Alaska Essential Health Benefit Public Comment Hearing

March 27, 2024, 11:00 am – 12:00 pm

Computer Generated Meeting Transcript, light editing for readability.

The first two minutes were not recorded due to technical glitch in the Juneau conference room. The time was taken introducing Heather Carpenter and Sarah Bailey from the DOI and introducing our contractor, Matt Sauter from Wakely Consulting.

0:02

I am Matt Sauter from Wakely Consulting. We have been working with states on exploring essential health benefits, seeing how the market in the nation is viewing these in any gaps or items there and then assisting them in the application process as well.

0:18

We are going to step through a bit of a recap and background on some of these items that we covered last time. Just as a quick refresher, we'll go through a little quicker today and get to some of the new items and decisions. So while we are nearing the finish line here, there's still several items that are you know still being reviewed. We're still going through CMS review once we make that that submission that's expected in May. So some of these numbers may still change, but we are feeling pretty confident about where they're landing.

So again as some quick background here, as we're talking about Essential Health benefits or EHBs and the benchmark plan, I want to make sure we're defining these. So EHBs are really the benefits that every fully insured commercial plan needs to cover at a minimum. Plans can offer more than these, but this is kind of the low, the minimum required benefits that must be covered and as we're defining these benefits and talking about them, it's important or maybe helpful to think about them as "what is covered"? versus "how"? So what benefit is covered, not how is that benefit actually administered. Issuers will still have their utilization, the providers that they have administered the benefits and items like that. And then once we compile all these EHBs up and define them, that's really where the EHB benchmark plan language comes in. And that benchmark plan is what has been set in the past to say here this plan is what defines the essential health benefits and what must be covered.

2:09

So Alaska is pursuing a new EHB benchmark plan to better serve Alaskans and also align with the state's goals a little bit better. And this will affect the fully insured commercial market such as individual ACA, small group ACA as well as a few large group plans as well.

2:35

So what have we done along this process? Again, we started as far back as 2022 as we started formally looking at this at least on the Wakely side. So we reviewed Alaska's current benchmark plan. We threw that up against the nation's benchmark plans just to see if there's any you know gaps that were notable and then also looked at a subset of states that maybe you know Alaska kind of align themselves with or had you know generally similar benefit coverage. And I know geography always is a little tough, but we did look at some Midwest and West states there as we did a comparison just for a kind of little more specific review. We then took that and some of the states thought and discussed you know internally as a group and then also with some issuers and stakeholders.

Through that we then identified options, analyzed benefits and identified the room we had, and now we're at this bolded item here where we're collecting more stakeholder feedback and then posting the documents publicly, and then we'll ultimately decide on a path forward and submit to CMS.

3:52
So we'll we will plan on posting this PowerPoint and likely the transcript of the call I believe, but just wanted to so you'll be able to reference this table. I'm not gonna walk through all of them now, but these are just the recently approved EHB benchmark plan changes that other states have done. And to date there's been nine states who successfully applied for benchmark plan change. That last table was a bit summarized. This one's more specific, but things like opioid reversals, other benefits dealing with opioids, increasing chiropractic limits, items like that have been examples of how states have changed the benchmark plan in the past.

4:33
As we're looking to make these changes, we have to comply with federal regulations. It was really in a 2019 NBPP that added flexibility for benchmark plan changes and that is the regulation that that we're kind of using today to apply for the benchmark plan. Currently we are intending to submit in May and that will take effect for the benefit year 2026.

5:04
Now there's a couple caveats that things may change in the 2025 NBPP. So certain items we might need to tweak, but generally we feel like most of our analysis and proposal will be able to move forward. But the main federal regulations that we need to adhere to are really the typicality test and the generosity test. And I think the simplest way to look at it is just think of it as a floor and a ceiling on how rich or how generous the benchmark plan can be. So we follow the CMS regulations to identify what they call benchmark comparison plans.

There's three small group plans, 3 state employer plans, three federal plans and then some large group options. So we can look at those plans and identify essentially the least generous and the most generous and that kind of gives us our bounds on the room we have to adjust benefits. Also as we update benchmark plan, some states such as Alaska have not done a formal reapplication or new benchmark plan. They set one back in the beginning of ACA think 2012/2014 timeline and then that benchmark plan was then carried forward for 2017 through current benefit years.

6:30
So as we're updating these benchmark plans, CMS is also asking that we make a few changes to just to make it a little more clear the actual essential health benefits and then also update for federal regulations and other changes that may have occurred such as discriminatory language and other items there. So you may notice the new benchmark plan will no longer be plan branded by a state insurer that will now likely have state of Alaska branding and cut out a lot of the non EHB items such as cost sharing and items like that and focus primarily on the benefits that are truly covered.

7:10
Again there is a proposed NBPP out there that is likely to be finalized I'd imagine in the next

month, likely the next week or two that would be my guess. So we're keeping an eye on that. That may tweak one or two items there and also potentially provide flexibility in the future for further changes.

7:30
So with that we started to look at benefit selections and benefits to analyze and add to the benchmark plan. So Alaska DOI had some ideas and goals here, discussion with stakeholders and issuers, and then also again looking at that national landscape gave us a starting point to work with. And then as we just walked through the federal regulations and generosity and typicality test, we keep those items in mind as well as we go to add items. As we were pricing these another just kind of clarification on what EHBs are and how we price them, we are looking at the total allowed cost. So that's going to be what the plan or insurance pays and what the member plays combined. So it's slightly different than the impact to premium, but it is looking at the total allowed cost as we look at these benefits and then as we price them for the future benefit years, we are looking at the steady state cost of these items. We're not trying to quantify year one pent up demands for a new benefit and also not trying to quantify the impact of downstream impacts on other services. We are trying to look at the marginal cost of just adding the benefit being proposed.

9:01
So we started with this list, we did look at more, but this was kind of our core list that we looked at for benefits to be considered. So hearing aids and hearing exams, acupuncture expansion, expanding the limits there, expanding the chiropractic limit, massage therapy which is often used for alternative to opioid or perhaps could be administered as an alternative to chiropractic care or even in a chiropractic setting. That specific benefit wasn't listed in the in the benefit plan. So we're looked at adding 20 visits of that to align with the acupuncture and chiropractic visit limits. Also looked at TMJ services, weight loss drugs and bariatric surgery. So not a complete list of everything we looked at, but this was one of the short lists that we looked at for analysis.

9:56
I won't go into too much detail on all these benefits but did want to provide a few items that we're looking into. So hearing aids and exams have been gaining some popularity for coverage in the ACA market. So we looked into covering this and found that certain states did cover this maybe about 1/2 or so and the most common range was about one hearing aid per ear for every three years. So that is what we're going forward as a recommendation.

10:28
We also looked at weight loss benefits and this was relatively complex benefit just because of the, the various ways this benefit could be offered. And then also as you get into items such as bariatric surgery, Alaska's provider network and number of specialty specialists and then also just the weight loss drugs and all the popularity they've kind of been in attention that they've been getting in, in recent years. And then it also gets into how EHB benchmark plans can dictate what's covered in the drug categories.

There's some nuances there of number of drugs that that can be that are required per United States Pharmacopia category classes. So there's limitations on what the benchmark plan can dictate there. So as we, we looked at these drugs, we recognize there's some really high cost

brand name drugs. Ozempic and Wegovy have probably been in the news the most, But and as we're looking at the total allowed costs, you know we are considering things like rebates, utilization management and also the availability of generics. When we looked at bariatric surgery, we did know that there was a state employer plan that covers bariatric surgery. We identified this benefit to be relatively high cost due to a variety of factors including availability of specialists, the cost of those specialists and then even potentially the travel cost if it was necessary to go to the Pacific Northwest for example, as some issuers offer in Alaska. Those costs kind of all contributed to our estimates.

12:30
So a few other benefits that we didn't walk through such as the chiropractor and acupuncture, but those were just kind of expanding visit limits. So with those analyses, we kind of had a better idea of how we define the benefits and their approximate pricing.

12:45
So now we kind of went into the phase of which benefits would we like to look at adding and how does those fit into the generosity or the room that we have to add those benefits. As we ultimately brought it down to a short list of what's displayed on the screen.

So hearing exam and hearing aids and again this will be hearing aids every three years plus an annual hearing exam, increasing the chiropractic limit from 12 to 20, and then adding a massage benefit with 20 visits, also adding TMJ services. And then for weight loss drugs we added an additional drug in the anti-diabetic agents USB class and this is the class that has, although named anti diabetic agents does cover a lot of weight loss drugs such as OZEMPIC. With that in mind, we're looking at adding those benefits, we then moved on to the CMS tests and regulations we need to comply with, and the first one we tend to look at is the generosity test which essentially sets the ceiling. So we compiled those plan documents. We compared the benefits line by line between the current benchmark, and the generosity, and then identified a total benefit difference for those.

14:20
We did identify the Alaska State Employees Association plan as the most generous among those plans that were eligible for selection. And the main differences are listed here. So these aren't all the differences, but are the main ones that contributed to notable cost differences. So we can see the benefits are listed in the left most column, the coverage of those benefits in the current benchmark plan and then the coverage of those benefits in the ASEA plan which we identified as the most generous. So for items such as physical, occupational and speech therapy where there was a difference in the 45 visit limit in the current benchmark plan versus no limit in the state plan, we then quantify approximately what percent of total allowed costs that difference makes up.

So for this example is .06% of total allowed costs. We did that for each benefit and got down to a total percentage the benefit differences. So said in words this is the ASEA state employee plan, was about 0.36% more rich or had .36% more costs of benefits than the current benchmark plan. And maybe that's still a little tough to digest. So on a PMPM basis it's about $5.63.

15:55

So next we moved on to the typicality test. And this test is really, I view it as kind of a form checking test where it's just to say that the new benchmark plan is typical in the market. And the specifics of it are it must exactly equal the, the richness of a benchmark plan. That is the new benchmark plan with which the additional benefits must equal one of the comparison tests in those listed 10 plans or so. Those are the same 10 that we use for the generosity as defined by federal regulations and we ended up selecting the Federal Government Employees Health Association or GEHA plan for this test.

Again, we lined up all the benefits line by line and identified these differences here. So for example, PT/OT/ST again there was benefit differences bariatric etcetera and then we totaled those up and it was about .19% of total cost difference. And as we compare that to the current benchmark plan plus the new benefits, we found that those did equal. So this does satisfy the typicality test. So with that we've satisfied both the generosity and typicality test and can move forward with within federal regulations with the new benchmark plan which would add these five benefits.

17:30
So with that proposal and knowing that we can pass the CMS test and we look forward, we have these key items coming up. So again the final notice of benefit payment parameters some new regulations will be released here in the next couple weeks. So just making sure we're still checking on the boxes with those and updating anything that's relevant. We're holding these stakeholder meetings and feedback. So that started, I believe our first meeting was in February and now having another meeting here and then we're having official public comment periods as CMS mandates in the regulations both in March and April. We'll have our official submission May 1st, so just a little over a month away. And then once CMS receives a submission, they'll begin their official review process which will likely be into the summer and fall. I believe other states have received approvals maybe September and October following their submission. So yeah, still about six months or so to go here. But we are wrapping up kind of our analysis and submission process here in the next month.

So with that we'll open it up to questions and any comments.

19:06
Hi, this is Sarah Bailey. And I would just like to make sure everybody knows that the questions and comments section is being recorded. So just just for your reference and again this is Sarah Bailey with the Division of Insurance. And then we also have Heather Carpenter, the Deputy Director here.

19:27
So I do not see anyone in this room or in the room in Anchorage that would like to provide comment or ask questions. Is there anyone online who would like to make a comment or ask a question?

You may raise your hand or take yourself off mute to make any comments.

19:57
Looks like Emily has taken herself off mute. Go ahead, Emily.

20:03
Hi, this is Emily Nenon and I'm the Alaska Government Relations Director for the American Cancer Society, Cancer Action Network. I have a question. When you talked about to making some changes to just sort of update language, I was wondering when I was looking through our existing Essential Health benefits document it mentions things like for cervical cancer screening, it specifically says Pap smears and now and there's an HPV stand-alone test that is one of the choices, standard choices for, It's easy. You don't necessarily need a Pap smear. I was wondering if that level of detail was something that you guys were looking at. It's certainly I can something I can include when I submit my comments, written comments, but I just wondered if that was one of the sorts of things that you were looking at.

20:58
Matt: Yeah, great question. I'll take a step back and again talk about just how we kind of think about EHBs and it really is what is the benefit that is covered and often times there are changing you know medical practices, changing options that are available.

So we do and CMS requires us to rely on medical evidence and medical best practices, and it really is you know what is the benefit that is covered. And then if medical evidence changes over time, the plan document doesn't fully capture that or says hey this is not covered. But then in the future you know that is the best practice. The plan document does not have to necessarily reflect that for it to be covered. So maybe the best example is colonoscopies are covered for men over age 40. That might be the current medical best practice to cover it starting at age 40. If that then changes to 35 that'll implicitly be covered. So it really comes down to a question of is the overarching benefit already being covered for this treatment of care and that's something I'd probably have to look into more. So I think if you document your question and submit it, we can we can look at that and get back to you and then also make sure if there's any tweaking of language that we make sure we're capturing that correctly.

22:31
Thank you.

22:37
Thank you Emily, is there anyone else who has a question or a comment? Please feel free to raise your hand or take yourself off mute.

22:57
Matt: Maybe while we're waiting for another question here, I did want to, I'll open the actual report on the plan document. We, we did put a section at the top of the planned document that to a degree gets into some of the, some of the items I just described where we are relying on you know, medical evidence, you know, preventive services and other items there. So we do try to have a blanket statement at the beginning of our the new benchmark plan document to tackle some of those concepts. But yeah, understand there will also be other benefits that may be getting a little more specific there, but we're going to point that out as well.

23:47
Sarah: Yeah, And I think we could also have a conversation just generally and this may not

address Emily your question, but hopefully it will help in documenting your question when you send it to us. So we have a state mandate that requires coverage of Pap smears. You're right, it is limited to Pap smears. But the Affordable Care Act requires that there be coverage of preventive services consistent with the US Preventive Services Task Force recommendations with an A or B grade. And then there's also and I apologize, I don't know the, the, the words that go into this acronym, but the HRSHA preventive Services recommendations for women and children. And so those are automatically included in the benchmark plan and they're required under the Affordable Care Act.

24:47
So my recollection is that the screening that you were looking for is covered by one of those, but I don't know it for sure. So that I really am welcoming your question and comment tonight and I look forward to seeing that.

Heather: And while folks are quiet, we are accepting those written comments like we said in the public notice. If you have you know questions in the meantime you can certainly send those questions, but we definitely encourage the public comment for anything you want us to consider and all documents are posted on the online public notice as well as the Division of insurance website.

25:43
Sarah: We do ask for those comments by April 8th, yes, for this first round, but we are going to have a second round as well.

25:54
Questions can be addressed to me, Sarah Bailey, and I believe that's what the notice says, sarah.bailey@alaska.gov.

Heather: And Emily, it's a great question on the timing for the second round because we have that May 1 submission deadline by CMS. It's going to be tight. So we're probably going out the following week. It just depends on how extensive our comments are, but we're going to be working overtime with the Wakely team to get things turned around. So ideally we'll get things out you know by the 15th and do another quick two week. And it gets tricky because CMS like, we really encouraged if you were like hey think of this thing we didn't consider, send those in that first round because oddly enough CMS doesn't want to see large changes before you submit it, you know that hadn't gone out for public comment and if that is the case we'll have that conversation with CMS we've already raised like hey, what if we get a big comment in the second round, and we'll tackle that issue when or if it comes. But you know we're open for discussions. So if you have anything please go ahead and submit it.

27:11
Emily: Thank you. So just to clarify, first comment period state submits, you guys division of insurance submits changes to CMS or submits that first proposal and then the second comment period, the second comment period is based on people having access to see what division of insurance comes up with in the first round, is that correct?

27:36
Heather: Mostly. So we won't submit to CMS until May 1st, which will be after the second

round. And so everything will be we're being transparent, it's all gonna be on our website So you can see those iterations. We'll make it clear, you know what changes came as a result of public comment.

So it will be taking those comments. We get that first round working with us with Wakely to say OK, what changes need to be made and then we'll put it back out for that second round. And if there were comments where we said, you know what, this is a great comment but it doesn't fit because of XY and Z. Like I imagine we will say here's a comment we received. Here's why we don't think it quite fits or maybe it fits somewhere else. So that's kind of the process that we will take. And then after that we submit it on May 1.

28:42
Heather: We don't have any more of a formal presentation, but because we did notice the public hearing until noon, we will hang on in case we have any late joiners for questions. And the Wakely presentation will be posted on the website so you can see and have access to that too.

29:21
Emily: Since you all have to hang on the phone for another 25 minutes, you can answer a question. I'm a little rusty on my AC as been a hot minute ago, so I just want to clarify that is it accurate that the only way to address the cost sharing piece is would be if the US Preventive Services Task Force A&B recommendations changed? Because those that's what comes without cost sharing? Did that make sense?

29:59
Sarah: Yes, that makes sense. I believe there could be legislation, state legislation, to address cost sharing. But we do run the risk of creating a mandate that the state would need to defray so the legislation would have to be extremely carefully worded. One example of that is under the Affordable Care Act the zero cost sharing is for network only or network excuse me in network providers and sometimes legislation might be broader than that and say no cost sharing for non-network providers as well as network and so that increases cost that the state may then need to defray. So it's one of those things that has to be done extremely carefully so that we don't run afoul of something that's going to increase cost.

31:37
Emily: Thank you.

31:40
Heather: Yeah, I think that's a great question, Emily. And I think if the legislature made that policy call, you know, and chose to fund something like that's their choice. But the division would definitely alert when there were concerns about where we might have to defray some of those costs.

32:20
Sarah: As a reminder, we have completed our formal presentation for this public comment hearing. If you would like to make a comment, please feel free to take yourself off mute or raise your hand and indicate that you have a question or a comment for us. All right. We will

hold this meeting open until noon, but I'm going to if there are no questions or comments, I'm going to go ahead and put us on mute.

53:34
Sarah: It is now 11:59 and we are wrapping up this Alaska Essential Health Benefit public comment hearing. If you have one final comment, please feel free to take yourself off mute or raise your hand and let us know that you have a question or a comment.

53:57
It is now 12 noon Alaska time and we are closing the Alaska Essential Health Benefit public comment hearing. As a reminder, public comments are due April 8th by 5:00 PM. They should be sent to sarah.bailey@alaska.gov and we will receive those comments and then we will have a second comment period, and we will provide information about any changes to the division's application for changes to our essential health benefits. All information is available on the division's website. And if you're a participant of this meeting and have provided your e-mail address, a link will be provided directly to those documents on the division's website. Thank you very much and have a great day.