



NovaRest
ACTUARIAL CONSULTING

Michigan Essential Health Benefit Benchmark Plan Certification

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

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Prepared by:

Donna Novak, FCA, ASA, MAAA

Alfred Bingham, FSA, MAAA

Wayne Novak

**Richard Cadwell
of NovaRest, Inc.**



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Executive Summary

Project Description

Michigan is proposing changes to the mental health/substance abuse category of its Essential Health Benefit (EHB) Benchmark Plan (EHB-benchmark plan) with emphasis on combating the opioid epidemic. To facilitate this, NovaRest, Inc. (NovaRest) was hired by the Michigan Department of Insurance and Financial Services (Michigan or DIFS) 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, to the extent any supplementation is required to provide coverage within each EHB category at 156.111(a), than the scope of benefits provided under a typical employer plan and does not exceed the generosity of the most generous of a set of small-group 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. Donna Novak, President and CEO of NovaRest, is an Associate 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 Michigan's proposed changes to its EHB-benchmark plan. The intended users of this report are Michigan 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, Michigan is proposing to require the following benefits to its Benchmark Plan in the mental health/substance abuse EHB category.

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

Please note that according to a carrier survey and an analysis performed by a consulting pharmacist, a majority of the market (approximately 95% of the Michigan combined ACA market), including the EHB-benchmark already include Narcan on their formulary. We also note approximately 100% of the Michigan combined ACA market currently include Buprenorphine or generic equivalents on their formulary.

This is 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

Conclusions

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

1. Typicality requirement: The EHB-benchmark plan must be greater than or equal to the extent any supplementation is required to provide coverage within each EHB category at 156.111(a), the scope of benefits provided under a typical employer plan as defined under 45 CFR 156.111(b)(2)(i); and
2. Generosity requirement: The EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed at 45 CFR 156.111(b)(2)(ii).

We believe Blue Cross Blue Shield Michigan Simply Blue plan represents a typical employer plan in Michigan, because it fulfills the CMS requirements of a typical employer plan as discussed later in the report. BCBSMI indicated they cover the proposed benefits and we believe the scope of benefits is at least equal to the proposed-EHB benchmark plan.

We estimate the total generosity impact per member per month (PMPM) to range from \$0.00 PMPM to \$1.73 PMPM. We estimate \$0 cost impact to removing barriers to prescribing Buprenorphine or generic equivalents as it is already covered by the current EHB-benchmark plan without barriers or prior authorization. The EHB-benchmark plan also currently covers at least one intranasal spray opioid reversal agent (Narcan), although we estimated \$1.73 PMPM as the total cost due to additional prescriptions resulting for requiring Narcan be prescribed with all opioids 50 MME or greater. Subsequent to our initial report, we discovered a recommendation letter from HHS² which recommends Narcan be prescribed with all prescriptions of opioids 50MME or greater. Due to this recommendation, we expect Narcan is already being prescribed more often, although we are unable to quantify that impact. We therefore believe the total impact is somewhere in the range of \$0 to \$1.73 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.

¹ Notice of Benefit and Payment Parameters for 2020

² 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.



Proposed Additional Benefits	Generosity PMPM Impact
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-\$1.73
Total	\$0.00-\$1.73

In 2012, Wakely Consulting Group provided Michigan with a report³ that provided an analysis of the premium impact of the benefit differences between the ten (10) category plan combinations considered for Michigan's Benchmark Plan. Wakely estimated that the BCBSM Community Blue PPO Plan 4, had a premium impact of \$2.00 to \$2.50 PMPM higher than the benchmark plan chosen, Priority Health – Priority HMO (Health Maintenance Organization) plan.⁴ This differential will be even higher in 2022 due to medical inflation for the benefits covered by the BCBSM Community Blue PPO Plan 4 compared to Priority Health's HMO benefits.

We believe the BCBSM Community Blue PPO Plan 4 is an appropriate plan to compare for the generosity test because it was the most generous small group plan included in the original 10 plans considered for the Michigan benchmark plan that was scored by Wakely⁵ and BCBSM is one of the largest carriers in the Michigan small group ACA market. We also note BCBSM indicated they already cover both of the proposed benefits on their formulary even though it is not in the State EHBs.

The following table is taken from that report.

³ State of Michigan Essential Health Benefits Analysis and Results – Updated August 16, 2012

⁴ Slide 11 from the Wakely PowerPoint presentation State of Michigan Essential Health Benefits Analysis and Results – Updated August 16, 2012

⁵ Please note the most generous plan score by Wakely was BCN (10), which was not included in the final 10 comparison plans.



Benchmark Option	Premium PMPM Impact of Benefit Differences
Small Group 2 - Priority Health (HMO)	\$0.00 - \$0.00
HMO - Priority Health (HMO)	\$0.00 - \$0.00
Small Group 1 - BCBSM Community Blue PPO Plan 4	\$2.00 - \$2.50
State Plan 3 - Priority Health (HMO)	\$2.00 - \$2.50
Small Group 3 - BCN10 (HMO) ⁶	\$2.75 - \$3.50
State Plan 1 - BCBSM (Self-insured)	\$3.50 - \$4.50
State Plan 2 - PHP (HMO)	\$4.00 - \$5.00
FEHBP - BCBS Standard Option	\$5.50 - \$7.00
FEHBP - GEHA Standard Option	\$13.00 - \$16.25
FEHBP - BCBS Basic Option	\$14.50 - \$18.25

Because the estimated additional generosity PMPM of \$0.00-\$1.73 PMPM is lower than the \$2.50 PMPM under BCBSM Community Blue PPO Plan 4, we believe that, assuming these cost relationships still hold, the proposed EHB-benchmark plan does not exceed the generosity of the most generous 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.⁷

For plan years 2017, 2018, and 2019, each state's EHB-benchmark plan is based on a plan that was sold in 2014.⁸

⁶ Please note this plan was included in Wakely's report, however, it did not make it into the final 10 comparison plans for Michigan. Instead the Small Group Plan 3 was BCBSM Simply Blue 2500.

⁷ 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.

⁸ 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.⁹ 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).¹⁰

States can choose a Benchmark Plan from among the following health insurance plans:¹¹

- The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national FEHBP plan options by enrollment; or
- The largest insured commercial non-Medicaid HMO operating in the State.

Guidance and Requirements for Changing Benchmark Plans¹²

Under 45 CFR 156.111 in the Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) finalized on April 9, 2018,¹³ 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:¹⁴

- 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.

⁹ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf>, page 3

¹⁰ 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>. State's 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.

¹¹ Ibid, page 3

¹² Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf

¹³ 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>.

¹⁴ <https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>

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.

This actuarial certification and associated actuarial report must affirm that the state's EHB-benchmark plan:¹⁵

- 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 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 small-group plan options used for the 2017 plan year described in 45 CFR 156.100(a)(1), supplemented as necessary under 45 CFR 156.110.¹⁶

¹⁵ Ibid

¹⁶ 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.

Michigan Proposal for Benchmark Changes

Ten Original Plans Considered

Michigan originally considered ten (10) category plan combinations as potential Benchmark Plans for its 45 CFR 156.111(b)(2)(ii) ACA individual marketplace.¹⁷ It considered one (1) HMO, three (3) small group plans, three state plans and three (3) FEHBPs. The considerations included the following:

1. HMO – Priority Health (HMO)
2. Small Group 1 – BCBSM Community Blue PPO Plan 4¹⁸
3. Small Group 2 – Priority Health (HMO)¹⁹
4. Small Group 3 – BCBS Simply Blue 2500^{20,21}
5. State Plan 1 – BCBSM (self-insured)²²
6. State Plan 2 – PHP (HMO)²³
7. State Plan 3 - Priority Health (HMO)
8. FEHBP – BCBS Standard Option²⁴
9. FEHBP – GEHA Standard Option²⁵
10. FEHBP – BCBS Basic Option²⁶

Michigan Benchmark Plan Chosen

Michigan selected the Priority Health – Priority HMO plan for its Benchmark Plan.²⁷

In 2012, Wakely Consulting Group provided Michigan with a report²⁸ that presented an analysis of the premium impact of the benefit differences between the ten (10) category plan combinations considered for Michigan’s Benchmark Plan. Wakely estimated that the BCBSM Community Blue PPO Plan 4, had a premium impact of \$2.00 to \$2.50 PMPM higher than the Benchmark Plan chosen, Priority Health – Priority HMO plan.²⁹

¹⁷ 2017_EHB_Benchmark_Report_493203_7.pdf and 2017_EHB_Comparison_Charts_493204_7.pdf

¹⁸ https://www.michigan.gov/documents/difs/BCBSM_Community_Blue_2017_489393_7.pdf

¹⁹ https://www.michigan.gov/documents/difs/Priority_Health_2017_489394_7.pdf

²⁰ https://www.michigan.gov/documents/difs/BCBSM_Simply_Blue_2017_489396_7.pdf

²¹ Please note the BCBS Simply Blue 2500 was included in the Michigan 10 comparison plans, but was not included in the Wakely analysis. The Wakely analysis included BCN 10 (HMO).

²² https://www.michigan.gov/documents/difs/BCBSM_2017_489398_7.pdf

²³ https://www.michigan.gov/documents/difs/PHP_2017_489399_7.pdf

²⁴ https://www.michigan.gov/documents/difs/BCBS_2017_489401_7.pdf

²⁵ https://www.michigan.gov/documents/difs/GEHA_2017_489402_7.pdf

²⁶ https://www.michigan.gov/documents/difs/BCBS_2017_489401_7.pdf

²⁷ 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.

²⁸ State of Michigan Essential Health Benefits Analysis and Results – Updated August 16, 2012

²⁹ Slide 11 from the Wakely PowerPoint presentation State of Michigan Essential Health Benefits Analysis and Results – Updated August 16, 2012

We believe that currently the BCBSM Community Blue PPO Plan 4, is at least \$2.00 to \$2.50 PMPM richer than the current Benchmark Plan, Priority Health – Priority HMO plan based on the Wakely analysis and our knowledge of trends in health care costs since 2012.

Proposed Changes

Illinois recently updated its EHB-benchmark plan adding five (5) new benefits to “focus around preventing and improving access to treatment for opioid addiction.”³⁰ Michigan reviewed the changes Illinois made to its EHB-benchmark plan for the 2020 plan year and is interested in making similar changes to its EHB-benchmark plan for the 2022 plan year; although, two (2) of the benefits Illinois added (Tele-psychiatry and a 7-day limit on opioid prescriptions for acute pain) are already required by Michigan state law, MCL 500.3476 and MCL 333.7333b, respectively. 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).³¹

Michigan proposes to use Option 3 by selecting a set of benefits that would become the state’s EHB-benchmark plan. The set of benefits proposed contains all of the benefits in Michigan’s current Benchmark Plan, Priority Health – Priority HMO plan, plus the following benefits:

1. Removal of barriers to prescribing Buprenorphine or generic equivalent products for medication-assisted treatment of opioid use disorder.³²
2. Coverage of at least one intranasal spray opioid reversal agent when prescriptions of opioids are dosages of 50MME or higher.

NovaRest Analysis

Data and Methodology

DIFS hired Karen Jonas, a consulting pharmacist, to compare and evaluate the Michigan and Illinois EHB formulary coverage to determine which provided the most comprehensive coverage. NovaRest reviewed this analysis and interviewed Karen Jonas on the analysis.

NovaRest also interviewed Teresa L. Jackson, MD, FASAM to gain a provider’s valuable perspective on how these 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.

³⁰ 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.

³¹ 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.

³² Please also note the Illinois EHB-benchmark plan changes require Buprenorphine or brand equivalent products, while Michigan is requiring generic equivalent products.



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NovaRest and DIFS performed a data call on Michigan 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 Michigan Department of Licensing and Regulatory Affairs (LARA) performs an annual analysis on drug utilization in Michigan.³³ The 2018 analysis was valuable in providing prescription counts for various opiate agonists in Michigan.

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)

To fulfill the typicality requirement, CMS guidance indicates the largest health insurance plan by enrollment in any of the five largest large group health insurance products by enrollment in the selecting state, as product and plan are defined at §144.103, can be selected as a typical employer plan provided that:

- (a) the product has at least 10 percent of the total enrollment of the five largest large group health insurance products by enrollment in the selecting state;
- (b) the plan provides minimum value;
- (c) the benefits are not excepted benefits; and
- (d) the benefits in the plan are from a plan year beginning after December 31, 2013.

Blue Cross Blue Shield of Michigan (BCBSMI) has the most membership in the Michigan large group market according to the 2019 SHCE. According to information provided by the Michigan Department of Insurance and Financial Services (DIFS), the plan BCBS Simply Blue plan is the largest large group employer plan in Michigan based on member months as of 2019 and has 15% of the total Michigan large group membership. Of the total enrollment of the five largest group health products in Michigan, BCBSMI Simply Blue plan has 27% of the total enrollment. Based on a review of the simply blue group benefits certificate and discussions with the Michigan DIFS, we confirm the plan provides minimum value and the benefits are not excepted benefits. Additionally, the benefits being considered were added after December 31, 2013. The intranasal opioid reversal agent was first approved in 2015.³⁴ Similarly, the generic version of buprenorphine and naloxone were approved in 2018.³⁵

Based on their response to our data call and an analysis performed by a consulting pharmacist, BCBSMI already covers the proposed benefits on their formulary, and they confirmed these benefits are covered in the large group market in the Simply Blue plan which we selected as a typical employer plan. Therefore we believe the scope of benefits under the proposed EHB-benchmark plan is equal to the typical employer plan.

³³ Annual Drug Utilization Reports. Department of Licensing and Regulatory Affairs. November 5, 2019. https://www.michigan.gov/lara/0,4601,7-154-89334_72600_72603_55478_55479---,00.html. February 17, 2020.

³⁴ Narcan Approval History. <https://www.drugs.com/history/narcan.html>. June 29, 2020.

³⁵ Kristen Coppock, MA, Editor. Generic Therapies Available for Treating Opioid Dependence. February 22, 2019. <https://www.pharmacytimes.com/news/generic-therapies-available-for-treating-opioid-dependence>. June 29, 2020.

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

NovaRest did an analysis of adding the two (2) new benefits.

1. Removal of barriers to prescribing Buprenorphine or generic equivalent products for medication-assisted treatment (MAT)³⁶ 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"³⁷ 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 as initially presented to the carriers would require coverage without barriers or restrictions for Buprenorphine or **brand** mixture products.³⁸ Karen Jonas' analysis concluded that a minority of plans currently provides coverage without barriers or restrictions for Buprenorphine products or brand mixture products for MAT and extensive formulary changes would be required. Our interpretation of the proposed benefit, as initially presented to carriers, is that carriers would not be required to cover all Buprenorphine and brand equivalent products, but rather Buprenorphine or brand equivalent products, thus our interpretation of Karen Jonas' analysis is that all carriers except for three (3) cover at least one (1) variation without restrictions.

The carriers' responses indicated all but two (2) carriers currently cover Buprenorphine or **generic** equivalent products without barriers. One carrier stated due to generic availability, the requirement to cover brand alternatives would increase costs. Another expressed concern for any benchmark changes, which would restrict utilization management on products not indicated for OUD.

After reviewing carrier responses to the data call and discussions with DIFS, the decision was made to change the language of the benefit to require Buprenorphine or generic equivalents without barriers as opposed to brand.

³⁶ 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.

³⁷ Also referred to as Subutex.

³⁸ The decision to allow generic mixture products was made after Karen Jonas' analysis was performed and after the carrier responses were received.

Because almost all carriers currently cover some variation of Buprenorphine or generic equivalents without barriers for OUD, 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.³⁹

2. 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.⁴⁰ Currently, Narcan is the only FDA approved naloxone nasal spray available on the market; even though the FDA has approved a generic version,⁴¹ it is not yet available due to a legal dispute.⁴² 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.⁴³ 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 reassess evidence of individual benefits and risks when considering increasing dosage to greater than or equal to 50 MME/day.”⁴⁴

Karen Jonas’ analysis showed that all carriers except two (2) currently cover Narcan Nasal spray. These 2 companies represent approximately 5% of the combined Michigan ACA marketplace. During our interview, Karen Jonas noted that there are other opioid reversal agents that are widely available as brand and generics, including injectable versions and capsules. Karen Jonas noted that the capsules are less effective as other versions and injectable versions may require some experience, making the intranasal much more user friendly.

³⁹ 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.

⁴⁰ “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.

⁴¹ 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.

⁴² 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.

⁴³ 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.

⁴⁴ “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.

All carriers except one indicated Narcan nasal spray is included on their formulary, many of which noted that it was available without prior authorization. While Narcan may be covered on most carriers' formularies, it does not appear to be co-prescribed with opioids of 50 MME or greater, which the proposed benefit would require. We did discover, subsequent to our initial cost estimate, an HHS recommendation⁴⁵ that recommends the co-prescribing practice that is being considered in the proposed benefit. Therefore, we believe some of the cost of additional scripts is already being experience, although we are unable to quantify how much.

One carrier provided a 2019 cost of \$0.01 PMPM based on its 2019 usage; however, NovaRest believes the usage would increase if co-prescribed.

A carrier stated that Michigan should consider allowing plans the flexibility to offer one type of naloxone reversal agent due to pricing and availability. A second carrier stated requiring this to be co-prescribed would lead to excessive waste and prescribing a reversal agent should take other factors into consideration in addition to opioid dose. A third carrier brought up the point that Narcan is currently brand only and with a single manufacturer that controls the cost.

⁴⁵ 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.

Analysis of Additional Generosity

No carriers provided cost estimates for this proposed change.

The Illinois analysis performed by Oliver Wyman estimated a 0.06% impact to premiums.⁴⁶

To determine the full cost for this benefit, we requested information from LARA, which performs an annual analysis on drug utilization in Michigan.⁴⁷ The latest report is from 2018. DIFS was able to request the number of scripts greater than or equal to 50MME in the commercial market in 2018 (906, 607). This report only provides MME amounts for opioids, so we did not need to filter out non-opioids.

The commercial market includes the large group market, the grandfathered market, transitional market, and self-funded market that would not be subject to the requirements of the Benchmark Plan; however, we assume the drug utilization would be uniform among all markets. We also assume all markets provide coverage for opioids. DIFS provided an estimate of the total covered lives in the commercial market as 5.9 million covered lives.⁴⁸ This amounts to approximately 154 scripts per 1,000 members.

The estimated cost of Narcan is approximately \$135 per script.⁴⁹ Assuming that Narcan will not increase the price due to increased demand resulting from co-prescribing, we estimate the full \$1.73 PMPM cost to the commercial market, and approximately 0.39% impact to the average individual and small group premium PMPM when using the 2018 National Association of Insurance Commissioners (NAIC) Supplement Health Care Exhibit (SHCE) earned premiums.

We note, however, that 95% of Michigan ACA carriers already carry Narcan on their formularies and due to the HHS recommendation on prescribing Narcan with opioids 50 MME or greater, we believe some of this cost is already being experienced.

⁴⁶ Beth Fritchen, FSA, MAAA. “EHB Benchmark Analysis with a Focus on the Opioid Epidemic.” June 29, 2018. Illinois Department of Insurance and Oliver Wyman.

⁴⁷ Annual Drug Utilization Reports. Department of Licensing and Regulatory Affairs. November 5, 2019. https://www.michigan.gov/lara/0,4601,7-154-89334_72600_72603_55478_55479---,00.html. February 17, 2020.

⁴⁸ From, FIS 322 (Michigan Health Insurance Enrollment, Premiums, and Losses Database) 2018.

⁴⁹ <https://www.goodrx.com/narcan>



3. Generosity Conclusion.

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

Proposed Additional Benefits	Generosity PMPM Impact
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-\$1.73
Total	\$0.00-\$1.73

Since the generosity of the most generous among the original small group plans considered and was valued by Wakely, the BCBSM Community Blue PPO Plan 4, had a premium impact of \$2.00 to \$2.50 PMPM richer than the current Benchmark Plan, Priority Health – Priority HMO plan, adding \$0.00-\$1.73 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 small group 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 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 Donna at 520-908-7246.

Sincerely,



Donna C. Novak, FCA, ASA, MAAA, MBA

Reliance

NovaRest relied upon the following information:

- The analysis and a subsequent interview of Karen Jonas, a DIFS consulting pharmacist who analyzed the comprehensiveness of the Michigan and Illinois EHB formulary coverage.
- 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 call.
- The report entitled, EHB Benchmark Analysis with a Focus on the Opioid Epidemic, authored by Beth Fritchen, FSA, MAAA of Oliver Wyman.
- 2018 membership information provided in the Michigan Health Insurance Enrollment, Premiums, and Losses Database.
- 2018 information provided in the NAIC Supplemental Health Care Exhibit.
- 2018 Prescription Counts provided in the LARA Annual Drug Utilization Reports.
- The Wakely report State of Michigan Essential Health Benefits Analysis and Results.

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.