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. In 2018, HHS modified this process to provide states with greater flexibility in determining, updating, or modifying their existing benchmark plans.[2]

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.

Given the shifts to Maryland's health system landscape to incorporate a holistic view of population health (i.e. the Total Cost of Care Waiver), state-wide initiatives to address pressing public health crises (i.e. the opioid epidemic), and the importance of maintaining a benchmark plan that is current with standard medical practice, MHBE sought to gather representative stakeholder insights into whether Maryland should utilize the new EHB flexibilities allowed under federal rule.

In the *2020 Letter to Issuers Participating in Maryland Health Connection (Issuer Letter),* MHBE established that it would provide a report to the MHBE Board of Trustees on the benefits in the State Benchmark Plan to:

1. Determine whether the current benchmark plan meets the needs of the individual market.
2. Provide recommendations on whether to leverage new state flexibility to modify the State Benchmark Plan
3. Report must include feedback from the Standing Advisory Committee~~, market impact of the change, and estimated savings/costs of the approach.~~

[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

4. Report must have a public comment period of no less than 30 days.[3]

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. The report sets forth the collective recommendations and positions of the members, and does not necessarily reflect the individual position of any member and/or the organization the individual represents.

State Benchmark Plan Work Group Membership

The membership of the Work Group represented a diverse set of stakeholders with subject matter expertise to add to 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

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.

[3] Link to *2020 Letter to Issuers Participating in Maryland Health Connection.*

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) who provided a presentation on the 50-state landscape of the Essential Health Benefits included within State Benchmark Plans.[4] The presentation revealed certain characteristics of Maryland's State Benchmark Plan when compared with those of other states.

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 a variability across states in the prescriptions drugs that are included in each state's EHB prescription drug 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.

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 that may be viewed 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 meets of 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) existing benefits should be expanded or subject to appropriate limitation and restriction. 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"). The development of Recommendation 1 used most of the meeting time

[4] Presentation may be viewed in the Appendix under the XX session meeting documents.

between Work Group members and is the result of extensive collaboration and consensus building.

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, including consideration of how any resulting modifications to the SBP would impact specific populations. It is important to note that the recommendation should be read under 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.

    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 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 within the SBP manifest within the marketplace from a unit cost/utilization, how the EHBs are perceived and accessed by marketplace participants, and how the EHBs intersect with social determinants of health. The Work Group also determined that effectiveness research on issuer chronic disease/utilization management programs 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.

Table 2. Recommendation 2 Studies

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. 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	New	Surveys, interviews,	Research Questions:

Study	Existing/New	Methods	Recommendation/Research Question
Experience with Benefits		& focus groups	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? Recommendations: 1. Study should controls 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?
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.

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. 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 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, 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 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, 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, 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 considered feedback from the Standing Advisory Committee (SAC) for this report following the comment period. One stakeholder from the (SAC) submitted comments on the report asking that all State Benchmark work address both the individual and small group market. Another favored a cautious approach of implementing the reports suggestions until the Maryland Health Care Commission had evaluated the merits of the current statutory mandates.

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

MHBE received feedback during the public comment period from a number of individuals and organizations. A consumer advocacy organization cited concerns from some disability rights advocates that utilizing quality-adjusted life years (QALYs) could have a negative unintended consequences for individuals with disabilities as well as those with chronic conditions. They suggested adding an additional research question to the "Study on the Intersection of Social Determinants of Health and Benefits" that would focus on disability and chronic illness intersecting with social determinants of health. This organization also suggested that the provider experience should be evaluated to determine what type of services patients commonly forgo because of cost issues. Additionally, providers may also be able to provide input on the potential effect of eliminating benefits from the essential health benefits.

Furthermore, an individual stakeholder commented that there were insurance access issues beyond the State Benchmark Plan that needed to be addressed before the State should even be able to evaluate current insurance plans.

MHBE evaluated all comments, and made additional changes where staff deemed necessary. A suggestion by a member of the work group to include a clause that states that the report is a collective recommendation of the members of the work group, and not necessarily a reflection of individual positions or positions of organizations represented by members, was incorporated.

Table 3. Commenting Organizations

Organizations Submitting Comments
Kaiser Permanente
Maryland Citizen's Health Initiative
Maryland Attorney General's Office, Health Education and Advocacy Unit
Individual (Name redacted for privacy purposes)