MARYLAND HEALTHBENEFIT EXCHANGE

Affordability Work Group Report

Recommendations to strengthen the individual market in Maryland

MHBE Policy and Plan Management
August 1, 2019

Background

In 2018, Maryland received a State Innovation Waiver (under Section 1332 of the Patient Protection and Affordable Care Act) to establish a State Reinsurance Program (SRP) that would offset rate increases in the individual market by 30 percent.[1] As a result, premiums in the individual market, on average fell by 13.2% in 2019.[2] A more favorable premium environment, coupled with a strategic investment in marketing, fostered enrollment growth in the individual market that was 24% above original projections.[3]

Although the State Reinsurance Program provided immediate relief through lower premiums, Marylanders continued to voice concern over rising deductibles, out-of-pocket costs, and limited plan options. MHBE summarized these concerns, with discussion, in the *Draft 2020 Annual Letter to Issuers Seeking to Participate in Maryland Health Connection.*[4] In response, MHBE proposed several policy proposals that sought to address these issues, including 1) the implementation of a standardized plan design; 2) create a requirement for issuers to offer additional product options; and 3) the establishment of a petition process to add Essential Community Providers.

In the *2020 Letter to Issuers Seeking to Participate in Maryland Health Connection* (2020 Issuer Letter) MHBE finalized two proposals that sought to address affordability in Maryland Health Connection plans:

1. Establishment of an Affordability Work Group that would provide the Board of Trustees with recommendations on policy solutions that would:

    - Reduce out-of-pocket costs
    - Maximize APTC for subsidized consumers
    - Maximize affordability for unsubsidized consumers

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-STC-MD-Signed.pdf [2] https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2018201
[3] https://www.marylandhbe.com/wp-content/uploads/2018/12/12.17.18_PressRelease.pdf
[4] https://www.marylandhbe.com/wp-content/uploads/2019/07/2020-Draft-Letter-to-Issuers-Seeking-to-Participate-in-Maryland-Health-Connection.pdf

2. A requirement for issuers to offer *Value* qualified health plans at the bronze, silver, and gold metal levels, with certain criteria to establish deductible ceilings and require certain services be covered before deductible.[5]

The Affordability Work Group began meeting on March 1, 2019 and ceased business on June 14, 2019. This document provides a summary of this business and presents the Work Group's recommendations.

Affordability Work Group Membership
Work Group members represented stakeholders with diverse perspectives and subject matter expertise to inform the business of the Work Group. To provide additional subject matter expertise from a regulatory, statutory, and policy perspective MHBE sought additional support from the Maryland Insurance Administration.

Table 1. Affordability Work Group Membership

Name	Organization	Role
Ken Brannan	Special Olympics Maryland	Co-Chair
Stephanie Klapper	Maryland Citizens' Health Initiative	Member
Robert Metz	CareFirst	Member
Maansi Raswant	Maryland Hospital Association	Member
Kim Rucker	Kaiser Permanente	Member
Beth Sammis	Consumer Health First	Co-Chair
Brad Boban	Maryland Insurance Administration	Support
Joseph Fitzpatrick	Maryland Insurance Administration	Support

Affordability 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.

Summary of Work Group business

The Affordability Work Group was provided data on Maryland's individual market that contextualized potential drivers for premiums and out-of-pocket costs, including:

- Chronic disease burden

[5] https://www.marylandhbe.com/wp-content/uploads/2019/02/Final-2020-Letter-to-Issuers-Seeking-to-Participate-in-Maryland-Health-Connection.pdf

- Utilization and per member per month for service categories
- Enrollment mix and plan selection
- Unit cost information and performance against other states

The Work Group also received information on affordability from an out-of-pocket cost at the point of service perspective. Drawing from this information, the Work Group noted the critical role of diverse plan design in market participation. Given the absence of an individual mandate where market participation is voluntary, it was also noted that plan cost sharing design could encourage or discourage enrollment based on the plan's perceived value to the consumer.

Presentations from Covered California and Families USA provided insights into the tradeoffs of standardized plan designs. States that have implemented standard plans to achieve specific goals may – depending on the degree of flexibility in offering other plan designs – limit issuer product innovation, create inequities for certain consumers with specific medical needs, and discourage participation from consumers whose specific needs may not be met by the prescribed plan design.[6]

A presentation from Chris Koller, Former Rhode Island Health Insurance Commissioner, provided an example of how RI promoted increased primary care spend through the use of regulatory authority without increasing consumer premiums. MHBE staff noted that given the Total Cost of Care Waiver and the population health metrics against which State performance will be measured, Rhode Island's experience may serve as an example of how coordinated regulatory policy can foster an environment for health system transformation.

Presentations from Families USA and the Urban Institute provided the Work Group with information on sub-populations where affordability issues may be concentrated (even with financial assistance) and potential policy solutions to help resolve them. While some of these solutions extended past the scope of MHBE's existing authority, the Work Group noted that it is still important to consider which solutions should be investigated further by other policy making bodies, i.e. the Health Insurance Coverage Protection Commission.

In the final sessions the Work Group established the following:

1. An analytical framework to inform the Work Groups recommendations.
2. Sub-populations for policy intervention.
3. Recommendations to strengthen the individual market.

The remaining sections of this document provide additional detail.

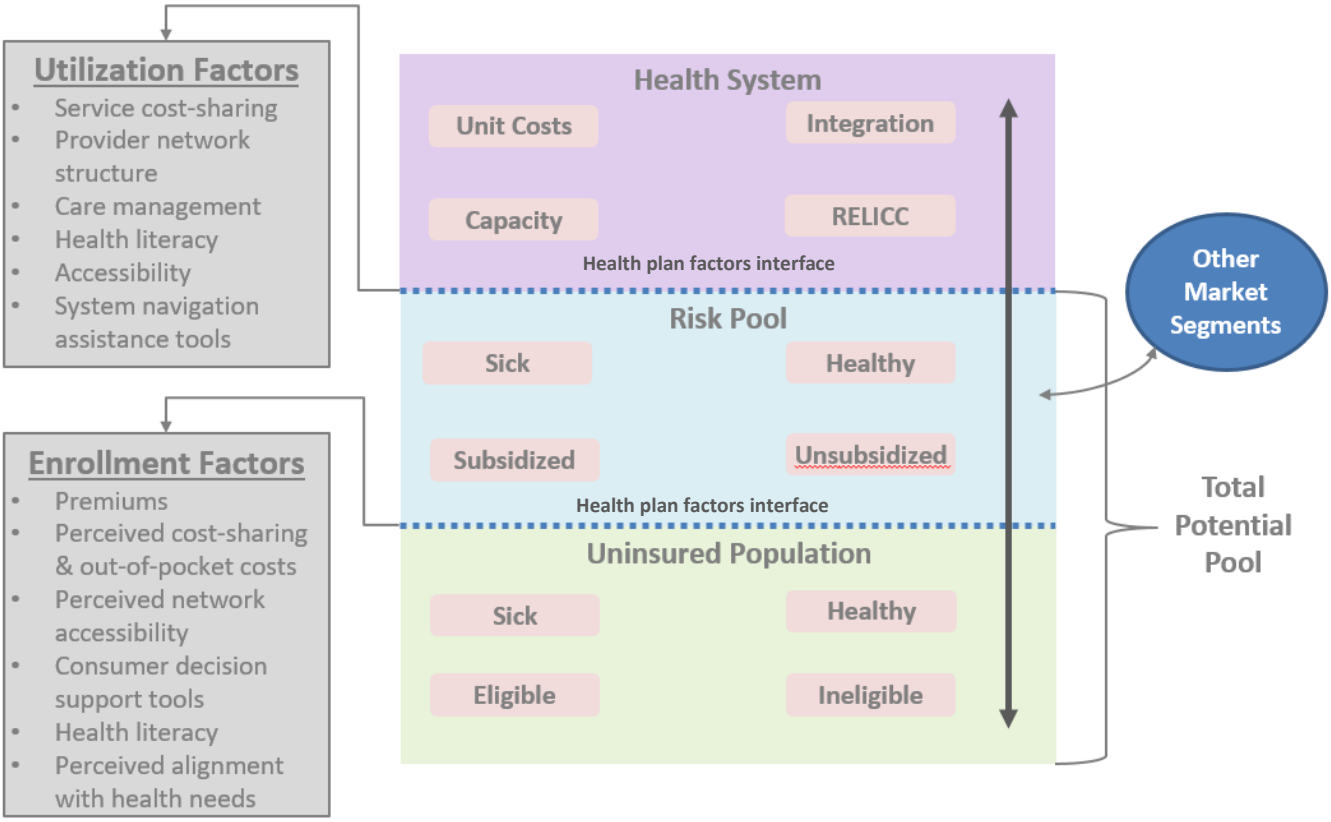
[6]Such specific goals include ensuring access to a minimum level of before deductible services, creating stability for consumers in expected out of pocket costs from year to year, creating an additional plan option, etc.

1. Analytical framework: Factors of health coverage that affect market participation and health system interaction.

Figure 1 provides an analytical framework for health coverage factors that affect enrollment take-up and health care utilization. The framework is drawn from the perspective of the uninsured population as they join the risk pool and interact with the health system. The dotted lines bordering the *Uninsured Population/Risk Pool* and *Risk Pool/Health System* represent the decision to enroll in coverage or utilize health care. Important sub-groups of the uninsured/risk pool populations have also been identified, as well as health system features that influence utilization.

Work Group members considered how policy recommendations that seek to affect health coverage factors would impact these sub-groups. Additionally, Work Group members considered the potential intersectionalities across sub-groups. For example, while reinsurance programs reduce premiums for those ineligible for financial assistance, the likelihood of an uninsured ineligible individual to enroll in coverage is usually dependent on whether the individual is sick or healthy (i.e., sick vs. healthy differences in price sensitivity). Therefore, while lower premiums increase coverage uptake for this population, it is important to consider 1) the cost of premiums after the reduction, and 2) whether the marginal enrollment, as a result of the premium reductions is healthier than, or of similar morbidity to, the existing risk pool. Work Group members noted that such an analysis is important when evaluating the long term impact of a policy on the risk pool and downstream self-sustained market stability.

Figure 1. Factors of health coverage that affect market participation and health system interaction.



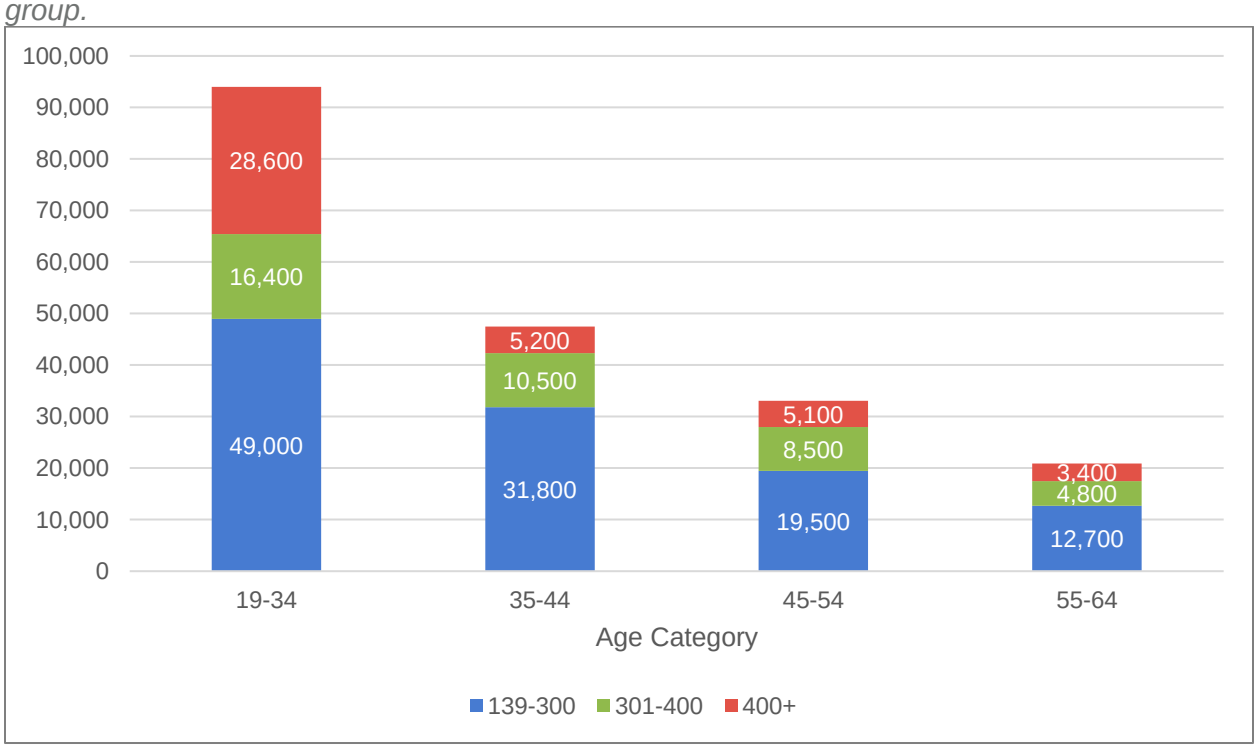
2. Determining populations for policy intervention.

To assist the Work Group in selecting populations for policy intervention, MHBE synthesized data on the remaining uninsured population (Maryland-specific) and chronic disease prevalence in the individual market into three charts below.[7,8]

Remaining uninsured in Maryland

Chart 1 provides additional information on the remaining QHP-eligible, uninsured population in Maryland (income strata that would be eligible for Medicaid have been removed), with stratification by age and income (by federal poverty level, FPL). The remaining uninsured population is skewed toward the younger age groups as the 19 – 34 age category accounts for approximately 50% (94,000) of the remaining uninsured population. With respect to eligibility for financial assistance programs, approximately 70% (19 – 34 age category) to 89% (35 – 44 age category) of the uninsured across age groups could be eligible for tax credits.

Chart 1. Uninsured, non-elderly Maryland adults stratified by income category (by FPL) and age group.



SOURCE: Presentation to the Affordability Work Group. (Families USA 2019)

The above 400% of FPL population for the 18 – 34 age category is the largest in magnitude and proportion across the age categories. The Work Group determined that this is likely attributed to the low propensity of young, healthy adults to enroll in health coverage. Additionally, it was noted that a long-term solution to ensuring affordability in the individual market requires the increased participation of the 18 – 34 age category to improve the composition of the risk-pool.

[7] https://www.marylandhbe.com/wp-content/uploads/2019/04/Affordability%20Work%20Group%20Presentation%204.19.19.pdf
[8] https://www.marylandhbe.com/wp-content/uploads/2019/05/May-31-presentation.pdf

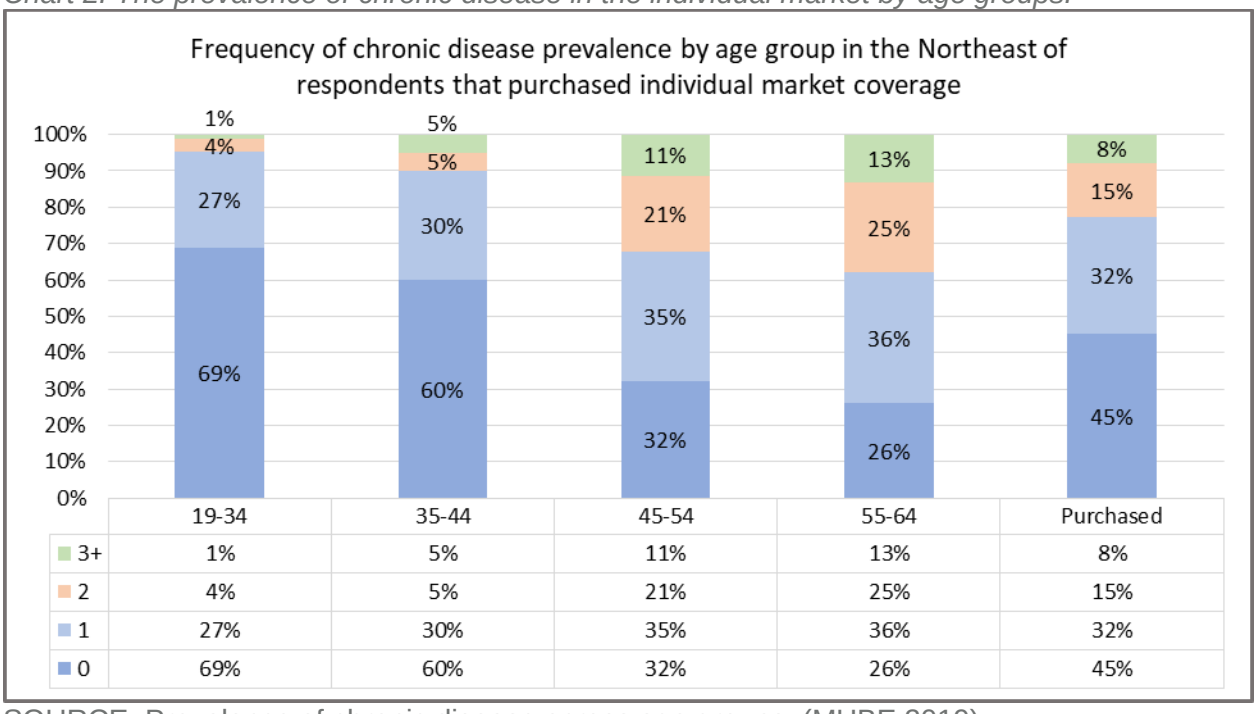
Further, the Work Group discussed that while the full implementation of the Maryland Easy Enrollment Health Insurance Program should work to reduce the proportion of the uninsured that is eligible for financial assistance, the degree of take-up may not be even, as risk aversion and the propensity to enroll in health coverage is likely to vary, across age groups.

Chronic disease prevalence in the individual market

Chart 2 provides insight on the prevalence of chronic disease in the individual market with data provided by the 2017 National Health Interview Survey. Given Maryland's individual market risk pool, it was important for the Work Group to consider this population's specific affordability concerns (ex. prescription drugs, etc.). While Chart 2 is not specific to Maryland, it speaks to the chronic disease burden in the individual market generally.

The Work Group noted that the data reaffirmed commonly held assumptions around the relationship of chronic disease and age – as an individual ages, the prevalence of one or more chronic diseases increases. The prevalence of more than one chronic disease is higher in the 45 – 54 and 55 – 64 age categories (68% and 74%, respectively) than in the 35 – 44 age category (40%). Additionally, the proportion of respondents with two or more chronic diseases increases as a share of total chronic disease prevalence in older age categories (i.e. compounding morbidity). For example, 25% of respondents with chronic diseases aged 35 – 44 have two or more diseases (40% have chronic diseases, 10% have two or more chronic diseases, 25% of total with chronic disease). For respondents in the 45 – 54 and 55 – 64 age categories this proportion increases to 47% and 51%, respectively. Additional information on this analysis may be view in the Appendix under *Chronic Disease Prevalence Across Age-Groups.*

Chart 2. The prevalence of chronic disease in the individual market by age groups.



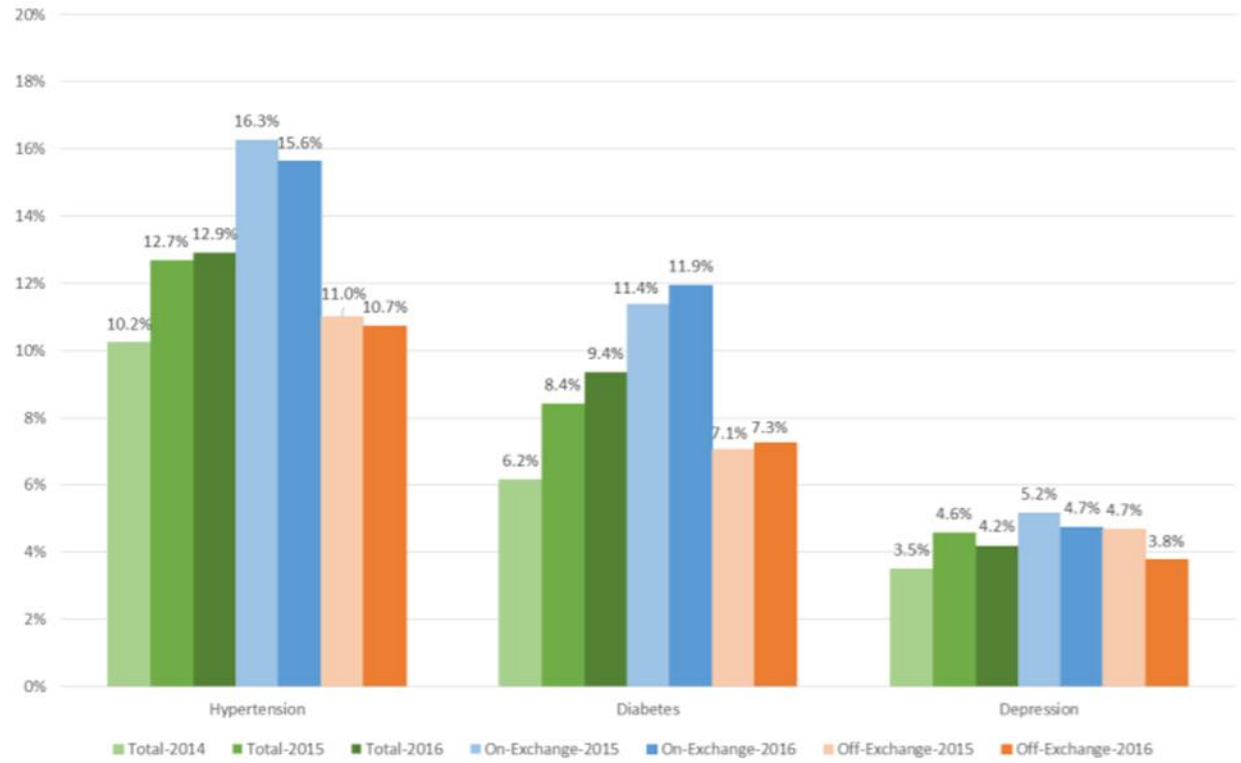
SOURCE: Prevalence of chronic disease across age groups. (MHBE 2019)

Work Group members noted the importance of effective chronic disease management programs in the individual market given the market's unique historic role as the coverage of last resort –

particularly with older populations that have manifested chronic diseases (i.e., this population has a high propensity to purchase health coverage). Additionally, the Work Group noted that it would be important to measure the interaction of the State Reinsurance Program with the claims of individuals with chronic diseases. For example, while only 5 – 6% of the individual market has a claims burden that is eligible for payment under the SRP, a larger population of enrollees in the individual market have chronic diseases whose claims do not meet the threshold. Work Group members discussed that it will be important to analyze claims data to determine which chronic diseases are drivers of claims under the SRP.

MHBE also provided the Work Group with data from the Maryland Health Care Commission (MHCC 2018) (Chart 3) on the prevalence of chronic disease in Maryland's individual market. Chart 3 provides insight on the prevalence of select chronic diseases (hypertension, diabetes, and depression) in the individual market (2014 – 2016) and breakouts for on- and off-Exchange enrollees for 2015 and 2016.

Chart 3. Total (ACA-Compliant & Noncompliant Plans, 2014 - 2016), and On-Exchange vs. Off-Exchange (ACA-Compliant Plans Only): Prevalence of Select Chronic Conditions, Individual Market, 2015 t0 2016.



Notes: (i) On v. off-Exchange data splits were not available in the MCDB until 2015.
(ii) Total includes both grandfathered and non-grandfathered plans.

SOURCE: Privately Insured Spending in Maryland's Individual Market, 2016. (MHCC 2018)

For *Total* individual market enrollment, the prevalence of enrollees with hypertension and diabetes grew each year from 2014 – 2016 (10.2% to 12.9% and 6.2% to 9.4%, respectively).[9] For ACA-compliant plans, the prevalence of both hypertension and diabetes was greater among on-Exchange members than among off-Exchange members in 2016 (15.6% vs. 10.7% for hypertension; 11.9% vs. 7.3% for diabetes).[10]

Selection of intervention populations
These charts, combined with the information received on drivers for unaffordability in the individual market (i.e., health of the risk pool, chronic disease concentration, trend/utilization, out-of-pocket costs, etc.), helped the Work Group identify sub-populations that should be focused on for policy intervention.

The Work Group noted that policy interventions to strengthen the individual market should 1) work to improve the risk pool by encouraging healthier risk to enroll; and 2) better manage the existing risk in the risk pool to improve health outcomes, encourage health system alignment, and support sustainability of the State Reinsurance Program.

Intervention Population #1: Young Adults (18 – 34)
Work Group members determined that Young Adults (18 – 34) should be focused on as an intervention population. Additionally, because the likelihood of a young adult enrolling in health coverage changes with their eligibility status for financial assistance and, if ineligible, the cost of health coverage relative to their income, consideration should be made for income. Work Group members also noted that 1) young adult women experience a higher need for health services and are more likely to enroll in coverage when uninsured; and 2) young adults have a large unmet need for behavioral health therapies, and therefore the need for health services should also be considered a factor.

Table 1. Young Adults (18 – 34)

Factor	Sub-populations
Income	1. Eligible for financial assistance (139% – 400% of FPL) 2. Ineligible for financial assistance (400+% FPL)
Need for health services	1. Women 2. Young Adults with Substance Use Disorder/Behavioral Health needs

Work Group members determined that policy interventions should seek to increase Young Adult participation in the risk pool by making individual market coverage more attractive/responsive to their needs

Intervention Population #2: Individuals with Chronic Diseases
Given the existing prevalence of chronic disease in the individual market and its effect on the risk pool, Work Group members determined that individuals with chronic diseases should be focused on as an intervention population. Furthermore, improvement in population health

[9] The Total category includes data for both ACA-compliant & ACA-noncompliant plans.
[10] It important to note that lower income populations have a higher prevalence of chronic disease than the general population. Given that the on-Exchange market offers income-based financial assistance to purchase health coverage such differences in chronic disease prevalence is not unexpected.

metrics/health outcomes for members with chronic diseases align with state-wide initiatives under the Total Cost of Care Waiver.

Recommendations to strengthen the individual market.

The Work Group's recommendations for the intervention populations are presented on the subsequent pages in Tables 3 & 4. The recommendations are comprehensive in scope and span from targeted investments in marketing to structural changes to the individual market. This section summarizes several recommendations and provides additional insights.

Value plans[11]
The Work Group members agreed that the Value plans will be an important additional option for consumers seeking lower deductibles and increased access to before-deductible services. To support this new initiative, Work Group members recommend a targeted marketing investment to inform consumers of the Value plans, specifically Young Adults for Value Bronze.

Given that Value plan outcomes are not yet available, the Work Group does not recommend specific modifications at this time. However, the Work Group does recommend that MHBE monitor the impact of Value plans (in terms of deductible relief from current enrollment) and enrollment outcomes (e.g., Young Adult enrollment in Value Bronze plans).

For potential future modifications to the Value plan requirement, the Work Group recommends that MHBE analyze the impact of replacing, or conjoining, the current Value Plan requirement that generic drugs be covered before deductible with a separate prescription drug and medical deductible. The Work Group members noted that these changes could increase plan Actuarial Value (i.e., generosity) above federal requirements, or affect the cost-sharing and utilization of other benefit categories to adjust.

State-subsidy for Young Adults[12]
The Work Group members agreed that increased participation of Young Adults in the individual market is critical for an improved risk pool and long term market sustainability. To achieve this, the Work Group recommends that the State commission a study for a State-subsidy for Young Adults. Data shows that this group represents approximately 50% of the remaining uninsured population, and given this group' high degree of price sensitivity and low risk aversion, additional premium supports – in the absence of a mandate – could maximize market participation.

Additionally, the Work Group recommends that the study consider the State-subsidy in conjunction with a State Innovation Waiver to access federal pass through funds (in a similar manner as the State Reinsurance Program), to determine if it would be advantageous. Importantly, the Work Group recommends that the waiver should not modify the existing federal tax credit structure and consider the potential for interaction with the State Reinsurance Program. The Work Group also recommended that the study should contemplate several funding source scenarios.

[11] See the Appendix for a full description of the 2020 Value plan requirement.

[12] It is important to note that new State Relief and Empowerment Waiver Guidance provides alternative subsidy structures as an option for future waivers.

It is important to note that the Work Group considered a broader State-subsidy for those eligible for financial assistance (under 400% FPL), as well as those ineligible for financial assistance (above 400% FPL). Further, the Work Group was also mindful of 1) the resources that could be available to the State to fund such initiatives; 2) the potential downstream impact to the risk pool; and 3) other policy initiatives (i.e., the Maryland Easy Enrollment Health Insurance Program, MEEHP) occurring in parallel.

Given these considerations the Work Group determined that a targeted State-subsidy for Young Adults would have the additive effect of improving the risk pool (lowering premiums for the above 400% FPL), would limit the utilization of State resources (when compared with a broader benefit), and, when coupled with the MEEHP, could have substantial enrollment impact.

State Reinsurance Program
Work Group members recommended the continual operation of the State Reinsurance Program (SRP). They noted that the SRP provides important premium stability for Marylanders who are ineligible for financial assistance due to income. Further, given the positive impact the SRP yielded in the first year, Work Group members note the importance of maintaining and building on those gains.

With respect to the recommended intervention populations, the SRP provides critical premium stability for individuals with chronic diseases who otherwise may not have access to continuous, more affordable coverage (given prior year's premium increases). The Work Group also noted that the SRP provides benefit to Young Adults who are ineligible for financial assistance due to income, with acknowledgement that the magnitude of the premium relief is smaller for Young Adults than it is for older members.[13]

Work Group members noted the importance of the sustainability of the State Reinsurance Program and recommend that MHBE closely monitor the claims experience under the SRP for disease-specific trends/opportunities to increase program integrity.

Chronic Disease Management Programs
The Work Group recommends that MHBE and issuers seek increased participation in these programs through marketing and health literacy efforts. Specifically for chronic diseases that have high prevalence in the individual market (hypertension, diabetes, and depression) and are drivers of claims to the SRP.

Additionally, Work Group members recommend state-wide coordination of chronic disease management programs and measurements across markets & programs (Medicare & Medicaid) to assist in the implementation and monitoring of the Total Cost of Care Waiver. These coordination efforts should also include diabetes prevention programs.

Other recommendations
The Work Group also provided recommendations on how to improve coordination across Maryland agencies with regulatory authority over health services delivery, cost, and coverage.

[13] Reinsurance programs modify the market index rate, which serves as the base for all premiums. Because this market index rate is further modified by age with a factor ranging from one (for 21 years old) to three (for 64+ years old) to reach the final premium, the magnitude of premium relief is greatest for older members. For example, a 21 year old in Baltimore City, who was enrolled in the second lowest cost silver plan, in 2018 saved nearly $125 for their plan in 2019 while a 64 year old saved $375, thrice the magnitude.

The Work Group recommends that the agencies establish a shared database of contacts and programs across agencies with the goal to:

1. Share data, learnings, and how learnings could be leveraged by each agency.
2. Prevent duplicative efforts.

The Work Group also recommends that MHBE host forums for agencies to coordinate on issues that pertain to affordability, population health, etc. including stakeholder participation and engagement. Topics that were specifically noted were – the MD Primary Care Program and coordination of agency action to address diabetes.

Opportunity for comment and next steps.

MHBE welcomes public comment on this document. MHBE will receive comments from the date of publication to August 31, 2019. MHBE will present these recommendation to the MHBE Board of Trustees at the September 16, 2019 session.

Comments may be submitted to: mhbe.publiccomments@maryland.gov

Table 3. Intervention Population #1: Young Adults (18-34)

Sub-Group	Near Term	Long Term
General *Women* *Young Adults with Substance Use Disorder/Behavioral Health needs*	1. Marketing investment focused on Young Adults 2. Value Plans: a. Evaluate the outcomes of the Value Plans b. Marketing investment in Value Plans 3. Consumer Decision Support Tools: a. Development of an Out-of-Pocket Cost Calculator b. Development of a plan shopping experience optimized to display service categories customized by the user, or automatically, by age 4. Development of a health literacy program focused on Young Adults 5. Successful implementation of the Maryland Easy Enrollment Health Insurance Program	1. Continued marketing investment focused on Young Adults
139% - 400 % FPL Eligible for financial assistance	1. A marketing investment focused on Young Adults 2. The State should commission a study on a supplemental premium subsidy for Young Adults that does not modify the existing federal tax credit structure. The study should: a. Analyze potential interaction with the State Reinsurance Program, and federal pass through, for the following scenarios: i. Supplemental premium subsidy w/ an independent funding source ii. Supplemental premium subsidy w/ funding carved-out from the existing premium assessment under Md. INSURANCE Code Ann. § 6-102.1	1. Establishment of a state-based supplemental premium subsidy for Young Adults: a. Utilizing only state funds or, b. Utilizing state & federal pass-through funds under a 1332 waiver.

Sub-Group	Near Term	Long Term
	iii. Supplemental premium subsidy under i & ii seeking federal pass through under a 1332 waiver b. Estimate required funding amount & identify potential funding sources c. Project impact of the subsidy on the individual market for a five- and ten-year time horizon d. Be updated at a later time to account for the implementation of other policies, i.e. the Maryland Easy Enrollment Health Insurance Program	
400+% FPL Ineligible for financial assistance	1. Continuation of the State Reinsurance Program	1. Continuation of the State Reinsurance Program 2. Establishment of a state-based supplemental premium subsidy for Young Adults: a. Utilizing only state funds or, b. Utilizing state & federal pass-through funds under a 1332 waiver.

Table 4. Intervention Population #2: Individuals with Chronic Diseases

Sub-Group	Near Term	Long Term
General	1. Value Plans a. Evaluate the outcomes of the Value Plans b. Study separate medical & drug deductibles and/or generic drugs before deductible i. Requirement within Actuarial Value ranges (+2/-4) ii. Impact on the utilization and cost-sharing of other benefit categories 2. Chronic Disease Management Programs a. Increase participation in these programs through education/health literacy b. Analysis of State Reinsurance Program claims for conditions that are drivers of claims to the SRP and the prevalence of those conditions c. Promotion of those with diabetes, hypertension, and depression into Care Management Programs d. State-wide coordination of chronic disease management programs and measurements across markets & programs (Medicare & Medicaid) including diabetes prevention programs 3. Consumer Decision Support Tools a. Plan shopping experience that is responsive to consumer's unique service category needs b. Prescription Drug Search that relays cost sharing, limitations/ exclusions, prior authorizations, and consumer protections for formulary changes	1. Continuation of the State Reinsurance Program

Sub-Group	Near Term	Long Term
	4. Provider Networks a. Expansion of care coordination for those with chronic diseases b. Expand capacity through telemedicine services c. Improve health literacy for the newly insured with provider selection	

APPENDIX

1. **Excerpt from the 2020 Issuer Letter – 2020 Value Plan Requirement**
2. **Prevalence of chronic disease across age groups**
3. **Meeting #1 – February 15, 2019**
    a. **Welcome Webinar Materials**
4. **Meeting #2 – March 1, 2019**
    a. **Agenda**
    b. **Preferred Provider Organization Analysis**
    c. **Presentation**
    d. **Covered California - *Key Ingredients to Creating a Viable Individual Market That Works for Consumers***
5. **Meeting #3 – March 15, 2019**
    a. **Agenda**
    b. **Presentation**
    c. **Minutes**
6. **Meeting #4 – April 5, 2019**
    a. **Agenda**
    b. **Presentation**
    c. **Minutes**
7. **Meeting #6 – April 19, 2019**
    a. **Agenda**
    b. **Presentation**
    c. **Minutes**
8. **Meeting #7 – May 31, 2019**
    a. **Agenda**
    b. **Presentation**
    c. **Minutes**
9. **Meeting #8 – June 14, 2019**
    a. **Agenda**
    b. **Presentation**
    c. **Minutes**

Excerpt from the 2020 Issuer Letter – 2020 Value Plan Requirement

Table 4-B-1. 2020 Qualified Plan Certification Standard – Out-of-pocket Costs.

"Value" plans	
1.	Standard plans are deferred for 2020 and will be included for evaluation in the 2019 Affordability Work Group with potential adoption in 2021.
2.	Issuers must offer at least one bronze plan, called a "Value" plan, with certain number of certain services available before deductible.
3.	Issuers must offer at least one, non-HSA silver "Value" plan with certain services before a certain deductible.
4.	Issuers must offer at least one, non-HSA gold "Value" plan with certain services before a certain deductible

a. "Value" plans.

In response to public feedback on the increasing consumer cost-sharing and rising out-of-pocket costs in QHPs offered through Maryland Health Connection (see *Draft 2020 Letter to Issuers Seeking to Participate in Maryland Health Connection*), MHBE will require that issuers offer "Value" plans, that meet certain cost sharing and branding requirements, at the bronze, silver, and gold coverage metal levels. It should be noted that MHBE seeks to implement the standard through a phased approach. Additionally, the standard will be further developed through the 2019 Affordability Work Group as a starting point for addressing affordability issues. Table 4-B-2 below details specific QHP requirements for the 2020 plan year.

Table 4-B-2. "Value" plan offering requirements for the 2020 plan year.

Requirements	**Bronze**	**Silver**	**Gold**
Minimum offering	Issuer must offer at least 1 "Value" plan.	Issuer must offer at least 1 "Value" plan.	Issuer must offer at least 1 "Value" plan.
Branding	Required for 2020.	Optional.	Optional.
Deductible ceiling	No requirement. Lower deductibles are encouraged.	$2500 or less.	$1000 or less.
Set Office Visits Before Deductible	Issuer may allocate no less than three office visits across the following settings: • Primary Care Visit (not including preventive care) • Urgent Care Visit • Specialist Visit	No requirement.	No requirement.
Services Before Deductible	See 'Office Visits Before Deductible' above.	The following services must be offered as copays before deductible: • Primary Care Visit	The following services must be offered as copays before deductible: • Primary Care Visit

Requirements	Bronze	Silver	Gold
		• Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging	• Urgent Care Visit • Specialist Care Visit • Laboratory Tests • X-rays and Diagnostics • Imaging • Generic Drugs
Encouraged Services Before Deductible		The following services are strongly encouraged to be offered as copays before deductible: • Generic Drugs	
Limitations & Exceptions	No requirement.	No requirement.	No requirement.
Facility Fees	No requirement.	No requirement.	No requirement.

b. Value Bronze Plan office visits requirement.

Under the "Value" Bronze three office visits requirement issuers may allocate, at minimum, any three office visits across the Primary, Urgent, and Specialist Care Visits. Issuers are encouraged to allow maximum consumer flexibility to the extent possible under existing technical/operational limitations. To incentivize appropriate utilization of lower cost sites of care MHBE strongly recommends the inclusion of at least one urgent care visit in the selected allocation. It

The 2019 Affordability Work Group will consider avenues to maximize the consumer flexibility of the three office visit requirement. To support innovation in this space, MHBE will gather the relevant expertise from other states/issuers that have offered, and priced for, flexible cost-sharing/utilization design under existing federal actuarial value and reporting requirements.

c. Branding requirements.

For the 2020 plan year, MHBE will require "Value" branding for bronze QHPs. Branding for the other metal levels will be explored after consultation with the 2019 Affordability Work Group. Given the expected contrast between currently offered bronze QHPs and the "Value" bronze QHPs, MHBE believes the additional branding will be helpful to consumers in identifying the distinction between bronze QHPs.

d. Issuer offering requirement.

For the 2020 plan year, MHBE clarifies that "Value" plan offering requirements will be applied at the branded, holding company level. To maximize impact and reduce administrative burden, it is recommended that branded holding companies offering plans with multiple product types, offer "Value" plans in the product with the greatest share of the holding company's enrollment and span of service area. MHBE recommends that holding companies offer "Value" plans under HMO product lines.

e. Other QHP offerings.

MHBE understands that "Value" plan requirements will increase QHP actuarial value and potentially premiums. "Value" plans are intended to supply consumers with alternative options that provide minimum expectations of the services that will be offered before deductible. MHBE encourages issuers to offer additional QHPs with lower actuarial value to support premium affordability for unsubsidized consumers and provide distinct options within each metal level.

MHBE also encourages issuers to consider the entirety of their product portfolios as they pertain to consumer access to premium tax credits within their respective service areas.

f. Mapping cost-sharing with services provided.

MHBE expects that issuers use the same service to cost-sharing mapping utilized when completing Plan and Benefits Templates and Summary of Benefits and Coverage.

g. Services before deductible deferred for 2020.

MHBE will defer before deductible/cost sharing requirements for preferred brand, non-brand, and specialty drugs until prescription drugs are deliberated by the 2019 Affordability Work Group. MHBE will also defer Emergency Room Visit deductible requirements for the 2020 plan year.

h. *About Doctors in This Plan (PDF).*

Currently issuers may supply MHBE with additional provider network information via the *About Doctors in This Plan (PDF).* MHBE will amend this option to allow issuers to supply additional information about their QHP offerings that may not be detailed, or described, through the Summary of Benefits and Coverage standard format. While issuers must still supply additional descriptive information about their provider networks, they may also provide:

- Information on their chronic disease management/cost-sharing programs
- Information on wellness/incentive programs
- Information on telemedicine services
- Other information

The URL will be retitled to reflect the change in provided information.

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Prevalence of chronic disease across age groups

Chronic Disease Prevalence Across Age-Groups

Background. MHBE utilized data from the 2017 National Health Interview Survey[14] (NHIS) to determine chronic disease burden across age-groups and specifically for individuals who sought, and then purchased, coverage in the individual market either directly from issuers or through the Marketplace. Additionally, the analysis seeks to provide insight on the experience of respondents who purchased individual market coverage on whether it was difficult to find affordable coverage and/or coverage that met their specific need.

The purpose of the analysis is to provide members of the 2019 Affordability Work Group with additional information on 1) the prevalence of chronic disease across age groups (n = 3003), 2) among those with interest in individual market coverage (n = 364), and 3) among those who purchased individual market coverage (n = 277). It is important to note that the data is specific to the Northeast region as the NHIS does not report state-specific geographic data.

MHBE did not perform statistical significance analysis for this white paper. The discussion of the findings is to provide members of the Affordability work group with additional insights on the distribution of chronic disease within the individual market population, contrast this allocation with the sample population, and detail the experience of finding appropriate coverage within individual market participants.

Source information. The source data for this analysis is the 2017 National Health Interview Survey, a comprehensive annual survey performed by the National Center for Health Statistics. The NHIS collects information on medical conditions, health insurance coverage, doctor's office visits, and physical activity/other health behaviors. Historically, the survey has been used to track "health status, health care access, and progress toward achieving national health objectives."

Methods. MHBE utilized the 2017 NHIS Sample Adult file as the base data for this analysis. The file contains survey data from 26,742 respondents to the NHIS. Of this sample 4348 respondents indicated they were from the Northeast region and 3003 respondents reported an age between 18 and 64 years old. Survey data for those older than 65 years old were excluded.

To determine whether a respondent took interest in, and purchased, coverage in the individual market MHBE considered answers of "yes" to the questions in Table 1.

Table 1. Interest in the individual market and associated questions.[15]

Scenario	NHIS Questions
1. Interest in individual market coverage (Interest)	[AINDINS2] DURING THE PAST 3 YEARS, did you try to purchase health insurance directly, that is, not through any employer, union, or government program? Please include insurance you tried to purchase through Healthcare.gov or the [Fill1: Health Insurance Marketplace/Fill2: Health Insurance Marketplace, such as (fill: state exchange name)]. [AEXCHNG] Have you looked into purchasing health insurance coverage through the [Fill: Health Insurance Marketplace/Health Insurance Marketplace, such as {fill: state exchange name}?
2. Purchased individual market coverage (Purchased)	[AINDPRCH] Was a plan purchased?

MHBE bucketed the age variable into the categories listed in Table 2. The shaded frequency columns apply to the Scenario to their right. It is important to note that the category sizes/cut-offs are arbitrary and have been selected for

[14] https://www.cdc.gov/nchs/nhis/index.htm
[15] ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2017/samadult_layout.pdf

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the convenience of the Affordability Work Group, matching the age categories presented in other analyses.

Table 2. Modified Adult Sample file age group frequencies.

Categories (yrs.)	Interest	(%)	Purchased	(%)	Sample	(%)
19 – 34	114	31.3%	83	30%	972	32.4%
35 – 44	58	15.9%	40	14.4%	517	17.2%
45 – 54	82	22.5%	62	22.4%	717	23.9%
55 – 64	110	30.2%	92	33.2%	797	26.5%
Total	364	100%	277	100%	3003	100%

To determine whether a respondent had one or more of six chronic conditions MHBE utilized the same criteria established by the NCHS in their 2009 report *Percent of U.S. Adults 55 and Over with Chronic Conditions.*[16] Respondents who answered "yes" to the questions in Table A (See Appendix) were considered as having the chronic disease associated with the question. Then, MHBE stratified the sample population by respondents who purchased individual market coverage.

To provide insight on the difficulty of finding individual market coverage that was affordable or met the respondent's specific needs MHBE counted respondents that answered "Somewhat difficult" or "Difficult" to the questions in Table B (See Appendix).

Chronic disease prevalence. Figure 1 depicts the prevalence of chronic disease by respondent age category. The data reaffirm commonly held associations of chronic disease and age as the prevalence of one or more chronic diseases increases in older age categories. Notably, the prevalence of more than one chronic disease is higher in the 45 – 54 & 55 – 64 age categories (68% and 74%, respectively) than in the 35 – 44 age category (40%). Additionally, the proportion of respondents with two or more chronic diseases increases as a share of total chronic disease prevalence in older age categories. For example, 25% of respondents with chronic diseases age 35 – 44 have two or more diseases. For respondents in the 45 – 54 and 55 – 64 age categories this proportion increases to 47% and 51%, respectively.

Figure 1.

[16] https://www.cdc.gov/nchs/data/health_policy/adult_chronic_conditions.pdf

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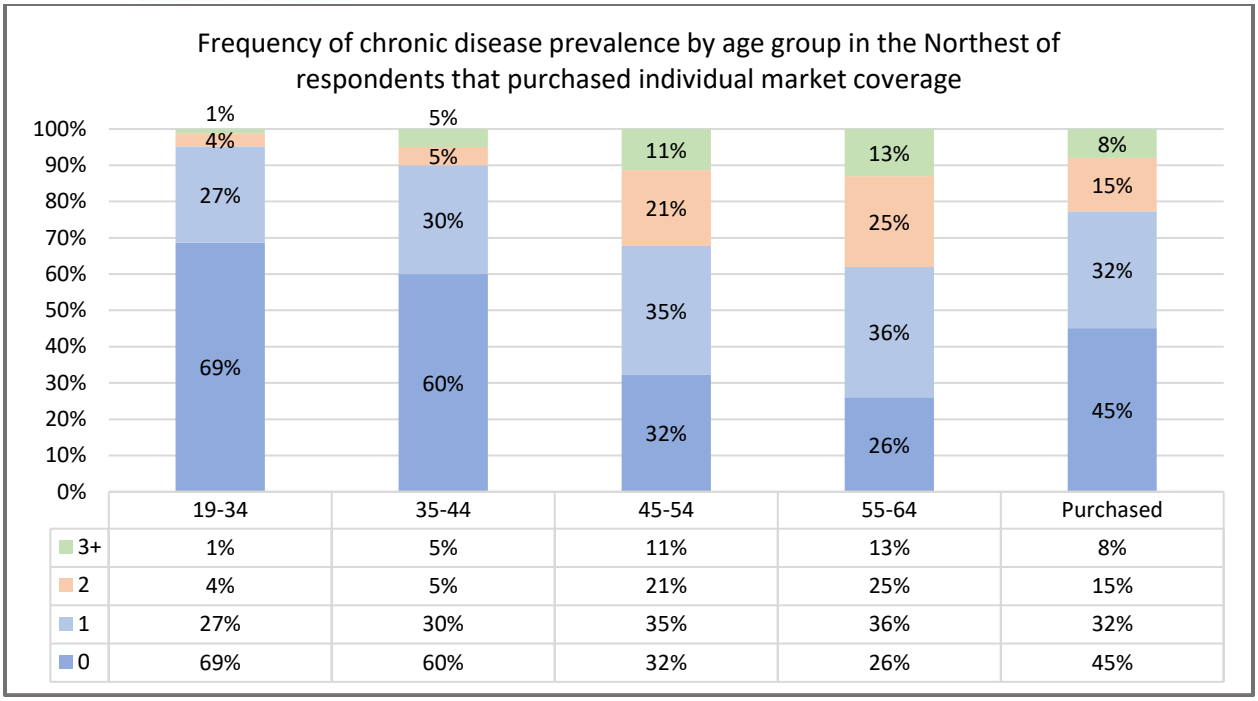

	19-34	35-44	45-54	55-64	Purchased
3+	1%	5%	11%	13%	8%
2	4%	5%	21%	25%	15%
1	27%	30%	35%	36%	32%
0	69%	60%	32%	26%	45%

Table 3 displays the relative prevalence of chronic disease between respondents who purchased individual market coverage (purchased) and the sample population across the age categories. The goal of this comparison was to gather additional insight on whether the purchased population has greater prevalence of one or more chronic diseases than the sample population. The data in Table 3 can be best understood as a metric for comparing the prevalence of chronic disease in the purchased population with the prevalence of chronic disease in the sample population. As an example, a 0% in this analysis would mean that the purchased population has an equal prevalence of chronic disease as the sample population.

Comparing the purchased and sample populations in the aggregate (the bottom right cell of Table 3), the purchased population has a prevalence of chronic disease that is 11% higher than the prevalence of chronic disease in the sample population. Further, when comparing across each chronic disease category (1, 2, and 3+) the purchased population has a higher prevalence of chronic disease than the sample population (9%, 13%, and 16%, respectively).

It is important to contextualize the insights from Table 3 with the age category distribution in Table 2. There is a notable difference between the proportion of the sample and purchased populations in the 55 – 64 age category (26.5% and 33.2%, respectively). Interestingly, when chronic disease prevalence is compared for this age category the purchased population has only 1% higher prevalence of chronic disease than the sample population. If the 55 – 64 age category is overrepresented in the individual market then, from a chronic disease perspective, this category is not disproportionately sicker than the sample population.

Unlike the 55 – 64 age category there appears to be an inverse association with the 45 – 54 age category. While there is a small difference in the representation of this age category between the purchased and sample population (22.4% and 23.9%, respectively), this category has the greatest difference in chronic disease prevalence at 21%.

This initial analysis can inform future research on what the drivers are for individual market participation across age categories. For example it is possible that the previously uninsured may be motivated to enroll in individual market coverage when chronic diseases begin to manifest. Enrollment into coverage by this group, those with emergent symptoms of chronic disease, may drive the differential in chronic disease prevalence for the 45 – 54 age category. This hypothesis may support the 1% difference in chronic disease prevalence in the 55 – 64 age category as chronic diseases that manifested when these respondents were younger already induced this group into maintaining consistent coverage since. When coupled with the additional participation of those 55 – 64 without chronic diseases

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because of increased risk aversion with age, it could be that chronic disease prevalence for this age category could be the same as that of the sample population. This hypothesis may be further supported by this age group having the lowest national uninsured rate across the age bins at 7.9% and the lowest share of the national uninsured population at 12%.[17]

Table 3. Relative prevalence of chronic disease between respondents who purchased individual market coverage and the sample population.

	Diagnosed Chronic Diseases				
Age	**0**	**1**	**2**	**3+**	**Total Chronic**
19-34	-1%	8%	-18%	-22%	3%
35-44	-1%	8%	-45%	85%	1%
45-54	-27%	9%	47%	23%	21%
55-64	-3%	5%	0%	-6%	1%
Purchased/ Sample	-11%	9%	13%	16%	11%

Chronic/non-chronic disease respondent experience. Table 4 provides insight into the association between chronic disease diagnosis and purchasing individual market coverage. For the purchased population, the odds of purchasing individual market coverage is 1.29 higher with a diagnosis of chronic disease compared to no chronic disease diagnosis.

Table 4. Purchasing outcomes of respondents who were interested in purchasing individual market coverage and diagnosis of chronic disease.

n = 364	**Purchased individual market coverage?**		
Chronic Disease	**Yes**	**No**	**Total Interested Pop.**
1-4	42%	12%	54%
0	34%	12%	46%
Total	76%	24%	100%
Odds-Ratio (Chronic vs. No Disease)	1.29		

To provide additional insight into the difficulty of finding coverage that was affordable/met respondent need MHBE considered responses of "Very Difficult" and "Somewhat Difficult" as difficult for the questions in Table B (see Appendix). 57% of respondents who purchased individual market coverage had difficulty in finding coverage that was affordable. Inversely, 58% of these respondents had no difficulty finding coverage that met their specific needs. Further, it was determined that the odds of difficulty in finding an affordable plan is 9.8 higher for respondents who indicated difficulty in finding a plan that met their needs compared with respondents who experienced no difficulty finding a plan that met their needs. It is important to note that these questions may interact as "affordability" is likely an important need for the non-chronic disease population when purchasing coverage.

Table 5. Respondents without chronic disease who purchased individual market plans and their difficulty in finding a plan that was affordable and/or the type of coverage the respondent needed.

n = 125	**Difficulty - Affordable**		
Difficulty – Meets Needs	**Yes**	**No**	**Total**

[17] https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

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n = 125	Difficulty - Affordable		
Yes	35%	6%	42%
No	22%	37%	58%
Total	57%	43%	100%
Odds-Ratio (Chronic vs. No Disease)	9.8		

For Table 6 MHBE performed the same analysis in Table 5 for respondents who have chronic diseases and purchased individual market coverage. The odds of having difficulty finding an affordable plan is 18.2 higher for respondents who also indicated difficulty in finding a plan that met their needs compared with respondents who experienced no difficulty in finding a plan that met their need. As with respondents without chronic disease it is likely that these two questions interact, but in a different manner. For those with chronic disease, affordability issues often compound with plan-specific attributes like benefits, cost-sharing, provider networks, and access to chronic disease/wellness programs.

Table 6. Respondents with chronic disease purchased individual market plans and their difficulty in finding a plan that was affordable and/or the type of coverage the respondent needed.

n = 152	Difficulty - Affordable		
Difficulty – Meets Needs	**Yes**	**No**	**Total**
Yes	40%	10%	50%
No	9%	41%	50%
Total	49%	51%	100%
Odds-Ratio (Chronic vs. No Disease)	18.2		

Discussion. Difficulty finding affordable coverage is an issue for those with, and without, chronic disease. Affordability also interacts with difficulty in finding a plan that meets their, albeit different, needs. When considering options to address affordability issues in the individual market it is important to think through how interventions in plan design can help meet the coverage needs of these disparate populations. For those without chronic diseases it will be important to consider plan features that encourage market participation and appropriate utilization while balancing premium pressures. For those with chronic disease it will be important to consider plan features that encourage maintenance, reduce out-of-pocket costs for prescription drugs, and include benefits that can improve health outcomes and health system savings.

APPENDIX

Table A. Chronic diseases and associated questions.[18]

Chronic Disease	NHIS Questions
Diabetes	[DIBEV1] Have you EVER been told by a doctor or health professional that you have diabetes or sugar diabetes?
Cardiovascular Disease	[HYPEV] Have you EVER been told by a doctor or other health professional that you had... Hypertension, also called high blood pressure? [HYPDIFV] Were you told on two or more DIFFERENT visits that you had hypertension, also called high blood pressure? [CHDEV] Have you EVER been told by a doctor or other health professional that you had ... Coronary heart disease? [ANGEV] Have you EVER been told by a doctor or other health professional that you had ... Angina, also called angina pectoris? [MIEV] Have you EVER been told by a doctor or other health professional that you had ...A heart attack (also called myocardial infarction) [HRTEV] Have you EVER been told by a doctor or other health professional that you had ...Any kind of heart condition or heart disease (other than the ones I just asked about)? [STREV] Have you EVER been told by a doctor or other health professional that you had...A stroke?
Chronic Obstructive Pulmonary Disease (COPD)	[EPHEV} Have you EVER been told by a doctor or other health professional that you had...Emphysema? [CBRCHYR] During the PAST 12 MONTHS, have you been told by a doctor or other health professional that you had...chronic bronchitis?
Asthma	[AASMEV] Have you EVER been told by a doctor or other health professional that you had asthma? [AASTILL] Do you still have asthma?
Cancer	[CANEV] Have you EVER been told by a doctor or other health professional that you had...Cancer or a malignancy of any kind?
Arthritis	[ARTH1] Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

Table B. Questions associated with purchasing individual market coverage.

Coverage Attribute	NHIS Question
Met need	[AINDDIF1] How difficult was it to find a plan with the type of coverage you needed? Would you say…
Affordable	[AINDDIF2] How difficult was it to find a plan you could afford? Would you say…

[18] ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2017/samadult_layout.pdf

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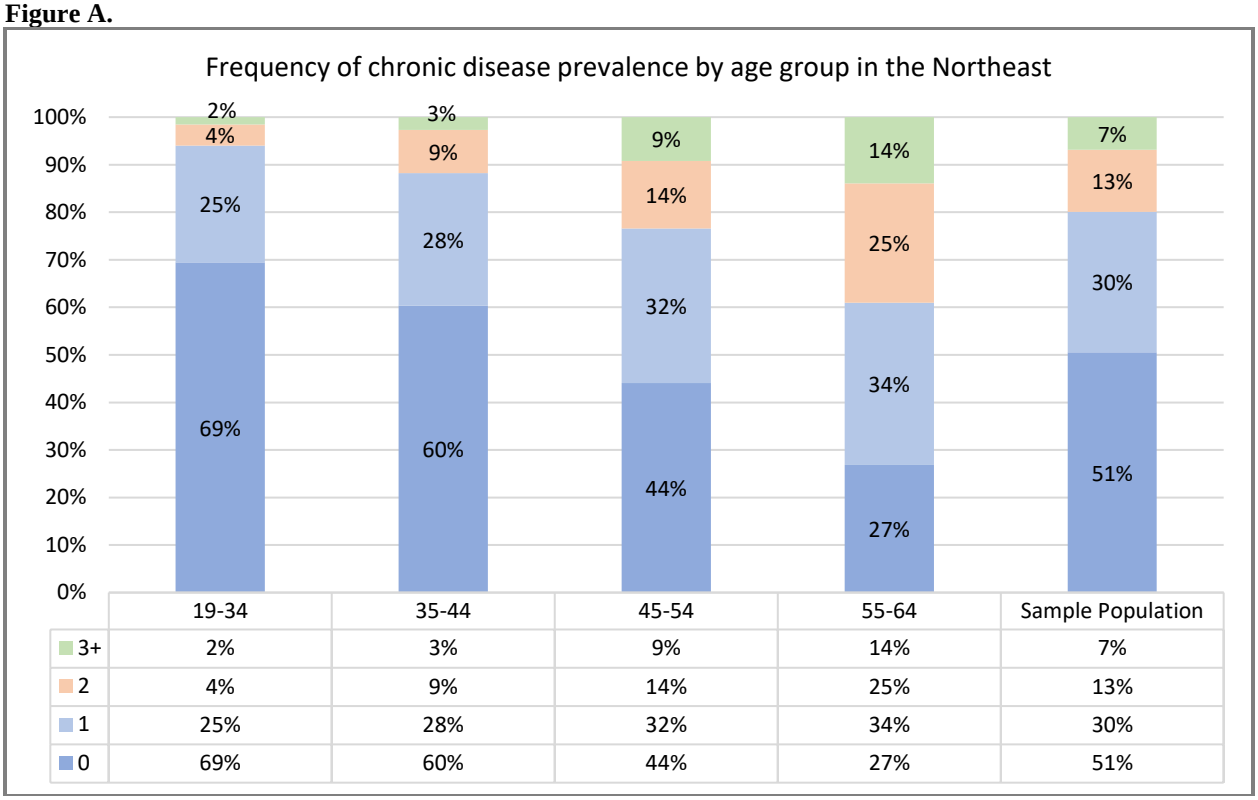
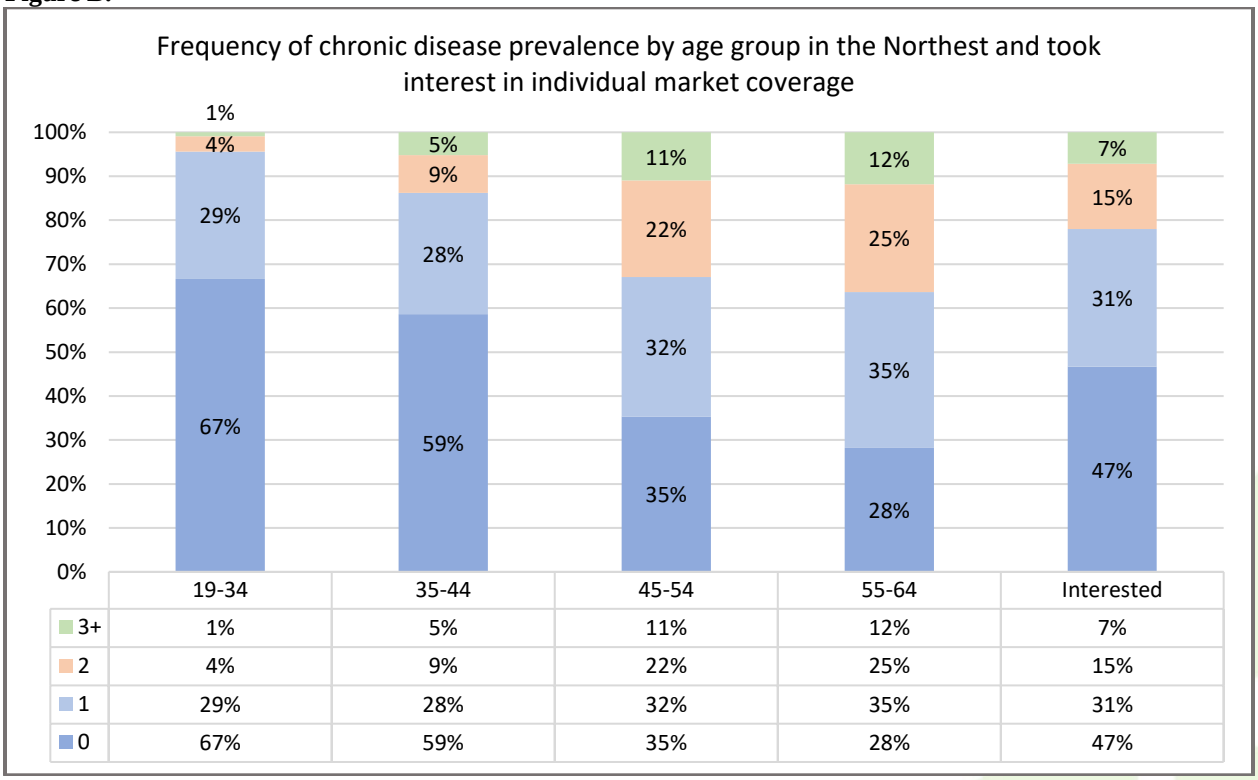
Figure A.



	19-34	35-44	45-54	55-64	Sample Population
3+	2%	3%	9%	14%	7%
2	4%	9%	14%	25%	13%
1	25%	28%	32%	34%	30%
0	69%	60%	44%	27%	51%

Figure B.



	19-34	35-44	45-54	55-64	Interested
3+	1%	5%	11%	12%	7%
2	4%	9%	22%	25%	15%
1	29%	28%	32%	35%	31%
0	67%	59%	35%	28%	47%

Meeting #1 – February 15, 2019

a. Welcome Webinar Materials

Meeting #2 – March 1, 2019

a. **Agenda**
b. **Preferred Provider Organization Analysis**
c. **Presentation**
d. **Covered California - *Key Ingredients to Creating a Viable Individual Market That Works for Consumers***
e. **Minutes**

Meeting #3 – March 15, 2019

a. **Agenda**
b. **Presentation**
c. **Minutes**

Meeting #4 – April 5, 2019

a. **Agenda**
b. **Presentation**
c. **Minutes**

Meeting #6 – April 19, 2019

a. **Agenda**
b. **Presentation**
c. **Minutes**

Meeting #7 – May 31, 2019

a. **Agenda**
b. **Presentation**
c. **Minutes**

Meeting #8 – June 14, 2019

a. **Agenda**
b. **Presentation**
c. **Minutes**