



NovaRest
ACTUARIAL CONSULTING

Oregon Essential Health Benefit Benchmark Plan Certification

Review and Evaluation of Proposed Changes to the Oregon EHB Benchmark Plan
Including Changes Regarding the Opioid Epidemic

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Executive Summary

Project Description

Oregon is proposing changes to their Essential Health Benefit (EHB) Benchmark Plan (EHB-benchmark plan) to add Alternative Care benefits including spinal manipulation and acupuncture benefits and to enhance the mental health/substance abuse category with an emphasis on combating the opioid epidemic. To facilitate this, NovaRest, Inc. (NovaRest) was hired by the Oregon Department of Consumer and Business Services Division of Financial Regulation (Oregon) to provide an actuarial certification, consistent with updated guidance provided by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

The 2019 Benefit and Payment Parameters indicated that if a state elects to select a new EHB-benchmark plan under any of the options provided by CMS, the state must determine that the proposed EHB-benchmark plan provides benefits equal to, or greater than the scope of benefits provided under a typical employer plan and does not exceed the generosity of the most generous small group plans of a set of comparison plans using an actuarial certification, developed by an actuary who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

NovaRest is an actuarial consulting firm that has extensive experience performing mandated benefit reviews. Al Bingham is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries and is qualified to provide this opinion. We have utilized generally accepted actuarial methodologies to arrive at our opinion.

We are providing this report solely for the use of supporting Oregon's proposed changes to its EHB-benchmark plan. The intended users of this report are Oregon and those federal agencies to which the application is submitted. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by NovaRest and is done at the other party's own risk.

Current Plan and Proposed Changes

Specifically, Oregon is proposing to add the following benefits to its Benchmark Plan.

- Up to 20 Spinal Manipulation visits per plan year
- Up to 12 Acupuncture visits per plan year
- Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication-assisted treatment of opioid use disorder.
- Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.

Two of these benefits (intranasal opioid reversal and removal of barriers for Buprenorphine) are consistent with the CMS encouraging states to explore changes that can be made in order to address this epidemic as stated in the 2020 Benefit and Payment Parameters.¹

¹ Notice of Benefit and Payment Parameters for 2020

Conclusions

CMS has provided guidance to the states on the requirements of making changes to their Benchmark Plan, which requires that:

1. The EHB-benchmark plan must be equal to, or greater than the scope of benefits provided under a typical employer plan as defined under 45 CFR 156.111(b)(2)(i); and
2. The EHB-benchmark plan does not exceed the generosity of the most generous small group among the plans listed at 45 CFR 156.111(b)(2)(ii).

We believe the current EHB-benchmark plan represents a typical employer plan in Oregon. The proposed changes to the EHB-benchmark plan add benefits to those currently included in the EHB-benchmark plan, and therefore the scope of benefits would be greater than under a typical employer plan.

We estimate the total generosity impact per member per month (PMPM) to be \$2.84 PMPM. A discussion of the methodologies and assumptions used to determine this estimate are described in the NovaRest Analysis section of this report. The breakout of each proposed benefit is provided in the following table.

Proposed Additional Benefits	Generosity PMPM Impact
Spinal manipulation – 20 visits	\$1.89
Acupuncture – 12 visits	\$0.95
Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication-assisted treatment of opioid use disorder.	\$0.00
Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.	\$0.00
Total	\$2.84

Wakely Consulting Group provided Oregon with a report² that provided an analysis of the premium impact of the benefit differences between the nine (9) category plan combinations considered for Oregon’s Benchmark Plan. Oregon provided this report to NovaRest. Wakely estimated that the richest small group plan, the Small Group 3 - United, had a premium impact of \$2.00 to \$3.00 higher than the benchmark plan chosen,³ PacificSource Preferred CoDeduct Value 3000 35 70.⁴ This differential will be even higher in 2022 due to medical inflation for the

² Overview of Key Benefit Differences and Premium Impact of 2017 EHB Benchmark Options – May 2015

³ Slide 9 from the Wakely PowerPoint presentation Oregon Essential Health Benefits Advisory – May 6, 2015

⁴ “Oregon EHB Benchmark Plan.” Centers for Medicare and Medicaid Services.

<https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Oregon-Benchmark-Summary.pdf>. Accessed 4/13/2020.

benefits covered by the small group united plan compared to PacificSource benefits. The following table is taken from that report.

Benchmark Option	Premium PMPM Impact of Benefit Differences
Small Group Plan 1 – Pacific Source (baseline)	\$0.00
Small Group Plan 2 - Health Net	\$1.00-\$2.00
State Plan 3 – Kaiser	\$1.50-\$2.50
Small Group Plan 3 – United	\$2.00-\$3.00
FEHBP 2 - BCBS Basic	\$4.50-\$6.00
FEHBP 1 - BCBS Standard	\$5.00-\$6.50
FEHBP 3 – GEHA	\$5.00-\$6.50
State Plan 1 - PEBB Providence Statewide	\$6.50-\$8.50
State Plan 2 - PEBB Providence Choice	\$6.50-\$8.50

Because the estimated additional generosity PMPM of \$2.84 PMPM is within the \$2.00 to \$3.00 PMPM under Small Group Plan 3 - United, we believe that, assuming these cost relationships still hold, the proposed EHB-benchmark plan does not exceed the generosity of the most generous small group plans among the plans listed at 45 CFR 156.111(b)(2)(ii).

CMS Benchmark Plan Background

Original Benchmark Plan Selection Guidance and Requirements

The Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover EHB, which include items and services in the following ten (10) benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.⁵

For plan years 2017, 2018, and 2019, each state’s EHB-benchmark plan is based on a plan that was sold in 2014.⁶

⁵ Information on Essential Health Benefits (EHB) Benchmark Plans. Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>. February 17, 2020.

⁶ Information on Essential Health Benefits (EHB) Benchmark Plans. Centers for Medicare and Medicaid Services. <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>. February 17, 2020.

CMS has codified regulations to allow each state to select a Benchmark Plan that serves as a reference plan.⁷ CMS will continue to evaluate the effectiveness of the benchmark policy, including whether the Benchmark Plans require further updating; whether the overall approach continues to balance affordability, comprehensiveness, and state flexibility; and how to account for medical innovations. All ten (10) statutory categories in section 1302(b)(1) of the ACA must be included as a part of EHB; therefore, if the selected or default Benchmark Plan does not initially cover a category, the benchmark must be supplemented in accordance with 45 CFR 156.110(b).⁸

States can choose a Benchmark Plan from among the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market.⁹

Guidance and Requirements for Changing Benchmark Plans¹⁰

Under 45 CFR 156.111 in the Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) finalized on April 9, 2018,¹¹ CMS finalized that states may select a new EHB-benchmark plan for plan years beginning on or after January 1, 2020. The Final 2019 Notice of Benefits and Payment Parameters provides States with greater flexibility by establishing standards for states to update their EHB-benchmark plans. CMS is providing states three (3) new options for selection starting in plan year 2020, including:¹²

- 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 EHB-benchmark plan.

If a state opts to select a new EHB-benchmark plan utilizing any of the selection options at 45 CFR 156.111(a), the state is required under 45 CFR 156.111(e)(2)(i) and (ii) to submit an actuarial certification and associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

⁷ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>, page 3

⁸ The Essential Health Benefits: List of the Largest Three Small Group Products by State for 2017 is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>. States' EHB-benchmark plans used for the 2017 plan year are available at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Final-List-of-BMPs_4816.pdf.

⁹ Ibid, page 3

¹⁰ Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

¹¹ A copy of the final rule is available on the Center for Consumer Information and Insurance Oversight website at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html>.

¹² <https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>

This actuarial certification and associated actuarial report must affirm that the state’s EHB-benchmark plan:¹³

- Provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at 45 CFR 156.110(a), the scope of benefits provided under a typical employer plan (“Typical Employer Plan”), as defined at 45 CFR 156.111(b)(2)(i), and
- Does not exceed the generosity of the most generous small group plans among the plans (“Comparison Plans”) listed at 45 CFR 156.111(b)(2)(ii)(A) and (B). This set of comparison plans for purposes of the generosity standard includes the state’s EHB-benchmark plan used for the 2017 plan year, and any of the state’s base-benchmark plan options used for the 2017 plan year described in 45 CFR 156.100(a)(1), supplemented as necessary under 45 CFR 156.110.¹⁴

Oregon Proposal for Benchmark Changes

Ten Original Plans Considered

Oregon originally considered nine (9) category plan combinations as potential Benchmark Plans for its 45 CFR 156.111(b)(2)(ii) ACA individual marketplace.¹⁵ It considered three (3) small group plans, three state plans and three (3) FEHBPs. The considerations included the following:

1. Small Group 1 – PacificSource (baseline)
2. Small Group 2 – HealthNet
3. Small Group 3 – United
4. State Plan 1 – PEBB Providence Statewide
5. State Plan 2 – PEBB Providence Choice
6. State Plan 3 – Kaiser
7. FEHBP – BCBS Standard
8. FEHBP – BCBS Basic
9. FEHBP – GEHA

¹³ Ibid

¹⁴ The states’ EHB-benchmark plans used for the 2017 plan year are based on plans from the 2014 plan year, but CMS occasionally refers to them as 2017 plans because these plans are applicable as the states’ EHB-benchmark plans for plan years beginning in 2017.

¹⁵ Wakely Consulting Group. “Overview of Key Benefit Differences and Premium Impact of 2017 EHB Benchmark Options – May 2015.” <https://dfr.oregon.gov/help/committees-workgroups/Documents/2019-ehb-committee/20200221-2017-EHB-Benchmark-Options.pdf>. Accessed April 20, 2020.



Oregon Benchmark Plan Chosen

Oregon selected the PacificSource Preferred CoDeduct Value 3000 35 70 (PacificSource plan) plan for its Benchmark Plan.¹⁶

In 2015, Wakely Consulting Group provided Oregon with a report¹⁷ that presented an analysis of the premium impact of the benefit differences between the nine (9) category plan combinations considered for Oregon's Benchmark Plan. Wakely estimated that the richest plan, the Small Group 3 - United, had a premium impact of \$2 to \$3 higher than the Benchmark Plan chosen, PacificSource plan.¹⁸

We believe that currently the richest plan, the Small Group 3 - United, has a premium impact of at least \$2 to \$3 higher than the EHB-benchmark Plan chosen, based on the Wakely analysis and our knowledge of trends in health care costs since 2015.

Proposed Changes

Oregon is proposing to add alternative care benefits, specifically as follows:

1. Cover up to 20 spinal manipulation visits per plan year
2. Cover up to 12 acupuncture visits per plan year

Additionally, Illinois recently updated its EHB-benchmark plan adding five (5) new benefits to “focus around preventing and improving access to treatment for opioid addiction.”¹⁹ Oregon reviewed the changes Illinois made to its EHB-benchmark plan for the 2020 plan year and is interested in making some of these changes to its EHB-benchmark plan for the 2022 plan year; although, one of the benefits Illinois added (Tele-psychiatry) is already required by Oregon state law, OR 743A.058, 743A.185 SB-144 in conjunction with Mental Health Parity regulations. Thus, this benefit is already being provided by all issuers. Another benefit added to the Illinois EHB-benchmark plan regarding a topical anti-inflammatory saw Diclofenac achieve over-the-counter status by the Food and Drug Administration (FDA).²⁰ Oregon was also concerned about the impact of limiting opioid prescriptions to seven days and did not currently wish to pursue that benefit. The remaining benefits, which Oregon is interested in pursuing, are as follows:

3. Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication-assisted treatment of opioid use disorder.
4. Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.

¹⁶ “Oregon EHB Benchmark Plan.” Centers for Medicare and Medicaid Services.

<https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Oregon-Benchmark-Summary.pdf>. Accessed April 13, 2020.

¹⁷ Wakely Consulting Group. “Overview of Key Benefit Differences and Premium Impact of 2017 EHB Benchmark Options – May 2015.” <https://dfr.oregon.gov/help/committees-workgroups/Documents/2019-ehb-committee/20200221-2017-EHB-Benchmark-Options.pdf>. Accessed April 20, 2020.

¹⁸ Slide 9 from the Wakely PowerPoint presentation Oregon Essential Health Benefits Advisory – May 6, 2015

¹⁹ Beth Fritchen, FSA, MAAA. “EHB Benchmark Analysis with a Focus (sic) on the Opioid Epidemic.” June 29, 2018. Illinois Department of Insurance and Oliver Wyman.

²⁰ Amanda Turney. “FDA Approves Three Drugs for Nonprescription Use Through Rx-to-OTC Switch Process.” February 14, 2020. U.S. Food & Drug Administration. Acc February 20, 2020.



NovaRest Analysis

Data

NovaRest interviewed Teresa L. Jackson, MD, FASAM to gain a provider's valuable perspective on how these opioid-related treatments are used and how the proposed benefits will address the opioid epidemic. Dr. Jackson is Board Certified in Addiction Medicine by the American Board of Addiction Medicine and the American Board of Preventive Medicine. Dr. Jackson does not opine on the results of the analysis offered in this paper.

We also requested data from the Prescription Drug Monitoring Program (PDMP) and the Oregon All Payer Claims Database (APAC) managed by the Oregon Health Authority (OHA). The 2019 data was not complete so we relied upon 2018 data which was valuable in providing claims for alternative care as well as prescription counts for various opiate agonists in Oregon in the commercial market. They also provided 2018 membership counts for the commercial market.

NovaRest and DIFS performed a data call on Oregon carriers to gain their perspectives on the current level of coverage in the market and the expected costs of adding these benefits to the EHB-benchmark plan. The actual data call document is included as Appendix A. Most of the carrier responses to this data call included estimates of the cost impact of adding these benefits. We believe that estimates provided by the carriers are more reliable than independent analyses based on non-carrier data. Thus, we performed our analysis using carrier estimates of additional costs.

The responses we received from the carriers (almost all carriers provided cost estimates) indicated no cost or minimal cost to cover the proposed benefits relating to combatting the opioid epidemic due to current levels of coverage, although there is some disagreement among the carriers about whether they are included in the EHB-benchmark plan or not. Oregon expressed interest in formally adding these benefits to the EHB-benchmark plan to avoid confusion for new carriers entering the market. Because current carriers all cover these benefits without prior authorization, the only cost impact will be from adding the alternative care benefits, which include spinal manipulation and acupuncture benefits.

Methodology

The alternative care estimates provided by the carriers which provided cost estimates were presented as ranges of additional costs depending on plan cost sharing. In our analysis, to be conservative, we used the high estimate in the range. Thus, actual average cost will be lower. For the one carrier that did not provide cost estimates, we assumed that this carrier's costs would be the average of overall weighted average for the rest of the market. Another carrier provided a cost estimate of "up to \$9.00 PMPM" for the spinal manipulation and acupuncture pieces combined with no cost of the opioid-abuse type benefits, but noted that they had not been able to perform actual analyses. Because this carrier's response is an outlier and not supported or documented, but the carrier still has a significant market share, we decided to use half of their estimate (\$4.50 PMPM) which is still significantly higher than other carrier responses.

Based on the carrier responses, some carriers already provide the same or more limited coverage of the proposed spinal manipulation and acupuncture benefits. One carrier included the current



cost of their benefit, so in our analysis we included only the additional cost for that carrier. One carrier already provides the proposed benefit, so there is no additional cost for that carrier. Some of the carriers currently provide spinal manipulation and acupuncture as a combined benefit, so they were not able to separate the cost of the two benefits. For our analysis, we derived a weighted average of the carriers' highest estimates of the combined spinal manipulation and acupuncture benefits weighted by 2019 member months obtained from National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), which resulted in a projected impact of \$2.84 PMPM.

The carriers that were able to separate the cost of the benefits indicated a majority of the cost would be from the spinal manipulation benefit (60% to 80% of the combined cost). We assumed two-thirds (67%) of the combined cost would be spinal manipulation which resulted in an expected cost of \$1.89 PMPM for spinal manipulation and \$0.95 PMPM for acupuncture. For carrier confidentiality reasons, we have not included the actual analysis in this report. We will be happy to make this available to CMS on a confidential basis.

Meeting the CMS requirement of the new Benchmark Plan provides a scope of benefits that is equal to, or greater than, the scope of benefits provided under a typical employer plan, as defined under 45 CFR 156.111(b)(2)(i)

NovaRest believes that Oregon's current Benchmark Plan represents the scope of benefits provided under a typical employer plan. Since the proposed new benchmark plan contains all of the benefits in Oregon's current Benchmark Plan plus four (4) additional benefits, the scope of benefits of the proposed plan is greater than the scope of benefits provided under a typical employer plan.

Meeting the CMS requirement of generosity compared to the most generous small group plans ("Comparison Plans") listed at 45 CFR 156.111(b)(2)(ii)

NovaRest did an analysis of adding the four (4) new benefits.

1. Cover spinal manipulation up to 20 visits

What is Currently Covered?

The proposed benefit would cover up to 20 spinal manipulation visits per plan year. The State Standard plans do not appear to offer coverage for spinal manipulation based on the responses we received. However, a majority of the carriers we surveyed indicated they had some level of coverage for spinal manipulation which varies by plan. Some plans may include coverage with benefit limits. The most common benefit limit appeared to be \$1,000, however, some for plans acupuncture may be combined with spinal manipulation up to this benefit limit. Other plans may include limits on visits, with 3-15 visits being most popular. Some plans were available without any benefit limits.

One of the carriers noted while there is no evidence-based research to indicate potential savings due to reductions in other associated health care costs, they have seen general industry data, such as data from National Center for Complementary and Integrative Health that suggests it is an effective pain management method.



Analysis of Additional Generosity

The carriers we surveyed calculated and expected cost ranging from \$0 to \$9 PMPM²¹ for this benefit. We do not believe the estimate of \$9 PMPM is accurate and the carrier noted they did not have sufficient time to investigate the cost. Disregarding the \$9 PMPM estimate provides a range of approximately \$0-\$2 PMPM.²²

The NovaRest analysis described in the ‘Data and Methodology’ section resulted in approximately \$1.89 PMPM for up to 20 visits for spinal manipulation.

No carriers indicated any material increases in administrative or indirect costs related to this benefit.

2. Cover acupuncture up to 12 visits

What is Currently Covered?

The proposed benefit would cover up to 12 acupuncture visits per plan year. The State Standard plans do not appear to offer coverage for acupuncture. Two carriers indicated coverage is included in their small group plans but not in their individual plans. Similar to spinal manipulation, many plans will include a benefit limit which range from \$500 to \$1500 or a visit limit of 3-15 visits.

Similar to spinal manipulation, one of the carriers noted while there is no evidence-based research to indicate potential savings due to reductions in other associated health care costs, they have seen general industry data, such as data from National Center for Complementary and Integrative Health that suggests it is an effective pain management method.

Analysis of Additional Generosity

The Center for Health Information and Analysis performed a benefit review of acupuncture for Massachusetts bill H.B. 3972 related to acupuncture.²³ The act provided “benefits for acupuncture and oriental medicine based diagnosis and treatment in the areas of pain management, post-traumatic stress disorder, substance abuse treatment, and nausea.” The bill does not restrict carriers’ ability to apply medical necessity criteria or set coverage limits. The analysis expected a cost ranging from \$0.38 PMPM to \$0.76 PMPM for this benefit.

²¹ The \$9 PMPM estimate was combined for spinal manipulation and acupuncture.

²² We note some carrier responses combined spinal manipulation and acupuncture.

²³ The Center for Health Information and Analysis. “Mandated Benefit Review Of H.B. 3972: An Act Relative To The Practice Of Acupuncture”. April 2015. <https://www.chiamass.gov/assets/Uploads/MBR-H3972-Acupuncture.pdf>. Accessed April 20, 2020.

An older benefit review was performed by California Health Benefit Review Program for Assembly Bill 72 which would require coverage of services provided by acupuncturists.²⁴ They estimated an impact in the range of \$0.0034 to \$0.2924 PMPM.

The carriers we surveyed calculated and expected cost ranging from \$0 to \$9 PMPM²⁵ for this benefit. Similar to the spinal manipulation benefit, we do not believe the \$9 estimate is accurate and disregarding the \$9 PMPM estimate provides a range of approximately \$0-\$1.25 PMPM, which is consistent with the Massachusetts analysis.

The NovaRest analysis described in the ‘Data and Methodology’ section resulted in approximately \$0.95 PMPM for up to 12 visits for acupuncture.

No carriers indicated any material increases in administrative or indirect costs related to this benefit

3. Removal of barriers to prescribing Buprenorphine or generic equivalent products for medication-assisted treatment (MAT)²⁶ of opioid use disorder (OUD).

What is Currently Covered?

We interviewed Dr. Teresa Jackson, MD, FASAM to gain an understanding on the use of Buprenorphine and its alternatives. Buprenorphine is a controlled substance and is a schedule III drug with the Drug Enforcement Administration (DEA). Buprenorphine is one of three approved medications for OUD, along with Methadone (which must be dispensed by a federally approved clinic whereas Buprenorphine can be prescribed at an outpatient clinic) and Naltrexone (which is an opiate blocker whereas Buprenorphine is an opiate agonist). The proposed benefit would only cover Buprenorphine or generic equivalents.

Buprenorphine can be offered by itself as a “mono-product”²⁷ or as a mixture with naloxone. The mono-product has a higher abuse potential, as the naloxone is used as an abuse-deterrent to prevent misuse. Mono-product Buprenorphine is typically prescribed to pregnant patients with OUD or those with an allergy to naloxone.

The proposed benefit would require coverage without barriers or restrictions for Buprenorphine or brand mixture products.

There was discrepancy among carriers about whether this was already included in the EHB-benchmark plan. Several carriers, including PacificSource whose plan, Preferred CoDeduct Value 3000 35 70, is the current EHB-benchmark plan, currently consider this covered under the current EHB-benchmark. Other carriers either indicated they were unsure or did not believe it

²⁴ California Health Benefit Review Program. “Executive Summary Analysis of Assembly Bill 72: Health Care Coverage Acupuncture.” March 18, 2011. <http://analyses.chbrp.com/document/view.php?id=473>. Accessed April 22, 2020.

²⁵ The \$9 PMPM estimate was combined for spinal manipulation and acupuncture.

²⁶ According to our interview with Dr. Teresa Jackson, medication for treatment of Opioid Use Disorder (MOUD) is the updated terminology for MAT, although we will continue with the language in the proposed benefit changes.

²⁷ Also referred to as Subutex.



was included in the EHB-benchmark plan, but indicated that they currently do not have prior authorization on most Buprenorphine or equivalent products, at least for the first 30 days. No carrier indicated any prior authorization inside of a 30 day supply on any Buprenorphine or equivalent if it was not used exclusively for pain.

Analysis of Additional Generosity

All carriers indicated either no or minimal cost for this proposal.

We do recognize there may be cost outside of the 30 days supply where some carriers indicate they do require prior authorization, however, we believe the number of cases that would be denied after a 30-day period to receive a prior authorization is de minimis.

Because almost all carriers currently cover some variation of Buprenorphine or brand equivalents without prior authorization, we do not believe there are many patients who are currently unable to receive treatments; therefore, we do not believe requiring coverage without barriers will incentivize additional utilization and believe the additional cost is \$0.00 PMPM. Dr. Jackson also noted this action is supported by the Addiction Medicine community and the American Society of Addiction Medicine.²⁸

4. At least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.

What is Currently Covered?

The proposed benefit would provide for at least one (1) intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50 Morphine Milligram Equivalents (MME) or higher. MME is the amount of morphine an opioid dose is equal to when prescribed.²⁹ Currently, Narcan is the only FDA approved naloxone nasal spray available on the market; even though the FDA has approved a generic version,³⁰ it is not yet available due to a legal dispute.³¹ The FDA is also considering supporting the development of over-the-counter versions of generic naloxone or whether it should be co-prescribed with all or some opioid prescriptions.³² The proposed benefit would co-prescribe an intranasal opioid reversal agent (Narcan at this time is the only prescription of this type available) with opioid prescriptions of 50MME or higher. The Centers for Disease Control and Prevention (CDC) guideline states that clinicians should “carefully

²⁸ Prior Authorization Cover Letter. American Society of Addiction Medicine. <https://www.asam.org/docs/default-source/advocacy/bup-prior-auth-form--as-approved.pdf?sfvrsn=8>. February 20, 2020.

²⁹ “CDC Guideline for Prescribing Opioids for Chronic Pain.” Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. February 17, 2020.

³⁰ Lyndsay Meyer. “FDA approves first generic naloxone nasal spray to treat opioid overdose.” U.S. Food & Drug Administration. April 19, 2019. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-generic-naloxone-nasal-spray-treat-opioid-overdose>. February 17, 2020.

³¹ Andrew Dunn. “Teva wins generic Narcan approval as FDA mulls bolder actions.” BioPharmaDive. April 22, 2019. <https://www.biopharmadive.com/news/teva-narcan-generic-fda-approval-co-prescription/553148/>. February 17, 2020.

³² Lyndsay Meyer. “FDA approves first generic naloxone nasal spray to treat opioid overdose.” U.S. Food & Drug Administration. April 19, 2019. <https://www.fda.gov/news-events/press-announcements/fda-approves-first-generic-naloxone-nasal-spray-treat-opioid-overdose>. February 17, 2020.



reassess evidence of individual benefits and risks when considering increasing dosage to greater than or equal to 50 MME/day.”³³

Similar to the Buprenorphine requirement, there was some disagreement among carriers as to whether this is currently included in the EHB-benchmark plan or not although all of the carriers indicated it is included on their formulary, without prior authorization, at least for the first 30-days, although one carrier indicated a general consensus on a state meeting was to remove the prior authorization after 30 days and monitor utilization retroactively. One carrier did indicate they had quantity limits.

While Narcan may be covered with prior authorization, it does not appear to be co-prescribed with opioids of 50 MME or greater, which the proposed benefit would require.

Analysis of Additional Generosity

All carriers indicated either no or minimal cost for this proposal.

The Illinois analysis performed by Oliver Wyman estimated a 0.06% impact to premiums.³⁴

We recognize there is potential for additional cost by requiring the intranasal naloxone with a prescription over 50 MME, however, currently all carriers would approve a prescription for an intranasal naloxone regardless. HHS released guidance recommending clinicians co-prescribe naloxone to any patients at a dosage of 50 MME per day or greater.³⁵ We believe clinicians will adhere to this guidance and because no carrier has prior authorization on Narcan, we believe all prescriptions would be approved and there will be no additional cost.

³³ “CDC Guideline for Prescribing Opioids for Chronic Pain.” Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. February 17, 2020.

³⁴ Beth Fritchen, FSA, MAAA. “EHB Benchmark Analysis with a Focus on the Opioid Epidemic.” June 29, 2018. Illinois Department of Insurance and Oliver Wyman.

³⁵ Adm. Brett P. Giroir, MD. “Naloxone: The Opioid Reversal Drug that Saves Lives.” <https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf>. Accessed April 20, 2020.



5. Generosity Conclusion.

The cost PMPM of each proposed new benefit is shown in the following table.

Proposed Additional Benefits	Generosity PMPM Impact
Spinal Manipulation – Up to 20 Visits	\$1.89
Acupuncture – Up to 12 Visits	\$0.95
Removal of barriers to prescribing Buprenorphine or generic equivalent products for medication-assisted treatment of opioid use disorder.	\$0.00
Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.	\$0.00
Total	\$0.00

Since the generosity of the most generous small group plan among the original plans considered, the Small Group 3 - United, is at least \$2 to \$3 PMPM richer than the current Benchmark Plan, adding \$2.84 in benefits to the current Benchmark Plan would result in a plan that does not exceed the generosity of the most generous among the original plans considered.

Certification

It is my belief that the proposed EHB-benchmark plan complies with the following requirements included in the CMS guidance regarding selecting a new EHB-benchmark plan.

1. The EHB-benchmark plan must be equal to, or greater than the scope of benefits provided under a typical employer plan, as defined under 45 CFR 156.111(b)(2)(i); and
2. The EHB-benchmark plan does not exceed the generosity of the most generous small group plan among the plans listed at 45 CFR 156.111(b)(2)(ii).

The actuarial methodologies utilized in order to arrive at our opinion were those that were considered generally accepted within the industry and are consistent with all applicable Actuarial Standards of Practice.

If you have any questions, do not hesitate to call Al at 770-365-6594.

Sincerely,

Al Bingham, FSA, MAAA



Reliance

NovaRest relied upon the following information:

- An interview and subsequent correspondence with Dr. Teresa Jackson, MD, FASAM. Dr. Jackson does not opine on the results of the analysis offered in this paper.
- A carrier data survey.
- The report entitled, EHB Benchmark Analysis with a Focus on the Opioid Epidemic, authored by Beth Fritchen, FSA, MAAA of Oliver Wyman.
- 2018 commercial membership, claims, and allowed cost information provided in the Oregon All Payer Claims Database.
- 2018 information provided in the NAIC Supplemental Health Care Exhibit.
- The Wakely report State of Oregon Essential Health Benefits Analysis and Results.

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Limitations

Opinions in this report should not be construed as providing legal advice.

Estimates in this report are precise enough to be used to confirm that CMS requirements are met, but should not be used for any other purposes.

This report should only be used by DIFS for the purposes intended and not for any other purposes.

This report should only be communicated in its entirety and not in parts or out of context.

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Appendix A: Data Call

Subject: Carrier Information Request Concerning Proposed Changes to the ACA Benchmark Plan

Oregon is considering updating the Oregon Benchmark plan, requiring the following additional benefits:

- 20 Chiropractic Visits.
- 12 Acupuncture Visits.
- Limiting opioid prescriptions for acute pain to no more than seven days.
- Removal of barriers to prescribing Buprenorphine or brand equivalent products for medication-assisted treatment of opioid use disorder.
- At least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.
- Tele-psychiatry.

Please respond to the following questions by Friday, April 17, 2020.

1. Please indicate if each benefit is already covered by (1) the benchmark plan, (2) mandated outside the benchmark plan, or (3) covered even though not covered by benchmark or mandated outside of the benchmark plan. If mandated outside the benchmark plan, please provide the mandate reference. If covered even though not currently in the benchmark plan or mandated, please explain why. If the answer varies by market or plan, please indicate which markets and plans cover each benefit.
2. For each benefit, please describe any potential benefits or savings. Are there any comparative research studies documenting potential savings due to reduction in other associated health care costs?
3. For each benefit, please estimate the cost implications of coverage for treatment if the benchmark plan changes went into effect (including utilization PMPM and cost PMPM). In discussing cost, include and describe anticipated increases in premiums, administrative expenses, and indirect costs for Individual and Small Group separately, taking into consideration that it may be a substitute for a more expensive service or product as discussed in question #2.