MHBE

Affordability Workgroup

August 31, 2022
1:00PM – 3:00PM
Via Google Meets

Members Present:
David Stewart, Co-Chair
JoAnn Volk, Co-Chair
Brad Boban
Steven Chen
Maya Greifer
Allison Mangiaracino
Jonathan McKinney
Emily Hodson
Lisa Solomon
Evalyne Bryant-Ward
Howard Haft
Matthew Celentano
Andrew York
Robert Metz

Staff
Johanna Fabian-Marks
Becca Lane

Members of the Public
Neal Karkhanis
Philemon Kendzierski

Welcome and Roll Call
David Stewart welcomed attendees to the meeting. He stated that there are two more meetings after today's meeting. Johanna Fabian-Marks, Director of Policy and Plan Management at the Maryland Health Benefit Exchange (MHBE), added that MHBE is hoping to finish consideration of the plan designs during the course of these final meetings. She also stated that they would like to discuss aspects of the Young Adult Subsidy Program with the Workgroup, but they may reconvene the Workgroup for an ad hoc meeting later in the year if data from an analysis of the subsidy program is not available by the final meetings in September.

Review of Feedback on Second Draft Plan Designs
Ms. Fabian-Marks went over the feedback on the plan designs from the last meeting. Feedback included the following: make preferred brand drugs pre-deductible; make outpatient facility plus outpatient surgery physician copays less than inpatient copays; reduce copays for preferred brand drugs for Base Silver and Cost-Sharing Reduction (CSR) 73% plans; allow carriers to cover telehealth with lower copays.

Updated Standard Plan Designs for Review
Ms. Fabian-Marks went over the changes that were made in consultation with Lewis & Ellis, Inc. Changes included making preferred drugs pre-deductible for the Gold plan and reducing copays for outpatient facility fees and outpatient surgery physician/surgical

services so that their combined total is less than the inpatient hospital services copay for the Base Silver and CSR 73% plans. Ms. Fabian-Marks presented comparison graphics showing the changes and the revised plans for all metal levels. These graphics are available in full in the presentation for this meeting.

Preferred brands were not made pre-deductible for the CSR 87% and the CSR 73% plans because the impacts on actuarial value (AV) would have been too large. The requested decrease in copays for preferred brand drugs Base Silver and CSR 73% plans also could not be achieved due to the AV impact, but Ms. Fabian-Marks noted that enrollment in these plans is very low and that their enrollees would generally receive better value from the Gold plan, meaning that sub-optimal benefits for these plans will have minimal adverse impact.

Regarding the discussion on whether to allow copays for telehealth to be lower than in-person services, Ms. Fabian-Marks noted that MHBE is comfortable allowing this, and carriers expressed that they appreciate the flexibility. She welcomed further feedback from the Workgroup. She also noted that there is currently not a clear way to display on Maryland Health Connection (MHC) that certain plans offer lower copays for telehealth.

Allison Mangiaracino stated that she appreciates the changes to copays for outpatient services as well as the efforts to reduce copays for preferred drugs. She asked whether it is possible to combine cost shares for outpatient facility and physician fees. Ms. Fabian-Marks responded that MHBE staff will discuss and reach out with an answer.

Mr. Stewart noted that the change Ms. Mangiaracino proposed would be consumer-friendly and would help navigators. He stated that the facility fee is currently the only thing that is shown when navigating plans with consumers, leading many navigators to erroneously assume that the two fees were already combined.

Dr. Howard Haft agreed that the change sounds consumer-friendly but urged that it be vetted to determine whether it causes downstream issues for counting relative value units for each provider and institution involved in care.

Maya Greifer noted that there is a field in the Plans and Benefits Template (PBT) related to outpatient fees, so it would be important to think about what the expected input for that field would be if the fees are combined, as well as how to communicate that to issuers.

Emily Hodson agreed that it would be helpful to combine the fees, but she noted that if downstream issues make that infeasible, just having them displayed transparently on MHC so that navigators do not have to go digging for them would be helpful.

Brad Boban stated that outpatient surgery is sometimes performed not in outpatient facility but instead in an office visit, where a facility fee is not charged. He asked how

these cases would be handled. Ms. Greifer agreed, noting that these types of situations do happen.
JoAnn Volk asked for clarification on whether outpatient services always entail facility fees. Mr. Boban responded that there is a facility fee whenever a service is performed in an outpatient facility but that a doctor's office does not bill a facility fee. He suggested that an answer could be to bill the specialist copay in that case.

Ms. Fabian-Marks then introduced the new services that MHBE staff are proposing to standardize. She presented a graphic detailing the new services, which is available in the presentation for this meeting. These services are on the Summary of Benefits and Coverage (SBC) document that insurers provide but not on the AV calculator, as the services are common enough to be on the SBC but not common enough to have an AV impact. Other states with Standard Plans have these services standardized, and the copays/coinsurance for each service is derived from what carriers are charging in Value Plans and the levels at which other states set copays/coinsurance.

Next, Ms. Fabian-Marks highlighted some of the new services. Durable Medical Equipment (DME) was the only service for which MHBE staff are proposing a coinsurance percentage rather than a fixed copay because there is a variable range of items and associated costs included in DME. This is common among other states' Standard Plans.

All of the new services are pre-deductible, with the exception of DME and Home Health Care Services. For Habilitation Services, Outpatient Rehabilitation Services, and Substance Abuse Disorder Outpatient Services, copay amounts were set equal to the copay amount generally used for office visits in similar service categories. Copays for Hospice Services were set at $0, as was the case in several Value Plans. The copay for Urgent Care Centers or Facilities was set at a level greater than a primary care provider visit but less than an emergency room visit.

Ms. Fabian-Marks asked for feedback on the Inpatient Physician and Surgical Services copay, which is charged per-doctor-visit while in the hospital, separate from the Inpatient Hospital Services fee. One other state only has a total Inpatient Hospital Stay copay and does not break copays down by services. Ms. Fabian-Marks asked for the Workgroup's thoughts on whether to keep the two fees separate or combine them, noting that a single combined copay would be higher but would be a flat rate.

Discussion
Dr. Haft asked how the Inpatient Physician and Surgical Services copay would be incorporated into a combined Inpatient Hospital Stay copay given the variability in the number of providers that see a consumer. He noted that copays mounting up could be worrying for a consumer, and there may be little oversight over what constitutes a visit by a consultant while in the hospital.

Ms. Fabian-Marks asked Mr. Boban for feedback on how MHBE could approach combining the copays. Mr. Boban responded that they could theoretically get the

average number of physician visits per admission. He acknowledged that there is a great deal of variability, though, and it raises the question of whether a simple hospital visit should have the same cost-sharing as a long, complex visit with many providers involved. Some states solve this by applying a coinsurance to physician services so that seeing more physician services results in higher cost-sharing.

Ms. Volk asked whether there are data available to compute an average number of physicians per admission. Ms. Fabian-Marks responded that they could ask carriers for that data or could use the All-Payer Claims Database (APCD). She noted that they could ask for data on those with less than average numbers of services specifically.

Ms. Volk asked whether having data on length of stay would be helpful, as there could be a correlation between length of stay and the number of providers seen.

Mr. Boban stated that one drawback of using the per-admission copay as opposed to a per-day copay is that having everyone pay the same amount no matter how many days they spend in the hospital advantages some and disadvantages others.

Mr. Stewart stated that because the Inpatient Hospital Services fee is per admission, the impact of the copays is lessened compared to a per-day copay. He noted that copays for emergency department (ED) visits are all-inclusive no matter how many providers are seen. He expressed support for having a separate, per-doctor copay, as is the case currently.

Evalyne Bryant-Ward stated that it will be difficult to parse out inpatient and ED utilization data by provider. She expressed that her organization has patients from DC to Virginia who go to the hospital and are attributed to each provider they see. She expressed that coinsurance would deter high utilizers from using the ED frequently and that it would be fairer to patients who use the ED more rarely.

Ms. Volk asked whether there is a wide range of ED utilization in the data that Ms. Bryant-Ward has seen. Ms. Bryant-Ward responded in the affirmative, noting that some consumers never use the ED while others use it frequently when they do not need to, representing a hurdle for identifying providers and tracking utilization.

Ms. Fabian-Marks stated that, if the data cannot be retrieved from carriers or the APCD in time, the Workgroup seems amenable to leaving the Inpatient Physician and Surgical Services copay separate from the Inpatient Hospital Services fee. She noted that these copays could be refined in future years.

Ms. Hodson agreed that charging a low coinsurance percentage for inpatient physician fees would be helpful, noting that consumers have no say in how many doctors see them or in the quality of care they are given in an inpatient setting. She expressed that having urgent care copays that are in between the levels of a specialist copay and an ED copay could help deter frequent ED users.

Mr. Stewart expressed that this issue may be similar to DME in that coinsurance is appropriate because of the variability involved. He noted that consumers struggle with coinsurance, but these services should not be used regularly anyways. He expressed curiosity about the carriers' thoughts.

Rob Metz stated that there is high variability in the category of DME, making it difficult to establish a copayment structure. He asked whether the proposal is to move ED visits to coinsurance. Ms. Hodson responded that the discussion is regarding whether inpatient physician fees should be billed as copays or coinsurance, and she expressed that coinsurance may be more affordable.

Ms. Fabian-Marks clarified that the original discussion was surrounding whether there should be one flat, combined Inpatient Hospital Stay copay but that the variability in charges that consumers incur led to the current discussion.

Mr. Boban expressed that coinsurance or copay are both fine, as either would scale with the number of physicians seen. He stated that unlinking the payment amount from physicians and putting it only on the facility is the concern, as it is very different from other states and removes the charge from the number of physicians you see. He asked for comments from carriers on the proposal to unlink the charge from the number of physicians seen.

Dr. Haft explained that copays are an incentive to use services appropriately. He stated that, because consumers have no control over the number of physicians seen during an inpatient visit, per-doctor-visit copays do not serve as a tool to change consumers' behavior in that setting. He expressed that, if there must be a copayment, he supports a per-day copayment independent of the number of providers seen.

Ms. Greifer noted that her organization attaches a flat coinsurance rate to Inpatient Surgical Services regardless of whether the Inpatient Facility Fee is a copayment or coinsurance. She stated that there are places to input Inpatient Physician and Surgical Services into the PBT and SBC documents, so there would need to be ways to complete those documents if only a combined Inpatient Hospital Stay copay was charged.

Ms. Mangiaracino agreed with Dr. Haft's point about copays' lack of function as an incentive in an inpatient setting. She stated that her organization could administer the fees combined or separately.

Mr. Metz noted that it would be important to understand feasibility on the PBT side but also the AV impact, as input on the AV calculator likely aligns with current industry practice, so change like this might require off-calculator work.

Mr. Stewart asked whether any Workgroup members have strong feelings about this, suggesting that the issue be revisited when the time comes to make more changes. He

stated that the Workgroup might not have enough knowledge at this point to fully understand the impact of such a change.

Matthew Celentano agreed. He further stated that facility fees are confusing to consumers and have almost nothing to do with the carrier, so conflating facility fees with plan design derails the discussion.

Ms. Volk agreed, expressing that she does not want to keep pushing here at the risk of squeezing out other services because of the AV impact.

Ms. Fabian-Marks stated that MHBE staff will follow up with the carriers about various options that were discussed but that the inpatient copays may just stay as they are. She welcomed further feedback from workgroup members.

Next, Ms. Fabian-Marks shared the proposed plan benefits for pediatric vision coverage, developed in consultation with Lewis & Ellis, with the caveat that Workgroup members did not have much time before the meeting to review the proposal; she invited feedback after Workgroup members had digested the information. The proposal aligns with the most common plan design found in other states' Standard Plans: no cost sharing for children's vision services; $0 copay for all metal levels. She asked for feedback from the Workgroup regarding the ideas of incorporating a dollar limit on frames and a quantity limit of one pair of glasses per year or a twelve-month supply of contacts per year, all of which are common practices in other states.

Mr. Metz acknowledged that quantity limits exist on other services but noted that this is not common for Standard Plans, which usually focus only on cost-sharing.

Ms. Volk asked if the question is whether standardized plans should impose a limit or whether they should simply allow carriers to set limits. Ms. Fabian-Marks responded that she was asking about imposing limits but that allowing carriers to set their own limits is another possibility for consideration.

Ms. Hodson expressed support for allowing carriers to set limits, as it gives carriers autonomy over their plans and benefits and lets consumer shop for plans between carriers based on benefits.

Ms. Volk asked whether limits on frames need to be on the number of frames because pediatric vision falls under Essential Health Benefits (EHB), for which dollar limits are prohibited. Ms. Fabian-Marks responded that her recollection is that dollar limits are used in the market and that she would need to check.

Ms. Volk stated that the issue of limits is worth clarifying given the potential adverse impact associated with them.

Mr. Stewart noted that a tiny percentage of people are affected by these limits and argued for letting the carriers continue to set their own limits.

Mr. Metz stated that, for his organization, there are no dollar limits, but there are quantity limits. He expressed that he would need to check on the limits allowed for frames, as he is not clear on what specific pediatric vision services are included in EHB.

Ms. Greifer stated that her organization imposes dollar limits on frames and that EHB regulations allow them to do so. She noted that benefits in this area are identical across all plans offered by her organization, with no cost-sharing specific to any plan.

Lisa Solomon noted that, in addition to quantity limits, a replacement pair of glasses is usually offered if a pair is lost or broken.

Mr. Boban stated that the contract language does not appear to reflect the replacement pair benefit.

Ms. Volk asked Mr. Boban whether carriers can impose dollar limits. Mr. Boban responded that carriers cannot set an annual dollar limit but can set an allowed amount for each individual service. He stated that the benchmark plan sets the most restrictive quantity limit – one frame, one eye exam. Carriers cannot be more strict than that, and most have followed the benchmark plan.

Ms. Fabian-Marks noted that the Workgroup's feedback seems to indicate a preference for simply setting the copay and allowing carriers to set their own limits.

Next, Ms. Fabian-Marks presented a set of proposed pediatric dental services categories, the list of which is included in full in the presentation for this meeting. She explained that dental benefits typically have categories with many detailed coded services under each class of benefits, each with its own copay. She asked whether the five categories presented look accurate and comprehensive. She further asked whether it would be feasible to have a single copay associated with each category rather than for each individual service, a notable departure from what is currently done in the market.

Ms. Fabian-Marks presented what other states have done with pediatric dental benefits in their Standard Plans. California has no charge for Diagnostic and Preventive Services and coinsurance for other services in their Silver and Bronze Plans but a copay schedule for Gold. She showed a sample of California's copay schedule, which can be found in the presentation for this meeting. DC has copays for common services and left other copays up to carriers.

Mr. Metz stated the categories make sense. He explained that the challenge is that cost varies widely within the categories, so applying a single copayment would make you overcharge significantly for some services and undercharge for others. This could introduce the problem of copayments that are more than the allowed amount. He recommended starting with coinsurance, noting that the copayments that result from standardization for pediatric dental services can be unattractive to consumers.

Ms. Mangiaracino agreed with Mr. Metz about the challenges introduced by variability in the price of services. She suggested that, for services not in Class 1 (for which there is no charge), the carriers' copay schedules should apply, or coinsurance should be used.

Mr. Boban stated that the standalone dental market is primarily coinsurance-based, meaning most consumers with standalone dental policies are used to paying coinsurances.

Mr. Stewart agreed, noting that dental is complicated. He noted that comparing dental plans is very difficult and asked whether there would be a standardized way of displaying plans on MHC. He also noted that a very small percentage of the Qualified Health Plan (QHP) population uses pediatric dental, so there is not much to do in that space.

Ms. Fabian-Marks stated that MHBE will propose standard coinsurance rates based on what is present in the market and share those with the group for feedback. She noted that about 10,000 children are enrolled in QHPs, representing about 6% of enrollment.

Mr. Stewart noted that this population is heavily weighted toward high income levels. Ms. Fabian-Marks agreed, as lower-income children are largely enrolled in Medicaid or the Children's Health Insurance Program.

Next Steps
Ms. Fabian-Marks reiterated that MHBE staff will propose coinsurances for pediatric dental and follow up with carriers on inpatient charge structures. She stated that the goal is to finish the Workgroup's tasks by the end of September. MHBE staff are working on a draft report of the Workgroup's recommendations and will share the finished draft, with the goal of having a vote by the end of September to finalize recommendations around Standard Plans.

The next meeting will be on September 14th at 1:00 pm.

Public Comment
None offered.

Adjournment
The meeting adjourned at 2:23 pm.

Chat Log
There were no chat messages during this meeting.