North Dakota Insurance Department

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Jon Godfread, Commissioner

NovaRest ACTUARIAL CONSULTING

JWHammer LLC

Access, Analysis, Results

Review & Evaluation of Proposed Changes to the North Dakota EHB Benchmark Plan

September 15, 2022

Commissioner Jon Godfread

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Agenda

1. Study Background
2. Funding & Implementation
3. Intent of the Study
4. What is an EHB Benchmark Plan?
5. Selecting a New EHB Benchmark Plan
6. Cost Difference
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8. Benefit Details and Costs
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Study Background

North Dakota's health care market has experienced **significant strains in recent years.**

- In rural regions that have seen **escalating premiums** on individuals and small businesses that must purchase in the individual and small group markets.
- These forces have prompted **significant concern** in the State surrounding how best to rein in spending while **ensuring access to affordable, high-quality health care services and coverage**.
- NDID is adequately assessing market activities, **identifying areas of potential change**, and strengthening the market to ensure compliance with plan availability, affordability and renewability.
- As NDID continues its efforts to promote and strengthen North Dakota's health insurance market, this study is **providing vital information necessary to aide in future decision-making** and program participation.

Funding & Implementation

FUNDING:

- North Dakota is reviewing its essential health benefits EHB Benchmark (EHB) plan and has thus received federal funding to conduct same.
- Funding Source**: Federal State Flexibility to Stabilize the Market Cycle II Grant Program**
- NO State funding has been utilized to conduct this study.

IMPLEMENTATION:

- NDID hired JWHammer, LLC to provide Program Manager Services and NovaRest to provide actuarial analysis as a Grant Studies Vendor.
- They have analyzed the potential changes to the current North Dakota EHB Benchmark Plan through a Study.

Intent of the Study

- Enhance and support the role of North Dakota implementing and planning for federal market reforms and consumer protections
- Legal Support for Consumer Protection
  - Section 2702 (Guarantee Availability of Coverage)
  - Section 2703 (Guarantee Renewability of Coverage)
  - Section 2707 (Nondiscrimination under Comprehensive Health Insurance Coverage-Essential Health Benefits Package) of Part A of title XXVII of the Public Health Service Act.

What is an EHB Benchmark Plan?

- A set of benefits required to be offered by all individual and small group Affordable Care Act (ACA) plans in the state of North Dakota.
- Changing the EHB Benchmark plan would change the required ACA benefits to be offered in the individual and small group ACA plans in North Dakota.
- Approximately 11% of the ND population would be impacted by EHB Benchmark plan changes.

Selecting a New EHB Benchmark Plan

- Option 1: Selecting the EHB Benchmark plan that another state used for the 2017 plan year.

- Option 2: Replacing one or more categories of EHBs under its EHB Benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB Benchmark plan that another state used for the 2017 plan year.

- **Option 3: Otherwise selecting a set of benefits that would become the state's new EHB Benchmark Plan.**

Selecting a New EHB Benchmark Plan

Current HHS rules concerning state selection of a new EHB Benchmark plan contain 2 important requirements. The requirements for the new EHB Benchmark plan are that the new EHB Benchmark plan must:

- Provide a scope of benefits that is **equal to, or greater than**, the coverage within each EHB category, of the benefits provided under a typical employer plan, and

- **Does not exceed the generosity** of the most generous among the plans considered when selecting the current EHB Benchmark plan.
    - The maximum value of added benefits is the difference in value between the current EHB Benchmark Plan and the richest of the 10 EHB Options
    - North Dakota would have to pay for benefits in addition to this value or required as a mandated benefit
- This set of comparison plans for purposes of the generosity standard includes the state's new EHB Benchmark plan adopted for the 2017 plan year, and any of the state's options considered for the 2017 plan year.

Selecting a New EHB Benchmark Plan

What did the Study find?

- The most generous plan considered when selecting the EHB Benchmark effective in 2017 was the Federal Employees Health Benefit Plan (FEHBP).
- Necessary to compare these two plans: Federal Employee Health Benefit Plan (FEHBP) – Richest of 10 Options AND BlueCare 90 500 – The current ND EHB Benchmark Plan
- How? Compared the benefits between these two plans and priced differences to determine dollar amount difference
- The difference between the most generous plan FEHBP and the current EHB Benchmark Plan is **$2.42**.
- Therefore, the value of any additional benefits to the EHB Benchmark Plan cannot exceed $2.42.

Please visit the full study for citations and additional information and analysis.

Cost Difference

- Value of the benefits covered in the FEHBP plan not covered in the current EHB Benchmark plan - $3.11
- Value of the benefits covered in the EHB Benchmark plan not covered in FEHBP as $0.69
- The result is then that additional benefits can be as much as $0.69 less than $3.11 or $2.42
- If some of the current EHB benefits are eliminated, it could increase the amount that could be added in benefits
- When surveyed, carriers did not believe that any benefits should be eliminated

- FEHBP includes adult dental $3.93 – did not consider because it cannot be EHB
- FEHBP includes treatment for gender dysphoria $0.21 – did not consider because it may be currently covered in EHB Benchmark Plan due to new CMS discrimination guidance

Please visit the full study for citations and additional information and analysis.

Cost Difference: New Benefit Estimates

Alternative EHBs for Consideration in the Benchmark plan					
		NovaRest Estimate		Issuer PMPM Range	
		PMPM Estimate	% of Premium	Minimum	Maximum
Alternative EHBs for Consideration in the Benchmark plan	Restricted Cost Sharing for Diabetes	$0.43	0.09%	$0.00	$1.49
	Infertility	$2.38	0.48%	$1.98	$24.85
	Hearing Loss/Aids-all ages	$0.55	0.11%	$0.00	$0.50
	Nutritional Counseling and Therapy	$0.03	0.01%	$0.00	$0.50
	Periodontal disease in med plan	$0.10	0.02%	$0.00	$31.35
	Private Duty Home Nursing	$1.15	0.23%	$0.00	$9.00
	PET scans for prostate cancer	$0.13	0.03%	$0.00	$0.50
	Combating opioid epidemic	$0.05	0.01%	$0.00	$0.50
	Medication Optimization	$0.00	0.00%	$0.00	$0.50
	Total estimated impact to premium	$4.82	0.97%		

Please visit the full study for citations and additional information and analysis.

How were these estimated by the actuaries?

- Team members estimate the cost of each proposed benefit
- Entire actuarial team reviewed the assumptions and approach
- Impact estimates were based on prior estimates, other state estimates, or new modeling
- Carriers also provided their estimate
- Providers were interviewed

Diabetes - $.43 PMPM

Details:

- Limited cost sharing for 30-day supply:
  - Prescribed insulin drugs not to exceed twenty-five dollars regardless of the quantity or type of insulin.
  - Prescribed medical supplies for insulin dosing and administration not to exceed twenty-five dollars regardless of the quantity or manufacturer of supplies.

- The proposed benefit would not add new benefits or services, but instead would limit the member cost sharing for the insulin and supplies specified above.

Cost:

- The estimated gross cost of adding the proposed insulin cap is $0.66 PMPM or about 0.13% of premium, however, some issuers have already implemented member cost sharing which are lower than the proposed $25 monthly cap. Therefore, the net cost of implementing the insulin cap is approximately $0.43 PMPM or about 0.09% of premium.

Infertility Treatment - $2.38 PMPM

Details:

- Analyzed the impact of North Dakota House Bill No. 1147. (HB 1147) on the individual and small group ACA compliant market which would provide for diagnosis, preservation, storage, and infertility treatment where medically necessary up to **a maximum $50,000 per covered individual**.
- The definition of medically necessary is (1) consistent with findings and recommendations of a licensed physician or (2) consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in any aspect of reproductive health, such as the American society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or (3) clinically appropriate in terms of type frequency, extent, site, and duration.
- Coverage for diagnosis of infertility, fertility preservation, gamete storage, and fertility treatment where medically necessary. As a result of these benefits, we also estimate the cost of additional live births.
- Due to ACA prohibition on dollar limits this will have to be converted to number of services, rather than $50,000 maximum.

Cost:

- Estimated gross cost of adding the proposed infertility benefits to be $2.38 PMPM or about 0.48% of premium.
- Don't believe any carriers currently cover these services and do not find significant cost savings from implementing the benefit, so assume the net cost is the same as the gross cost, or $2.38 PMPM or about 0.48% of premium.
- The issuers estimated between $1.98 and $24.85 PMPM. Removing the outlier estimate produces the issuer estimate of $1.98 to $2.50 PMPM or 0.4% to 0.5% of premium.

Please visit the full study for citations and additional information and analysis.

Hearing Loss and Hearing Aids - $.55 PMPM

Details:

- Issuers would be required to provide coverage for one hearing aid per hearing-impaired ear every 36 months unless there is a significant change in the insured's hearing status.
- Issuers may impose pre-authorization or other limits to provide a benefit commensurate with this limit.
- The hearing loss must be documented by a licensed physician or audiologist
    - Hearing loss is diagnosed based on the patient history, behavior, and the result of medical and audiological examinations.
    - The degree of hearing loss is measured as: mild, moderate, severe or profound. In adults, the most common causes of hearing loss are noise and aging.
    - Hearing loss can occur suddenly or there may be a gradual decrease in hearing ability over time.
    - There is a strong relationship between age and reported hearing loss.
- Devices must be purchased from licensed audiologists

Cost:

- Apply to all ages and provide coverage for one hearing aid per hearing-impaired ear up every 36 months unless there is a significant change in the insured's hearing status. (Average cost of hearing aid estimated at $2,500)
- $0.55 or 0.11% of premium
- The issuers estimates were between $0.20 and $0.50 PMPM or 0.04% to 0.10% of premium.

Please visit the full study for citations and additional information and analysis.

Nutritional Counseling and Therapy – $.03 PMPM

Details:

- Coverage and reimbursement for dietary or nutritional screening, counseling and/or therapy for obesity, diabetes-related diagnosis or a chronic illness or condition that could be managed through nutritional or weight loss programs up to twelve sessions every policy year, if prescribed by the patient's physician.
- There doesn't appear to be a definitive list of all chronic illnesses or condition that could be managed through nutritional or weight loss programs, however, there are approximately 410,000 people in North Dakota that have at least 1 chronic disease, or about 53% of the population. NovaRest estimates that 85% of those age 65 and older have at least 1 chronic disease, leaving approximately 47% of the under-age 65 population with chronic disease, or about 41,000 members who would be eligible for benefits.
- While 47% of the population are eligible for benefits as described above, low usage of the benefit is expected.
- AARP found usage rates for nutritional counseling under 1% for eligible Medicare enrollees.
- Unlikely that individuals will use all 12 sessions or will continue to use the service every year.
- Assumed an annual cost of $950 for nutritional counseling and $80 for screening.
- Assumed nutritional screening is fully covered for obesity, Dyslipidemia, Diabetes, Hypertension or elevated blood pressure, and CVD currently.
- Assumed nutritional counseling is fully covered for all except diabetes which is covered up to 4 visits
- Assumed obesity, dyslipidemia, Hypertension or elevated blood pressure, and CVD represent 30% of the population and 9% of the population reflects diabetes.
- Assumed an annual savings ranging from $3-$4 based on the USPSTF study, which provided the expected 25-year cost savings from interventions.

Cost:

- Gross cost before cost savings: $0.04 PMPM or 0.01% of premium
- Net cost after cost savings: $0.03 PMPM or 0.01% of premium
- Two issuers estimated $0.00 PMPM, and one estimated $0.50 PMPM or a range of 0% to 0.10% of premium.

Periodontal Disease in the Medical Coverage - $.10 PMPM

Details:

- The proposed benefits would provide coverage for diagnosis and treatment of periodontal disease when *recommended by a board-certified medical practitioner* based on health-related impacts or further deterioration in disease state due to gum disease. This would apply to all ages, rather than just children.
- Only provide coverage if deterioration in existing acute or chronic disease state.
- Periodontitis can include minor or moderate which would require cleanings or minor procedures, which we assume would not be covered under the proposed language. ONLY severe cases would be covered, as those cases are likely to worsen acute or chronic disease states.
- Also assume members who have dental policies would also use dental coverage to cover mild or moderate cases. Considering prevalence rates by age, and members who would already have dental coverage, we estimate the proposed benefit would impact approximately 2,500 members in North Dakota.

Cost:

- The estimated cost of treating severe periodontal disease to be $0.10 PMPM, or 0.02% of premium.
- The issuers estimated between $0.00 and $31.35 PMPM. Removing the outlier $31.35 PMPM estimate produces an issuer range of $0.00 to $0.50 PMPM or 0% to 0.10% of premium.

Please visit the full study for citations and additional information and analysis.

Private Duty Home Nursing - $1.15 PMPM

Details:

- The proposed benefits would require all health issuers to offer coverage for in-home private duty nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN) licensed to provide individualized and continuous nursing care, as ordered by a physician who is involved in the patient's care, when such care is medically necessary and is a viable alternative to an inpatient facility. Services may be provided on a per hour or per diem basis.
- The current EHB Benchmark plan excludes private duty nursing. At least one ACA issuer in North Dakota covers private duty nursing subject to prior authorization. Other issuers cover skilled nursing but do not include private duty nursing.
- There continues to be a shift to in-home care across the country. Estimates from CMS suggest a growth of in-home expenditures of 73% from 2020 to 2028, moving to whole person care.

Cost:

- Johns Hopkins developed a hospital-at-home program for elderly care and estimated at-home care was 32% less than hospital care and also experienced a 1/3 lesser length of stay. It is highly likely that the overall net impact could be a reduction in claim costs and negative impact to premium.
- Estimated gross premium impact of $1.47 or 0.03% of premium.
- After considering reduced facility costs, we estimated a net impact of $0.78 or 0.14% of premium
- The issuers estimated between $0.00 and $9.00 PMPM or 0% to 1.80% of premium.

Please visit the full study for citations and additional information and analysis.

PET scans for Prostate Cancer Diagnosis and Treatment Planning - $.13 PMPM

Details:

- The proposed benefit would cover PET scans for any member who has received a prostate cancer diagnosis including those in remission or who have been cured.
- The coverage would include at least two different types of PET scans (FDG, PSMA, Choline, etc.) upon initial diagnosis if requested by a physician, and one PET scan every six months for the life of the member.
- Providers report that issuers may cover one PET scan, but if a PET scan with another agent is recommended after the first scan, the second may be denied. The issuers' responses indicate PET scans would be covered with no limitations if medically necessary, although the definition of medically necessary is not clear. No issuers reported denied claims for PET scans.
- PET scans would replace the bone scans/CT scans that are currently used. According to our discussions with medical providers, bone scans/CT scans would not be required if 2 types of PET scans were used. We estimate $685 per CT scan and $180 per bone scan.
- Cost avoidance that comes from the effectiveness of the PET scans compared to conventional scans which is in the form of less complications from the cancer and less surgeries. Two studies show cost savings[,], when converted to US dollars, cost savings estimate of $977 per new case.

Cost:

- Gross cost before cost saving: $0.55 PMPM or 0.11% of premium
- Net cost after cost savings: $0.13 PMPM or 0.03% of premium
- The issuers estimated $0.00 to $0.50 PMPM or 0% to 0.10% of premium.

Please visit the full study for citations and additional information and analysis.

Combating the Opioid Epidemic – $.05 PMPM

Details:

The proposed benefits would expand benefits for combating the opioid epidemic:

- Limiting opioid prescriptions to seven days – Not an EHB but recommended practice and inclusion in EHB
- Remove barriers such as prior authorization for drugs used in treatment of opioid use disorder: Removal of any prior authorization requirements for Buprenorphine and similar opioid replacement drugs
- Require prescriptions of easy use overdose antidote when prescribing high-dose opioids: An intranasal spray opioid reversal agent would be prescribed when prescriptions of opioids are 50 MME and higher.

Cost:

- Intranasal spray opioid reversal: Gross $0.07 PMPM or 0.01% of premium. Net $0.02 PMPM or 0.00% of premium
- Removal of prior authorization of Buprenorphine and equivalents: $0.03 PMPM, or 0.01% of premium.
- Gross total cost before savings $0.10 PMPM or 0.02% of premium
- Net cost estimate after savings $0.05 PMPM or 0.01% of premium
- The issuers estimated $0.00 - $0.50 PMPM or 0.0% to 0.1% of premium

Medication Optimization – $.00 PMPM

Details:

- Medication optimization, also known as Comprehensive Medication Management (CMM) would not be a benefit change or increase in benefit to the EHB Benchmark plan but rather would be a programmatic change among issuers to implement CMM for eligible disease states to ensure members have access to doctors and pharmacists to review their medication mix and have medications adjusted to reduce possible side effects or adverse drug interactions.
- Issuers already provide for benefits to access primary care doctors and this would be extended to apply to pharmacists participating in the CMM program.
- The patient conditions, and prevalence rates in North Dakota, for which an optimization program should be considered are: Diabetes (9.1% diagnosed, 2.8% undiagnosed, 32% pre-diabetes), Hypertension (24%), Hyperlipidemia (29%), Smoking cessation, COPD (4.7%), Heart Failure, Asthma (8.6%), Transplants, HIV (0.9%), Mental Health
- For issuers already applying a form of MTM or CCM, we would not expect there to be a meaningful cost impact to hire or contract more pharmacists to build out a more robust program. Issuers without an integrated approach to medication optimization would likely need to contract with or hire internal pharmacy resources to review high risk member drug mix and possible adverse interaction.
- North Dakota does not currently legislate the practice of optimizing medication prescribing, including use of pharmacists to work with the patient. However, it does appear most issuers in the fully insured markets in North Dakota have implemented a form of Medication therapy management (MTM) or CCM for their members to engage and opt in. This includes outreach by prescribing physicians and pharmacists to work with the member on medication adherence and monitoring drug interactions.

Cost:

- The M Health Fairview use case indicated an increased number of members with diabetes and asthma who were being optimally managed and a resulting cost savings associated with these members' overall healthcare costs. This savings was net of increased in-person, phone consults and video chats between doctor/pharmacist and the member. Issuers providing this program to their members have likely already built in the savings to their premiums. For issuers that have not, we would expect a net reduction in total cost of care for engaged members.
- The issuers estimated between $0.00 and $0.01 PMPM or 0% of premium.

What is Medication Optimization?

Optimize medication use through patient-centered, team-based care leveraging health information technology, precision medicine and value-based payment models.

The entirety of the content of this slide is sourced from: GTMR-Blueprint-FINAL-WEB.v3.pdf (netdna-ssl.com)

Why discuss comprehensive medication optimization?

- "We believe that optimizing medication use is the decade's most urgent—and promising—opportunity to save lives and save money."
- "Almost 75% of patients leave their physician's office with a prescription, and nearly one-third of adults in the U.S. take five or more medications."
- "Comprehensive medication management (CMM) addresses medication therapy problems, thereby improving medication-related outcomes."
- "Failure to ensure appropriate use of medications comes with a tremendous human toll."
- "Avoidable illness and death resulting from non-optimized medication therapy led to an estimated 275,000 avoidable deaths in 2016."
- "The cost: $528.4 billion . . That's 16% of the annual $3.2 trillion in U.S. health care expenditures."
- "The financial return on investment (ROI) of team-based medication management services has been well documented, as articulated by Cipolle, et al., 'to average around **3:1 to 5:1** and can be as high **as 12:1,** resulting in a reduction in the direct mean medical cost of between $1200 and $1872 per patient per year for each of the first 5 years for those patients with chronic diseases such as diabetes, cardiovascular health issues, asthma and depression.'" *Cipolle RJ, Strand L, and Morley P. Pharmaceutical Care Practice: The Patient Centered Approach to Medication Management. Third Edition. New York, NY: McGraw-Hill Medical; 2012.*
- "CMM has demonstrated improvement in patient clinical outcomes, including control of hypertension, diabetes, hyperlipidemia and HIV. It has also resulted in fewer hospital and emergency department visits."
- "Patients find CMM and the role of the pharmacist to be of value. Specifically, CMM can improve their overall health and well-being, enhance medication adherence, help them reach and maintain their therapy goals, minimize medication adverse effects and improve their understanding of medications."

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What did bipartisan, national thought leaders discover?

- Optimal patient care requires optimal medication use.
- Achieving medication optimization requires a more rational, patient-centered, team-based and integrated approach called comprehensive medication management.
- The evidence supports comprehensive medication management
- Optimal medication use requires better data
- Data must be actionable
- Optimal medication use may require advanced diagnostics
- New payment models will be necessary for broad access to
- Health insurance plan sponsors save more than money from medication optimization
- Medication optimization provides patients with more than health
- Inability to meet desired clinical outcomes is an important trigger for identifying patients who can benefit the most from comprehensive medication management
- Medication optimization leadership requires buy-in and an organizational supporting culture

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10 Steps to Achieve CMM

1. Identify patients that have not achieved clinical goals of therapy.
2. Understand the patient's personal medication experience, history, preferences, & beliefs.
3. Identify actual use patterns of all medications including OTCs, bioactive supplements & prescribed medications.
4. Assess each medication for appropriateness, effectiveness, safety (including drug interactions) & adherence, focusing on achievement of the clinical goals for each therapy.
5. Identify all drug therapy problems.

6. Develop a care plan addressing recommended steps including therapeutic changes needed to achieve optimal outcomes.
7. Ensure patient agrees with & understands care plan which is communicated to the prescriber or provider for content & support.
8. Document all steps & current clinical status vs. goals of therapy.
9. Follow-up evaluations are critical to determine effects of changes, reassess actual outcomes & recommend further therapeutic changes to achieve desired clinical goals & outcomes.
10. CMM is a reiterative process! Care is coordinated with other team members & personalized goals of therapy are understood by all team members.

McInnis T, Webb E, and Strand L. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Patient Centered Primary Care Collaborative, June 2012

Figure 1

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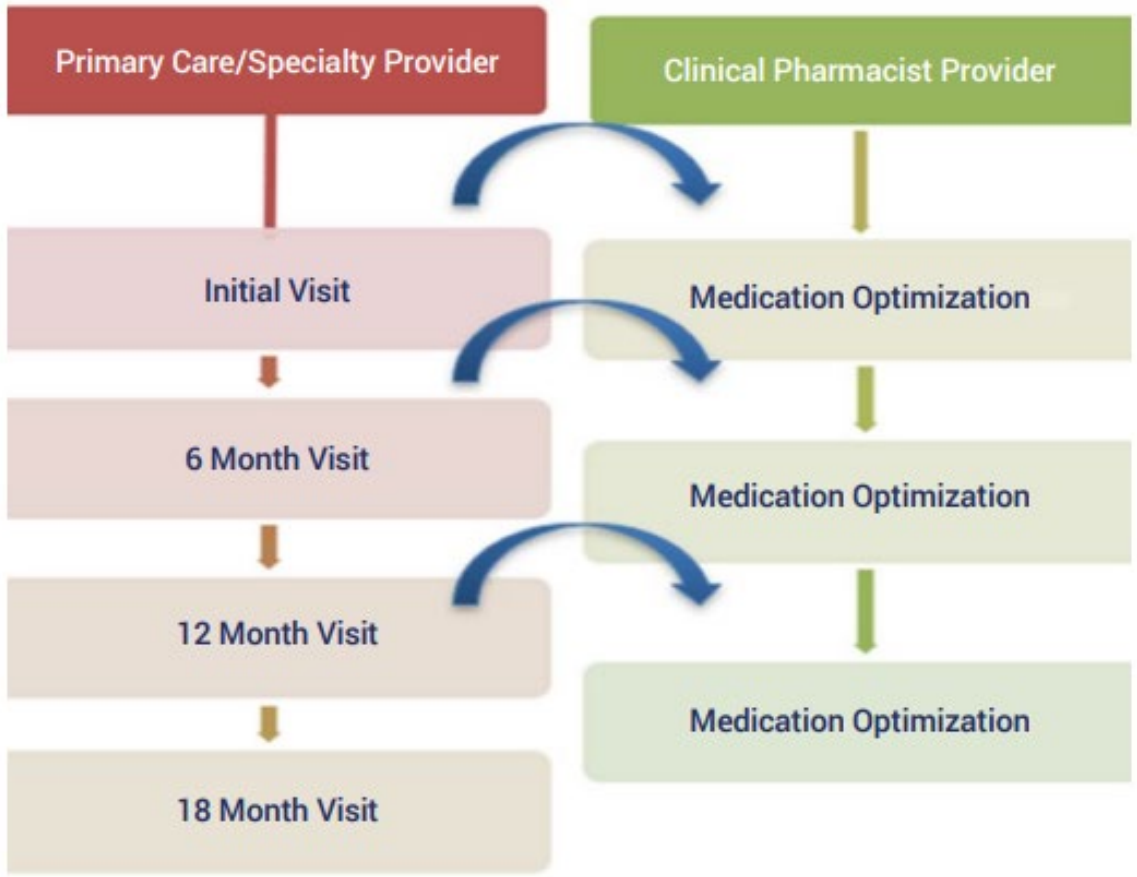
Practice Integration: Visualization of Approach



Optimizing Clinical Pharmacist providers to see patients between Provider visits increases quality, patient access and provider satisfaction.

Figure 3

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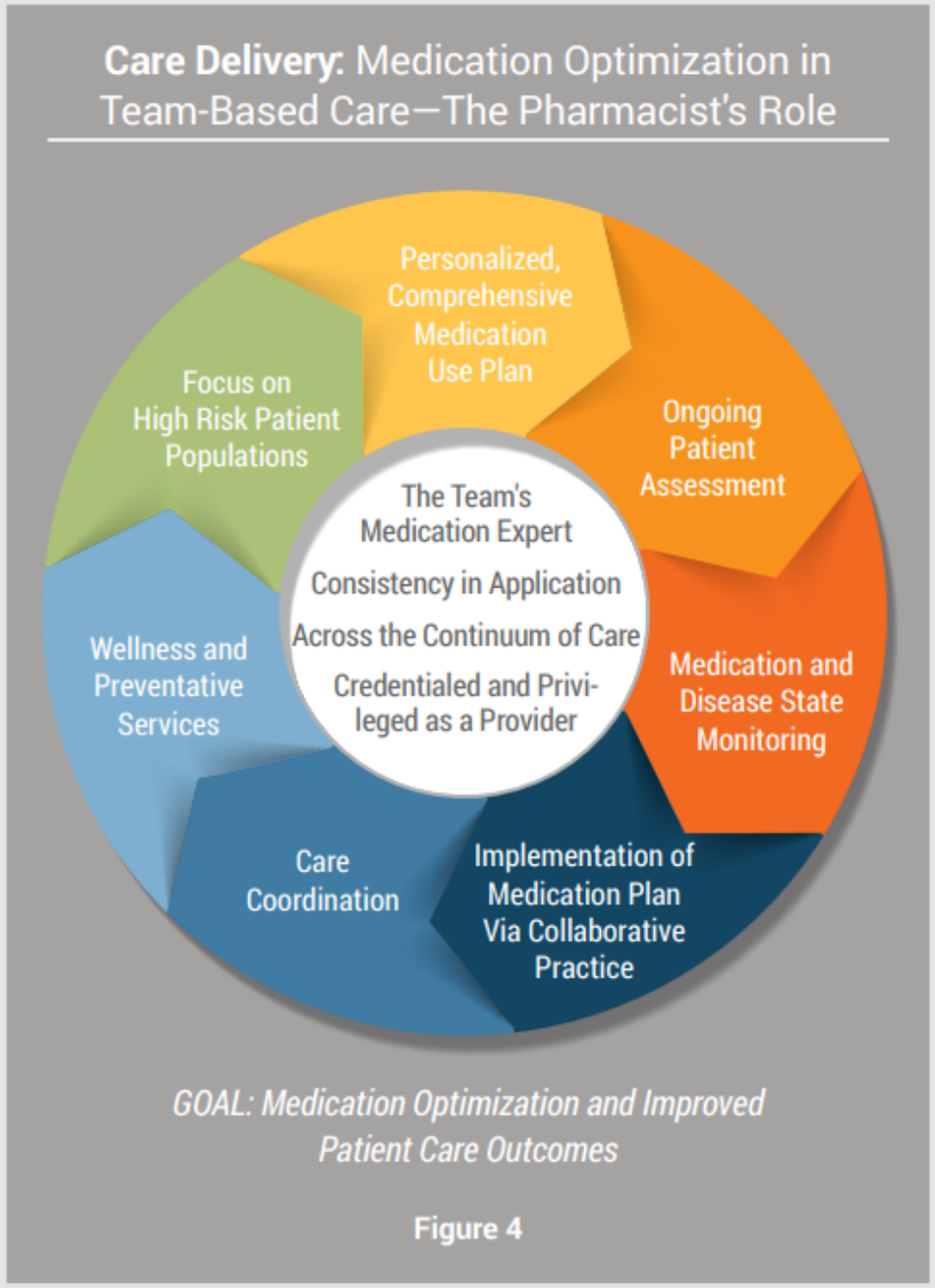

What Needs to Be Done Now?

Practice and Care Delivery Transformation

- Identify evidence to promote the value of optimized medication use for payors, consumers and providers.
- Develop tools to engage and educate key stakeholders (patient advocacy organizations, professional groups, physicians, caregivers, care teams, consumers, pharmacists and employers) to gain support for a standardized definition and process for CMM.
- Further develop the essential structures and language of value-based agreements within CMM services.
- Offer guidance and use cases to key stakeholders on contract standards and the consistent practice of CMM in clinical care.
- Identify leadership and champions to ensure more rapid practice transformation nationwide.

The entirety of the content of this slide is sourced from: GTMR-Blueprint-FINAL-WEB.v3.pdf (netdna-ssl.com)

Solution for North Dakota

Engage with and Implement the "Get the Medications Right: A Blueprint for Change".

1. Work with the GTMR to develop a report due to the healthcare committee.
2. Require the benefit be offered to all beneficiaries (including in the EHB Benchmark Plan).

Decisions for the Committee:

- Require Benefit in EHB Benchmark Plan
- Require Benefit for any other payers/products
- Reporting Requirements for Payers and Providers
- Content/Metrics to be reported
- Frequency of Reporting
- Regulatory Consequences of noncompliance

Have other states adopted a new EHB Benchmark Plan?

2020

Illinois

2021

South Dakota

2022

Michigan

Oregon

New Mexico

2023

Colorado

Please visit the full study for citations and additional information and analysis.

How do these benefits compare to South Dakota's EHB Benchmark Plan?

Alternative EHBs for Consideration in the Benchmark Plan

		South Dakota
		Covered EHB?
Alternative EHBs for Consideration in the Benchmark plan	Restricted Cost Sharing for Diabetes	Diabetic supplies are covered per state requirements
	Infertility	No
	Hearing Loss/Aids-all ages	No
	Nutritional Counseling and Therapy	No
	Periodontal disease in med plan	No
	Private Duty Home Nursing	Yes
	PET scans for prostate cancer	Yes, however no specific requirements as proposed for ND
	Combating opioid epidemic	Yes, however no specific requirements as proposed for ND
	Medication Optimization	No

Please visit the full study for citations and additional information and analysis.

What are next steps?

- The North Dakota legislature will determine which of the benefits, if any, to add to the current EHB Benchmark plan.

- If it is decided to add benefits, an application for the new EHB Benchmark plan for HHS as well as a public comment period will be needed prior to May of 2023 for 2025 implementation.

Questions

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