



MHBE

Affordability Workgroup

July 6, 2022

1:00PM – 3:00PM

Via Google Meets

Members Present:

David Stewart, Co-Chair

JoAnn Volk, Co-Chair

Brad Boban

Matthew Celentano

Steven Chen

Lindsey Finne

Maya Greifer

Emily Hodson

Dr. Howard Haft

Neal Karkhanis

Stephanie Klapper

Michelle Livshin

Allison Mangiaracino

Jonathan McKinney

Robert Metz

Lisa Solomon

Andrew York

Staff

Johanna Fabian-Marks

Becca Lane

Members of the Public:

Arissa Falat

Welcome and Roll Call

JoAnn Volk opened the meeting and asked attending members to indicate their presence. She reviewed the agenda.

Survey Feedback

Johanna Fabian-Marks, Director of Policy and Plan Management at the Maryland Health Benefit Exchange (MHBE), discussed the responses to the survey that some workgroup members completed. She expressed that MHBE staff would appreciate a higher response rate but acknowledged that several factors may have made it difficult or uncomfortable for workgroup members to complete this survey. She urged members who had not yet responded to the survey to do so.

The majority of responses that were submitted indicated that MHBE should pursue standardized plans. Those who did not answer “Yes” for this item noted concerns that standardized plans could be less consumer friendly than Value Plans or felt more information was needed about the benefits of standardized plans. MHBE would not be pursuing Standardized Plans if they were less consumer friendly than Value Plans. Ms. Fabian-Marks stated that MHBE staff would act on these responses by collaborating with Lewis & Ellis, Inc. and the Maryland Insurance Administration (MIA) to draft proposed standardized plan designs to present to the workgroup.

Ms. Fabian-Marks then noted that survey results suggested that respondents' preferences about what benefits should be covered pre-deductible largely mirror what MHBE covers in its existing value plans and what is common in standard plans nationwide. This includes primary care, generic drugs, and mental health outpatient visits, with specialists, urgent care, and lab tests of secondary importance. Preferences for the lowest-cost benefits were similar, with diabetes supplies mentioned as an additional priority.

The next survey items centered around whether higher deductibles with more pre-deductible services or lower deductibles with less pre-deductible services were preferable, as well as whether a higher premium for a richer plan or a lower premium for a less rich plan was preferable. These items garnered mixed responses. As such, Ms. Fabian-Marks explained that staff will seek to prepare options reflecting each of these scenarios when working with Lewis & Ellis and MIA to create proposed plan designs.

Other comments shared through the survey included the following: MHBE staff should consider a hybrid of value plans and standard plans where cost-sharing maximums are set but carriers can have lower cost-sharing requirements; plan design should be tailored to each metal level; Maryland should continue to create its own standards rather than following federal models.

Ms. Fabian-Marks sought to assuage concerns about standard plans, stating that any proposed plan would be in the interest of promoting affordability and consumer understanding. She stated that the window for responding to the survey will be extended for two more weeks. She underscored that members do not need to have actuarial expertise to offer valuable opinions on these topics and that everyone should feel free to respond based on their interests and background. She also reiterated that this survey is only to provide initial feedback and will not be interpreted as summarizing the workgroup's recommendations.

Matthew Celentano expressed appreciation for the extended time and stated that he will complete the survey. He noted that responses from workgroup members will likely be colored by their own experience, and he stated that having the conversation be as data-driven as possible would be ideal, perhaps using claims data.

Michelle Livshin expressed a desire to learn more about the benefits and risks of standardized plans and echoed Mr. Celentano's statement that without data points it is difficult not to rely on anecdotes.

Allison Mangiaracino stated that, given her assumption that standardized plans will replace value plans if they are adopted, minimizing member disruption should be prioritized: current value plan enrollees should not have to experience much change year-to-year. She suggested determining cost sharing requirements based on the actuarial value (AV) levels of existing plans. Noting one of the survey questions, she clarified that AV level is not always correlated with the level of premiums; it depends on

the benefits structure, which, she explained, will be an important part of the proposed standardized plans for the workgroup to look at.

Stephanie Klapper affirmed the value of looking at data such as the claims data that Mr. Celentano suggested but countered that hearing about consumers' experiences, including from members of the workgroup, provides valuable nuance that aggregate data may lack. She also noted that looking at concrete proposed plan designs will be helpful.

Dr. Howard Haft noted that both the data-driven approach and the consumer perspective are valuable. He expressed that using data can help not only in determining the specifics of these plans but in moving the state toward lower healthcare costs overall. He suggested using national data on what contributes to lower healthcare costs in addition to Maryland data. He further stated that consumer perspectives offer insights into the ways they choose plans based on their respective life situations.

Lisa Solomon expressed that the introduction of value plans was game-changing for low-income individuals who could not afford high premiums because it allowed them to receive many highly utilized services pre-deductible.

David Stewart agreed with Ms. Mangiaracino about the importance of minimizing member disruption, stating that consumers have appreciated the recent consistency in plans year-to-year. He also encouraged workgroup members who assist consumers directly to contribute more to the conversation because they learn about what consumers like and dislike about plan offerings.

Ms. Fabian-Marks stated that the process of creating proposed plan designs will be innately data-driven because it will use a national dataset of utilization and average claims costs, but she expressed that staff can pull out some of this data regarding the most utilized benefits for the workgroup when they present their proposed designs.

Brad Boban agreed that the process will be data-driven. He cautioned that there may be a high degree of variation in cost-sharing depending on the service category, even among plans that have the same AV. He stated that it will be important to examine the data to ensure that no one service category is overburdened while another is not. He stated that, in addition to the national data on which AV is based, MIA collects aggregate claims data that could be shared with the workgroup. This may be especially important given that some services may be more utilized in Maryland than nationally, meaning that the federal AV calculator may under-weight them.

Emily Hodson expressed that, while quantitative data are important, qualitative data will help with understanding how consumers are using their healthcare and what they need. She stated that people who help consumers directly with enrollments would be good sources for this information, citing the example of hearing directly from consumers in her own work at a federally qualified health center about what is unaffordable to them.

Robert Metz noted that there are two separate issues being considered. The first is how to use the plan certification requirements or the value plan construct to target certain consumer types or medical conditions for savings. He stated that the example of offering \$0 diabetic supplies has been raised and expressed that this does not need to be done within a standard plan specifically. Mr. Metz explained that the second issue under discussion is whether to use standardized plan designs. He called for the workgroup to think about these two issues as separate. He stated that existing plan design differences will likely make it difficult to avoid the member disruption that Ms. Mangiaracino and Mr. Stewart discussed.

Ms. Volk expressed that both quantitative data and qualitative information about how consumers think about coverage are important. She stated that one of the major aims should be to demystify health insurance by offering easily comparable plan options. She also noted that having access to benefits pre-deductible will be key to helping consumers see the value in having insurance. She explained that her preference is to have lower-cost, frequently used services be available pre-deductible and put a lower priority on higher-cost less frequently used services. She acknowledged, however, that there is a trade-off wherein deductibles will grow as more services are added pre-deductible.

Ms. Klapper agreed with Ms. Volk about the necessity to demystify plans for consumers. She expressed optimism about being able to move to standardized plans and help consumers without causing the market disruption about which several workgroup members have expressed concern.

Standardized Plan Concepts Review and Q&A

Ms. Volk reviewed background information on standardized plans, including reviewing the spectrum of standardization levels and policy options associated with standardization. Detailed slides are available in the presentation for this meeting.

Prescription Drug Affordability

Andrew York, Executive Director of the Maryland Prescription Drug Affordability Board, explained drug affordability concepts and reviewed evidence in the research literature. Detailed slides are available in the presentation for this meeting. He stated that there is an inverse relationship between cost-sharing and consumer adherence for medications. Overall, higher cost-sharing showed a neutral to negative impact on total costs.

Ms. Klapper asked for clarification on whether “cost-sharing” refers to deductibles. Mr. York responded that the definition in the research literature generally includes all out-of-pocket costs for consumers, including deductibles.

Mr. York went over categories of policy options for improving drug affordability in exchange plans: separate medical and drug deductibles; pre-deductible drug coverage; and tier design, structure, and standardization. He expressed that it is important to consult the carriers on how they arrived at current models and how those models function, as well as understanding the implications of changing plan designs. He noted

that, in his work with Medicare, premiums were the primary metric that consumers weighed when deciding on plans, meaning that special consideration should be given to how premiums will be affected.

Mr. York reviewed the policy options in greater detail. Separating medical and drug deductibles can avoid prohibitive out of pocket (OOP) costs associated with drugs. This feature is available in Maryland but is not mandatory. This policy option is the most commonly implemented of the 3 categories; California is an example of a state that separated medical and drug deductibles.

Pre-deductible drug coverage is another option that also lowers OOP costs. It can be limited to certain drug types, and Mr. York underscored that which drugs would be eligible would be an important but difficult conversation.

The final option would be to use a policy in the category of tier structure and standardization. Policies to consider include rules for formulary and tier design, copay standardization policies, and policies around no-waste formularies.

Mr. Stewart noted that prescription drug considerations can complicate plan selections significantly, especially as drug tiering has gotten more complex. He expressed the hope that the workgroup will explore the separate drug deductible option because it is a major benefit for many consumers.

Mr. Celentano agreed with Mr. Stewart that prescription drug tiering has gotten more complicated and noted the importance of managing drug spending, especially given that drug costs make up a much a larger portion of premiums than a decade ago.

Mr. Metz agreed that the separate drug deductible option is important to discuss. He stated that there may be significant unintended consequences for overall healthcare costs if formulary design and tiering structure are altered. He noted that carriers may not have all the relevant information about rebating structures because pharmacy benefit managers often handle that.

Mr. Boban clarified that there are currently value plans with a separate drug deductible. He expressed support for separate drug deductibles, identifying integrated drug deductibles as a major barrier to consumers' access to drugs. He stated that integrated drug deductibles have increased so much that many consumers are paying 100% of their drug costs. He stated that value plans currently only put a cap on medical deductibles, not drug deductibles, and he expressed that the next iteration of plans should standardize integration and non-integration of drug deductibles. He agreed with Mr. Metz about the infeasibility of changing formulary design at this point but contended that standardization of which tiers are covered pre-deductible should be on the table, along with the level and integration of drug deductibles.

Ms. Klapper expressed that nonadherence may often mean that consumers are not able to afford the drugs they need, and she noted that this can lead to hospitalization or

death. She reported feeling disturbed at the findings that having a copay for drugs can result in nonadherence and that a high total cost for all of a consumer's drugs may result in them being unable to afford any of their medication.

Dr. Haft argued for pre-deductible coverage without a copay for diabetes drugs. He explained that the disease is the number one medical priority across the state and has a disproportionate impact on people of color and poorer individuals. He expressed that it would be unconscionable to impose any limitations on drug access and argued that access should not be limited to particular drug tiers because medications above the generic tier have proven far more effective for some of diabetes' most serious effects. He stated that hypertension drugs may be a secondary concern that also demands similar access.

Ms. Volk asked if there is a policy option that Mr. York considers most essential for consumers with multiple scripts, expressing that even low co-pays can add up and make adherence a challenge. Mr. York responded by noting that the scenario Ms. Volk discussed is plausible and demands consideration, perhaps with parameters like total OOP cost maximums. He stated that there is no one option that has proven especially important within the current evidence base, and he invited any representatives from the carriers to weigh in.

Ms. Hodson expressed support for the separate drug deductible option. She asked whether establishing a maximum for prescription drugs in a plan year that is separate from a plan's OOP maximum is an option. She acknowledged that changing tiering structures may be too complicated at this stage. Mr. York replied that establishing a separate OOP maximum for prescription drugs could be possible but that there could be unintended consequences as a result.

Ms. Hodson asked whether data are available on the amount of people whose coverage was terminated during the plan year due to nonpayment of premiums as well as the amounts of those premiums. Ms. Fabian-Marks responded that MHBE does have some data on the number of people terminated for nonpayment and data on termination for nonpayment due to consumers feeling the cost for coverage is too high, but she is not confident in the data quality; MHBE is currently trying to improve the data quality. Mr. York added that the All Payer Claims Database is an option, and the Center for Consumer and Insurance Oversight (CCIIO), the federal agency that coordinates exchange plans, also has an extremely robust dataset that could be used.

Ms. Solomon expressed that, especially for Medicare beneficiaries who have transitioned from group insurance, copays can be completely unaffordable even after consumers have met their deductibles. She stated that she has often had to use drug manufacturer patient assistance programs, which many people are unaware of but which can provide no-cost medication.

Follow-Up from Session Two

Ms. Fabian-Marks presented additional information gathered after the previous meeting in response to questions from workgroup members about what limits on cost sharing exist within state law. Detailed slides are available in the presentation for this meeting. Limits exist on copays for prescription drugs and specialty drugs specifically, diabetes drugs, and contraceptives, along with some miscellaneous limits.

Noting the cap of \$150 for a 30-day supply of specialty drugs, Ms. Volk asked whether only certain tiers of specialty drugs are included.

Mr. Stewart commented that the variation in tiering and formularies makes these plan components difficult to navigate for people involved in consumer assistance, especially when working with consumers who have many prescriptions.

Mr. Boban responded to Ms. Volk's question with the statutory definition of a specialty drug. Ms. Volk asked whether there is an explicit list of drugs that MIA produces. Mr. Boban responded that there is not an explicit list; instead, carriers use the criteria laid out in law to draft formularies, which MIA reviews.

Ms. Volk asked whether the criteria result in variation among which drugs different carriers interpret as specialty drugs. Mr. Boban responded that the regulation only lays out the requirements for the minimum amount of drugs that carriers classify as specialty drugs, and there may be some cases wherein specialty drugs could be put on the non-preferred tier but still fall under the specialty drug coinsurance cap, so more drugs may be included in certain carriers' lists.

Mr. Metz stated that having a centralized list would be challenging because of how much change happens regularly in the drug market, including price changes and the introduction of new drugs, necessitating that carriers update their formularies regularly. He expressed that the statute's intention was to create a broad definition, and he stated that this example illustrates the difficulties involved in formulary standardization.

Discussion

Ms. Fabian-Marks asked for feedback on whether MHBE should move toward standard plans, as well as considerations involved in that transition. Secondly, she asked for thoughts on how to differentiate value plans and standard plans, suggesting the options of continuing to include "Value Plan" in the plan name or perhaps using an icon to denote these types of plans.

Ms. Volk added that it is important to consider the order in which plans are displayed, what plan components are displayed, and how consumers can sort through plans to find the value and standard plans.

Ms. Mangiaracino argued for seeking to minimize the impact on overall AV levels of offering zero cost sharing for diabetes treatment. She agreed that diabetes is an important health concern and that high cost sharing can discourage consumers from

seeking treatment but argued against causing patients with other chronic conditions to pay more for treatment to accommodate major cost share waivers for diabetes services.

Mr. Boban commented that bronze AV is difficult, so bronze may need to be excluded from changes that would preferably be made to every metal level. There is more room for trade-offs within the silver and gold metal levels.

Mr. Metz expressed support for the idea of a value plan or standard plan icon and emphasized the importance of communicating the distinct differences between standard plans and other plans, including differences in benefits, formularies, and networks.

Ms. Hodson agreed that an icon associated with standard plans and value plans would be helpful and should explain what is included, what differentiates it from other plans, and why it is called a standard or value plan.

Mr. Stewart floated the idea of drawing attention to the cost sharing reduction (CSR) levels for silver plans; other marketplaces have done so.

Mr. Boban stated that value plans currently do not have restrictions on CSRs, resulting in variability in CSR plans. He argued for clearly delineating CSR plans in addition to value or standard plans given that CSR members are the most cost-sensitive.

Jonathan McKinney expressed support for moving toward standard plans but argued for evaluating the pieces of value plans that have worked and integrating those into standard plans.

Ms. Klapper highlighted the importance of including standard and value plans in the search and filter features on the exchange in addition to the plan names and icons. Ms. Fabian-Marks clarified that this feature is in place currently for value plans and would be retained for standard plans.

Ms. Volk urged workgroup members who have not yet completed the survey to do so.

Ms. Fabian-Marks gave the workgroup several questions to consider in preparation for the discussion for the next meeting. The full list is available in the presentation for this meeting.

Building on Mr. McKinney's point, Ms. Volk asked whether there are data that suggest certain aspects of the value plan have been especially effective. Ms. Fabian-Marks responded that MHBE worked with the Hilltop Institute to examine value plan utilization in the first year of the plans being available and that she can follow up with information from that analysis.

Public Comment

None offered.

Adjournment

The meeting adjourned at 2:56 pm.

Chat Log

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Johanna Fabian-Marks -MHBE-: Specialty drug definition:

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Johanna Fabian-Marks -MHBE-: + statute specific to diabetes & HIV/AIDS:

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