the Affordable Care Act:

(1) shall be the benefits in the State benchmark plan, determined in accordance with this section; and

(2) notwithstanding any other benefits mandated by State law, shall be the benefits required in:

(i) subject to subsection (f) of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange

(ii) subject to § 31-115(c) of this title, all qualified health plans offered in the Exchange.

(b) Determination of State benchmark plan. -- In determining the State benchmark plan, the State seeks to:

(1) balance comprehensiveness of benefits with plan affordability to promote optimal access to care for all residents of the State;

(2) consider populations receiving and not receiving financial assistance, with particular attention to avoiding increasing financial burden due to increased out-of-pocket costs or consumers forgoing recommended medical care in addition to premiums;

(3) consider the diverse health needs across the diverse populations within the State across all demographic factors, geographic areas, and disability statuses with particular attention to primary drivers of health disparities; and

(4) ensure the benefit of input from the stakeholders and the public.

(c) Open, transparent, and inclusive process. –

(1) The State benchmark plan, shall be determined by the Commissioner, in consultation with the Exchange and the Maryland Health Care Commission based off the State benchmark plan selected in 2017:

(ii) through an open, transparent, and inclusive process, which shall include at least one public hearing and an opportunity for public comment with a minimum comment period of 30 days..

(2) In determining the State benchmark plan, the Commissioner, in consultation with the Exchange and the Maryland Health Care Commission, may consistent with applicable federal regulations:

(i) add, remove, or modify a health care service, benefit, coverage, or reimbursement for covered health care services that are determined to meet the criteria in (b) based off studies performed by the Maryland Health Care Commission;

(ii) exclude a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health - General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(iii) exclude reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(3) If determining a modification to the State benchmark plan is necessary the Commissioner shall, in consultation with the Exchange and the Maryland Health Care Commission, submit the required documentation to the U.S. Secretary of Health and Human Services, for approval, in compliance with federal regulations.

(d) Considerations in the determination process. -- In determining the State benchmark plan, the Commissioner, in consultation with the Exchange and the Maryland Health Care Commission, shall:

(1) ensure the plan complies with all requirements of this title and the Affordable Care Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and any other federal laws, regulations, policies, or guidance applicable to state benchmark plans and essential health benefits;

(2) for individual health benefit plans, require that the health benefit plans include any mandated benefits that were required in individual health benefit plans before December 31, 2011, if the benefits are not included in the selected benchmark plan

(e) Report. -- Within 10 days after determining the State benchmark plan, the Commissioner shall submit a report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee advising the Committees of the Commissioner's determination and the process used in making the determination.

Requirement 3: Report must include feedback from the Standing Advisory Committee~~, market impact of the change, and estimated savings/costs of the approach.~~

MHBE will incorporate feedback from the Standing Advisory Committee with this report following the comment period.

Requirement 4: Report must have a public comment period of no less than 30 days.

MHBE will attach feedback received during the public comment period to the final issuance of this report.