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EHB BENCHMARK ANALYSIS WITH A FOUCS ON THE OPIOID EPIDEMIC

ILLINOIS DEPARTMENT OF INSURANCE

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MARSH & McLENNAN COMPANIES

Contents

1. Executive Summary

Purpose and Scope

The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in ten benefit categories. HHS regulations (45 CFR 156.100) define EHB based on state-specific EHB benchmark plans, which apply to individual and small group ACA compliant plants. For plan year 2020 and after, the Final 2019 HHS 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 new options for selection starting in plan year 2020, including:

- 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.

The Illinois Department of Insurance (DOI) wants to utilize the greater flexibility granted by CMS to update their EHB benchmark plans to help address the opioid crisis and improve access to mental health and substance abuse resources for plan year 2020.

This is the actuarial report which is part of the State of Illinois' application for a change in the Federal CMS Plan Year 2020 Essential Health Benefit Benchmark Plan under Selection Option 3. The Illinois Department of Insurance is using the flexibility of benchmark as a tool to help address the opioid crisis and improve access to mental health and substance abuse resources.

In general, there are two actuarial requirements for the certification and report.

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

Proposed EHB Benchmark Plan

The current Illinois benchmark plan is the Blue Cross Blue Shield of Illinois Blue PPO Gold 011 plan in the small group market because it was one of the most popular among the state. This plan was chosen in accordance with the EHB rules and approved by CMS. Under Option 3, the State is allowed to develop its benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. Therefore, in the process of developing the 2020 EHB

benchmark plan, the Illinois DOI started with the 2019 EHB benchmark as the basis and added five new benefits. The five new benefits focus around preventing and improving access to treatment for opioid addiction.

For the research and development behind these recommendations, the Illinois DOI asked doctors, Dr. Connolly and Dr. Wolf, and Public Consulting Group (PCG) to provide recommendations for the current EHB benchmarks with regard to the opioid crisis. Michael Connolly, MD is an assistant professor and Chief Medical Officer at the SIU Center for Family Medicine in Quincy, Illinois. Kari M. Wolf, MD is a chair for the Department of Psychiatry at the Neuroscience Institute in the SIU School of Medicine. The doctors and PCG provided several recommendations and the research to demonstrate how these items could help to address the opioid crisis in the state. We relied upon the information provided by the doctors and PCG in our analysis.

The new recommended benefits are as follows:

- **Recommendation 1**: Within the prescription drug benefit category, the recommendation is to provide benefits for at least one intranasal opioid reversal agent for initial prescriptions of opioids with dosages of 50 MME.
- **Recommendation 2**: Within the prescription drug benefit category, the recommendation is to add a required category to the formulary for topical anti-inflammatory medication, such as Ketoprofen or Diclofenac, for acute and chronic pain.
- **Recommendation 3**: Within the prescription drug benefit category, the recommendation is to provide short-term opioid prescriptions for acute pain shall be provided for no more than 7 days.
- **Recommendation 4**: Within the prescription drug benefit category, the recommendation is to remove barriers to prescribing Buprenorphine products for medication-assisted treatment (MAT) of opioid use disorder. This should include removing prior authorization, dispensing limits, fail first policies and lifetime limit requirements.
- **Recommendation 5**: Within the access to care category, the recommendation is to add a requirement that telepsychiatry care (by both a prescriber and a therapist) become a covered benefit.

More details of the EHB benchmark plan can be found in the EHB-Benchmark Plan Document and EHB-Benchmark Summary Chart found in the Illinois DOI's application.

Actuarial Findings

We find the proposed 2020 EHB benchmark plan meets the two actuarial requirements cited above.

The first requirement states the EHB benchmark plan must be equal to or greater than the scope of benefits provided under a typical employer plan. The starting point for the proposed benchmark is the current 2019 benchmark, which is one of the most popular small group plans offered in Illinois. Further, since it is the current 2019 benchmark plan, it already meets the criteria of being equal to or greater than a typical employer plan. The DOI has elected to add

five benefits or criteria to the 2019 benchmark plan. Since the DOI is enhancing the plans, the proposed benchmark continues to meet the criteria of the first requirement.

The second requirement states the EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii). To demonstrate compliance with this requirement, we performed a cost study on each of the recommendations to determine the materiality of each and the impact it would have on the overall premiums of the benchmark plan. The findings of each recommendation and overall results are shown in the table below.

Impact of Recommendations

Recommendation	Annual Cost Per Member	Cost as Percentage of Premium
Recommendation 1	$3	0.06%
Recommendation 2	$0	0.00%
Recommendation 3	$0	0.00%
Recommendation 4	$0	0.00%
Recommendation 7	$1	0.01%
Total Impact	**$4**	**0.07%**

The detailed analyses of the cost studies can be found in Sections 3 through 9 of this report.

Based on the information shown above, we believe the five additional recommendations do not have a material impact on premium rates. As such, we believe the proposed 2020 EHB benchmark plan meets the criteria of the second requirement.

In our opinion, the proposed 2020 EHB benchmark plans meets the criteria of both requirements.

2. Overall Background and the EHB Plan

Purpose and Scope

The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in ten benefit categories. HHS regulations (45 CFR 156.100) define EHB based on state-specific EHB benchmark plans, which apply to individual and small group ACA compliant plants. For plan year 2020 and after, the Final 2019 HHS 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 new options for selection starting in plan year 2020, including:

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The Illinois Department of Insurance (DOI) wants to utilize the greater flexibility granted by CMS to update their EHB benchmark plans to help address the opioid crisis and improve access to mental health and substance abuse resources for plan year 2020.

This is the actuarial report which is part of the State of Illinois' application for a change in the Federal CMS Plan Year 2020 Essential Health Benefit Benchmark Plan under Selection Option 3. The Illinois Department of Insurance is using the flexibility of benchmark as a tool to help address the opioid crisis and improve access to mental health and substance abuse resources.

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The current Illinois benchmark plan is the Blue Cross Blue Shield of Illinois Blue PPO Gold 011 plan in the small group market because it was one of the most popular among the state. This plan was chosen in accordance with the EHB rules and approved by CMS. Under Option 3, the State is allowed to develop its benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. Therefore, in the process of developing the 2020 EHB

benchmark plan, the Illinois DOI started with the 2019 EHB benchmark as the basis and added five new benefits. The five new benefits focus around preventing and improving access to treatment for opioid addiction.

For the research and development behind these recommendations, the Illinois DOI asked doctors, Dr. Connolly and Dr. Wolf, and Public Consulting Group (PCG) to provide recommendations for the current EHB benchmarks with regard to the opioid crisis. Michael Connolly, MD is an assistant professor and Chief Medical Officer at the SIU Center for Family Medicine in Quincy, Illinois. Kari M. Wolf, MD is a chair for the Department of Psychiatry at the Neuroscience Institute in the SIU School of Medicine. The doctors and PCG provided several recommendations and the research to demonstrate how these items could help to address the opioid crisis in the state. We relied upon the information provided by the doctors and PCG in our analysis.

The new recommended benefits are as follows:

- **Recommendation 1**: Within the prescription drug benefit category, the recommendation is to provide benefits for at least one intranasal opioid reversal agent for initial prescriptions of opioids with dosages of 50 MME.
- **Recommendation 2**: Within the prescription drug benefit category, the recommendation is to add a required category to the formulary for topical anti-inflammatory medication, such as Ketoprofen or Diclofenac, for acute and chronic pain.
- **Recommendation 3**: Within the prescription drug benefit category, the recommendation is to provide short-term opioid prescriptions for acute pain shall be provided for no more than 7 days.
- **Recommendation 4**: Within the prescription drug benefit category, the recommendation is to remove barriers to prescribing Buprenorphine products for medication-assisted treatment (MAT) of opioid use disorder. This should include removing prior authorization, dispensing limits, fail first policies and lifetime limit requirements.
- **Recommendation 5**: Within the access to care category, the recommendation is to add a requirement that telepsychiatry care (by both a prescriber and a therapist) become a covered benefit.

More details of the EHB benchmark plan can be found in the EHB-Benchmark Plan Document and EHB-Benchmark Summary Chart found in the Illinois DOI's application.

3. Recommendation #1

Provide benefits for at least one intranasal opioid reversal agent for initial prescriptions of opioids with dosages of 50 MME.

Background

Within the prescription drug benefit category, the recommendation is to provide benefits for at least one intranasal opioid reversal agent for initial prescriptions of opioids with dosages of 50 MME.

Review of prescription drug coverage has an indication for zero opioid reversal agents. Naloxone is a full opioid antagonist that rapidly reverses the effects of respiratory depression in opioid overdose.[1] In a retrospective analysis in Massachusetts overdose death rates declined where intranasal Naloxone distribution programs were initiated.[2] Providing naloxone as a part of the strategy to combat the opioid crisis is recommended by several US federal agencies and is mandated by 15 states now.[3] Naloxone is available in multiple routes of administration; intravenous, intramuscular, subcutaneous and intranasal. All of these routes have equal efficacy and bioavailability.[4] Safety and ease of use of newer formulations, auto injector and intranasal spray, may improve compliance and safety, however formal studies are lacking. The evidence shows that the risk of unintentional overdose begins to increase after 20 morphine milligram equivalents (MME) daily with a relative risk of 2.81 when compared to < 20 MME. Additionally, when prescribed 50-100 MME daily the relative risk was 3.87 and above 100 MME the relative risk is 4.28.[5]

Based on research provided, the recommendation of prescribing an opioid reversal agent would be required with the initial prescription in cases where the MME is over [50 or 100]. These are the most common current requirements and consistent with expert recommendations.

Further, the goal or purpose of this recommendation is to have an opioid reversal agent on hand in the event of an overdose in order to reduce the rates of death by stabilizing patients until first responders and/or qualified medical professionals can treat the patient. Given this is the goal,

[1] Boyer EW. Management of opioid analgesic overdose. N Engl J Med. 2012;367(2):145-155.

[2] Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 30;346:f174. doi: 10.1136/bmj.f174.

[3] Throckmorton DC, Compton WM, Lurie P. Management of opioid analgesic overdose. N Engl J Med. 2012 Oct 4;367(14):1371. author reply 1372–1373.

[4] Kerr, D, Kelly, AM etal.Randomized controlled trial comparing the effectiveness and safety of intranasal and intramuscular naloxone for the treatment of suspected heroin overdose. Addiction. 2009 Dec;104(12):2067-74

[5] Adewumi AD, Hollingworth SA, Maravilla JC, Connor JP, Alati R. Prescribed Dose of Opioids and Overdose: A Systematic Review and Meta-Analysis of Unintentional Prescription Opioid Overdose.CNS Drugs. 2018 Feb;32(2):101-116. doi: 10.1007/s40263-018-0499-3. Review.

the recommendation specifies the nasal injector or auto-injector as the form since these forms have quicker reaction rates.

Data

We used a proprietary dataset, Truven Health MarketScan® Research Database, to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan. The data comes from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private-sector health data from over 6 million member months.

Using MarketScan, we extracted costs and utilization statistics associated with opioid drugs and with Naloxone. We only included opioids that were provided in outpatient settings since it is our understanding that inpatient opioids after a major event like surgery will be monitored by the hospital. Any issues that would arise in an inpatient setting would be treated accordingly. Naloxone is Narcan, the fast acting reversal agent for opioids that can be administered intravenously, by mouth or through a nasal spray. Further, since this recommendation addresses emergency treatment only, we reviewed claims provided in outpatient settings only.

Methodology and Results

Currently, the Illinois benchmark plan includes coverage for at least one Opioid Antagonist for all individual and small group policies of accident and health insurance that offer prescription drug benefits. The proposed recommendation would add a prescription for an opioid reversal agent, such as Naloxone, as a take home drug in the case of an emergency overdose. In these cases, the opioid reversal agent has the potential to stabilize the patient until first responders and/or other medical professionals can administer medical treatment.

There are several assumptions we employed in the calculation of the cost impact on health insurance premium rates in the state.

- The opioid reversal agent would be prescribed with the initial prescription of an opioid of more than [50 or 100] MMEs.
- Research shows Naloxone in the form of a pill is poorly absorbed, so in this form it is generally used for the purpose of reducing opioid addiction. As such, we have assumed the nasal spray would be the form prescribed. There is significant cost difference between the nasal spray and auto-injector forms.
- In the event of an overdose or emergency medical visit, another prescription of the opioid reversal agent would be prescribed if an opioid was again prescribed.
- There would be no potential offsets in the cost of health insurance with this recommendation. In the event of an overdose, where the opioid reversal agent is administered, it is our assumption that emergency medical treatment would be provided to the patient. Based on research, the opioid reversal agent would be used to stabilize the patient until first responders and/or medical professional could provide treatment.

The effect of the opioid reversal agent generally lasts about 30 to 60 minutes. As such, we have assumed other medical treatment would be required.

We extracted historical opioid claims information with dosages over [50 or 100] MMEs from MarketScan for Illinois specifically to estimate the impact of this recommendation. Further statistics were extracted regarding the number of opioid refills, the number of drug related emergency room visits and the total cost of medical and pharmacy services in the state. Below are the key statistics based on the Illinois specific data:

- Approximately 2.5% of insured members have prescriptions for opioids with 50 MMEs or more. [0.5% of insured members have prescriptions for opioids with 100 MMEs or more.]
- For members with at least one opioid prescription of 50 MMEs or more, the average number of opioid prescriptions is 2.7. [3.7 for prescriptions with 100 MMEs or more]
- Approximately 0.25% of the insured members with an opioid prescription (of 50 MMEs or more) had a drug related emergency room visit and later opioid prescriptions. [The corresponding amount for opioid prescriptions of 100 MMEs or more is 0.68%]
- The average cost of the nasal spray opioid reversal agent is $125 per prescription. Please note the average cost of the auto-injector is approximately $4,000. Given the significant price difference, we did not use the auto-injector in our cost estimate.

The results show an estimated increase in premiums of 0.06% when an opioid reversal agent is prescribed with the initial opioid prescription of 50 MMEs or greater. [Note, the corresponding increase in premiums for opioid prescriptions of 100 MMEs or greater is 0.01%.]

The table following shows the calculation for the recommendation for opioid prescriptions of 50 MMEs or greater.

Development of Estimate	
1. Number of Initial Scripts per 1000 members	29.30
2. Number of Members with Refills with drug related ER visit per 1000 members	0.02
3. Total Number of Opioid Reversal Agent Scripts (Row 1 + Row 2)	29.32
4. Cost per Script	$125.00
5. Total PMPM (Row 3 x Row 4) / 12,000	$0.31
6. Illinois Total Medical Costs PMPM	$472.81
7. **Estimated Impact of Recommendation** (Row 5 / (Row 5 + Row 6)	**0.06%**

Other Considerations

There are a couple of other considerations and caveats regarding the financial impact on the rates.

- The impact analysis does not take into account an offset for saved inpatient and emergency room costs.

- The analysis above assumes a maximum of two opioid reversal agent prescriptions per unique opioid user. This may not be true in all instances, but the impact of multiple opioid reversal agent prescriptions would be immaterial.
- The impact of the auto-injector form has a significant impact on the results. If the auto-injector was required or allowed the overall impact could change from 0.06% to 2% for opioid prescriptions of 50 MMEs or more. Correspondingly, the analysis with the auto-injector for prescriptions of 100 MMEs or more increases from 0.01% to 0.5% of health costs.
- We have assumed the opioid reversal agent would be prescribed with the initial opioid prescription, so insurers have methods or rules in place to control utilization and costs.

4. Recommendation #2

Adding a required category for topical anti-inflammatory medication, Ketoprofen or Diclofenac, for acute and chronic pain.

Background

Within the prescription drug category, the recommendation was to add a required category for topical anti-inflammatory medication, Ketoprofen or Diclofenac, for acute and chronic pain.

CDC recommendations in the 2016 guidelines state "nonpharmacological and nonopioid therapies are preferred for chronic pain."[6] In a systematic review, Dr. Connelly found strong evidence for acute musculoskeletal pain and moderate evidence for chronic musculoskeletal pain and the use of topical the anti-inflammatory medications Diclofenac and Ketoprofen.[7] The use of topical agents has increased concentration at the site and decreased systemic absorption which lowers the risk of adverse events associated with oral or parenteral anti-inflammatory medication.[8]

Data

We used a proprietary dataset, Truven Health MarketScan® Research Database, to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan. The data comes from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private-sector health data from over 6 million member months.

Using MarketScan, we extracted costs and utilization statistics associated with opioid drugs, Ketoprofen and Diclofenac. We looked at members with outpatient drug claims and compared diagnoses between the two groups. We were only interested in looking at opioids that were provided in an outpatient setting since we believe the substitution of topical anti-inflammatory medication in an inpatient setting would not be reasonable.

Methodology and Results

Ketoprofen and Diclofenac are both non-steroidal anti-inflammatory drugs (NSAIDs). They are in the same class as ibuprofen but are stronger. They are useful for musculoskeletal pain,

[6] Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016 [published online March 15, 2016]. JAMA. doi:10.1001/jama.2016.1464.

[7] Derry S,Wiffen PJ,Kalso EA,etal. Topical analgesics for acute and chronic pain in adults-review of Cochrane Reviews. Cochrane Database Syst Rev. 2017;5:Cd008609.

[8] Haroutiunian S., Drennan D.A., and Lipman A.G.: Topical NSAID therapy for musculoskeletal pain. Pain Med 2010; 11: pp. 535-549

kidney stones, and arthritis, but would not be used for an acute pain such as a long bone fracture or sickle cell crisis. They provide increased concertation at the site and decreased systematic absorption, which lowers the risk of adverse events associated with oral medications. The safety profile is better than opioids to send a patient home with, but they cannot be used for certain patient populations such as bleeding disorders or kidney disease.

Using members based in Illinois, Oliver Wyman compared the difference between opioid drug prescriptions and compared them to Ketoprofen and Diclofenac prescriptions. We looked at the most prevalent diagnoses for members who were prescribed opioids verse Ketoprofen and Diclofenac. From there, we looked to see if Ketoprofen or Diclofenac would be a good substitute for acute and chronic pain for similar diagnoses.

There are several assumptions we employed in the calculation of the cost impact on health insurance premium rates in the state.

- The recommendation is for the substitution of anti-inflammatory topical medication for opioids in the case of acute cases. We assumed that acute cases are defined as cases where the opioid prescriptions are less than 30 days.
- We assumed the substitutions would occur for diagnoses in the musculoskeletal categories.
- We assumed that 40% of the acute cases eligible would be substituted and have a successful result with the anti-inflammatory and not need any opioid prescription. This created an offset to the cost of this recommendation.
- We assumed the duration of the treatment when anti-inflammatory medication is used would increase by about 25%.

We extracted historical opioid and anti-inflammatory claims information for acute cases with diagnoses in the musculoskeletal categories. Only similar diagnoses were in the analysis and assumed could be substituted. Next, we substituted the costs of the anti-inflammatory medication for the opioid drugs. We assumed the duration of the treatment would be longer under the new recommendation.

The combination of the additional anti-inflammatory medication and the offsetting reduction in opioid medications generates an estimated impact on premiums of 0%.

Other Considerations

There are a couple of other considerations and caveats regarding the financial impact on the rates.

- We made overall estimates for changing practices patterns. However, while we made reasonable assumptions, actual results will likely vary.
- The analysis looked at Diclofenac, but did not discuss other topical anti-inflammatory medications. Further, the historical data does not include any prescriptions for Ketoprofen.

- The substitution rate could be impacted by the effectiveness of the treatment, specifically if the topical anti-inflammatory regiments take significantly longer patients may switch back to opioid medications to relieve pain more quickly. We have not taken this into account.

5. Recommendation #3

Provide short-term opioid prescriptions for acute pain shall be provided for no more than 7 days.

Background

Within the prescription drug benefit category, the recommendation is to provide short-term opioid prescriptions for acute pain shall be provided for no more than 7 days.

In the CDC 2016 guidelines for prescribing opioids for chronic pain, it is stated that "Long term opioid use often begins with treatment of acute pain." It is known that tolerance and dependence to opioids develops at different rates in different individuals. While opioids can be useful for acute pain the true needed duration needed is not known to reduce potential harm. Several small studies, most Emergency Department based, find that <3 days of opioid therapy and not >7 days treatment is sufficient for most patients.[9,10,11] These studies and expert opinion led the CDC to make the recommendation that "for acute pain, when opioids are appropriate, prescribe <3-day supply and more than 7 days will rarely be required."

Data

We used a proprietary dataset, Truven Health MarketScan® Research Database, to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan. The data comes from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private-sector health data from over 6 million member months.

Using MarketScan, we extracted costs and utilization statistics associated with opioid drugs. We looked at outpatient claims only, assuming that this recommendation would not impact opioids prescribed and administered in an inpatient setting.

Methodology and Results

Currently, the Illinois benchmark plan does not have any limitations on the day supply for short-term opioid use. The proposed recommendation would limit the day supply for opioid

[9] Coste J, Delecoeuillerie G, Cohen de Lara A, Le Parc JM, Paolaggi JB. Clinical course and prognostic factors in acute low back pain: an inception cohort study in primary care practice. BMJ 1994;308:577–80.

[10] Chu J, Farmer B, Ginsburg B, Hernandez S, Kenny J, Majlesi N. New York City emergency department discharge opioid prescribing guidelines. New York, NY: New York City Department of Health and Mental Hygiene; 2013.

[11] Thorson D, Biewen P, Bonte B, et al. Acute pain assessment and opioid prescribing protocol. Bloomington, MN: Institute for Clinical Systems Improvement; 2014.

prescriptions to 7 days for acute cases. For this recommendation, we have assumed there would be no change in procedures or requirements for chronic cases with opioids.

The following key assumptions and methodology used in our analysis.

- For patients with opioid prescriptions of less than 7 day supplies, we have assumed there would be no change in utilization or costs.
- Patients with opioid prescriptions with day supplies between 7 days and 60 days are the only cohort impacted by this recommendation. In these cases, we have split the opioid prescriptions into equivalent 7 day prescriptions.
- For each “new” 7-day prescription we have assumed the patient would need to visit a physician before another prescription could be filled.
- The cost of additional office visits is $150 per visit.
- With the increased monitoring of short term opioid prescriptions, we have assumed there would be offsetting savings with the reduction of the length of opioid prescriptions.

The combination of the additional physician visits and the offsetting reduction in opioid medications generates an estimated impact on premiums of 0%.

Other Considerations

There are a couple of other considerations and caveats regarding the financial impact on the rates.

- We made overall estimates for changing practices patterns. However, while we made reasonable assumptions, actual results will likely vary.

6. Recommendation #4

Remove barriers to prescribing Buprenorphine products for medication-assisted treatment (MAT) of opioid use disorder. This should include removing prior authorization, dispensing limits, fail first policies and lifetime limit requirements.

Background

Within the prescription drug benefit category, the recommendation was to remove barriers to prescribing Buprenorphine products for medication-assisted treatment (MAT) of opioid use disorder. This should include removing prior authorization, dispensing limits, fail first policies and lifetime limit requirements.

MAT has been approved to non-specialist providers for office based treatment of opioid use disorder, as detailed in the Drug Addiction Treatment Act of 2000 (DATA 2000).[12] The number of physicians with waivers to prescribe buprenorphine is only 4% of licensed physicians, according to the Substance Abuse and Mental Health Administration SAMHSA.[13] This disparity exists despite the evidence for the benefit of continued abstinence and the cost effectiveness, showing a cost-effective ratio of $35,100 per quality adjusted life year.[14] One of the reasons that providers cite for not being waived or prescribing Buprenorphine is the increased regulations and insurance coverage difficulties. Removing prior authorization, dispensing limits, fail first policies and lifetime requirements would have a positive effect in increased MAT providers and ease of treatment.[15,16,17] This recommendation would more fully align the bench marks with the Mental Health Parity and Addiction Equity Act of 2008.[18]

[12] 106th U.S. Congress. Drug Addiction Treatment Act of 2000. www.gpo.gov/fdsys/pkg/PLAW-106publ310/pdf/PLAW-106publ310

[13] The President's Commission on Combatting Drug Addiction and the Opioid Crisis. Final Report of The President's Commission on Combating Drug Addiction and the Opioid Crisis. www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf. Published 2017.

[14] B.R. Schackman, J.A. Leff, D. Polsky, B.A. Moore, D.A. Fiellin Cost-effectiveness of long-term outpatient buprenorphine-naloxone treatment for opioid dependence in primary care J Gen Intern Med, 27 (6) (2012), pp. 669-676, 10.1007/s11606-011-1962-8

[15] R.E. Clark, M. Samnaliev, J.D. Baxter, G.Y. Leung The evidence doesn't justify steps by state Medicaid programs to restrict opioid addiction treatment with buprenorphine Health Aff (Millwood), 30 (8) (2011), pp. 1425-1433, 10.1377/hlthaff.2010.0532

[16] R.E. Clark, J.D. Baxter, B.A. Barton, G. Aweh, E. O'Connell, W.H. Fisher The impact of prior authorization on buprenorphine dose, relapse rates, and cost for Massachusetts Medicaid beneficiaries with opioid dependence Health Serv Res, 49 (6) (2014), pp. 1964-1979, 10.1111/1475-6773.12201

[17] R.M. Burns, R.L. Pacula, S. Bauhoff, et al. Policies related to opioid agonist therapy for opioid use disorders: the evolution of state policies from 2004 to 2013 Subst Abus, 37 (1) (2016), pp. 63-69, 10.1080/08897077.2015.1080208

[18] U.S. Department of the Treasury, U.S. Department of Labor, HHS Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 Fed Regist, 78 (2013), pp. 68239-68296

Data

We used a proprietary dataset, Truven Health MarketScan® Research Database, to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan. The data comes from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private-sector health data from over 6 million member months.

Using MarketScan, we extracted costs and utilization statistics associated with MAT programs. Given the credibility associated with the frequency of MAT programs, we used the nationwide data to review costs and utilization statistics. Further, the analysis was primarily focused on pharmacy data.

Methodology and Results

Currently, the Illinois benchmark plan includes coverage for MAT programs for all individual and small group policies of accident and health insurance that offer prescription benefits. The proposed recommendation would remove prior authorization requirements, dispensing limits and fail first policies.

Based on our independent research and information found in our claims database, there are generally three drugs used with MAT programs - Buprenorphine, Methadone and Naltrexone. These three have different agents and methods for treating the addiction, for example Naltrexone is an antagonist which blocks the “high”. Further, these drugs are administered differently, and there are different requirements for use.

The data extracted from MarketScan shows all three are covered currently in the market, with Buprenorphine used the most by providers in the treatment of opioid dependence. The table below shows the key statistics for all three separately.

Member Distribution by Drug and Diagnosis

	Buprenorphine	Methadone	Naltrexone
Dependence - Opioid	45%	14%	41%
Pain	46%	32%	22%
Dependence – All Other	22%	8%	70%

The total cost of care for Buprenorphine associated with MAT programs range from $13,800 to $19,700[19] in one study. Recent cost estimates from the U.S. Department of Defense for a

[19] Shah, A., Duncan, M.E., Atreja, N., Tai, K.S., & Gore, M.B. (2018). Healthcare utilization and costs associated with treatment for opioid dependence. Journal of medical economics, 21 4, 406-415.

treatment in a certified opioid treatment program (OTP) are about $6,000 per person.[20] This assumes Buprenorphine for a stable patient provided in a certified OTP, including medication approximately two visits per week.

We believe the impact of this recommendation will have no material impact on health insurance premiums.

There are several assumptions we employed in the calculation of the cost impact on health insurance premium rates.

- We assumed the cost of Buprenorphine will not materially change, even if more providers are wavered to prescribe these.
- Buprenorphine is an effective method for the treatment of opioid addiction, based on the studies. It is currently the preferred approach. Further, there are cases where the other two types of treatment may be better for a specific patient. As such, we do not believe this recommendation will change the prescribing patterns.
- The number or frequency of potential patients not seeking treatment due to insurance requirements is difficult to estimate / quantify. In general, we believe the number of new patients seeking treatment will not increase in a material way.

Other Considerations

There are a couple of other considerations and caveats regarding the financial impact on the rates.

- We are unaware of any unintended consequences that could occur by removing the prior authorization requirement. In general, prior authorization requirements are used to monitor costs and frequency of services.
- The current ACA-compliant policies have unlimited lifetime costs. As such, we believe adding the requirement to remove lifetime limits is not necessary.
- We are unsure of any unintended consequences for the removal of dispensing limits. Similar to prior authorization, dispensing limits are generally utilized to encourage professional monitoring of the patient.

[20] https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost

7. Recommendation #5

Adding a requirement that telepsychiatry care (by both a prescriber and a therapist) is a covered benefit.

Background

Within the access to care category, the recommendation was to add a requirement that telepsychiatry care (by both a prescriber and a therapist) become a covered benefit.

Studies have demonstrated that utilizing telemedicine to deliver mental health care is comparable to in-person care and provides a cost-effective way to expand access to mental health care.[21,22] Multiple studies have also demonstrated efficacy at utilizing telemedicine to deliver therapy.

Telepsychiatry has become more prevalent in recent years. For example, the Comprehensive Opioid Addiction Treatment Program (COAT) has been treating more than 2,000 patients since 2004, with a waiting list of more than 600 patients.[23] The COAT program ran a study in West Virginia comparing the differences between telepsychiatric and face-to-face therapy, but in the end concluded that a larger sample size, as well as less confounders, were needed to determine statistical significance between the two groups. The telepsychiatry group was held at a mental health facility, with treatment administered through a web cam. The face-to-face group had regular office visits for their treatments.

Data

We used a proprietary dataset, Truven Health MarketScan® Research Database, to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan. The data comes from a selection of large employers, health plans, and government and public organizations. The annual medical databases include private-sector health data from over 6 million member months.

In addition to using Truven Health MarketScan® Research Database, we used literature research and public information to estimate the financial impact of the proposed recommendation on the current EHB benchmark plan.

[21] Hilty DM, et. al. An Update on Telepsychiatry and How It Can Leverage Collaborative, Stepped, and Integrated Services to Primary Care.

[22] Hubley S, et. al. Review of Key Telepsychiatry Outcomes. World J Psychiatry. June 22, 2016; 6(2):269-82. DOI:10.5498/wjp.v6.i2.269

[23] "Good Outcomes with 'Telepsychiatry' in Medical Treatment of Opioid Use Disorder" https://wolterskluwer.com/company/newsroom/news/2017/01/good-outcomes-with-telepsychiatry-in-medical-treatment-of-opioid-use-disorder.html

Methodology and Results

MarketScan data does not have enough telepsychiatry services included in the database to generate reasonable estimates for the cost of these additional services. Therefore, we used a combination of information found in public research and overall market costs. However, it has become more prevalent in recent years. In the development of the estimate of additional costs for telepsychiatry, we relied upon public information found on general telemedicine and the relationship of costs between physical and mental health services.

Further, there are studies available that compare the costs of telepsychiatry to the costs of face-to-face visits. The results of these studies vary – with some stating telepsychiatry is more expensive while others showing savings between 40% and 70%. However, the goal of this recommendation is to improve access to mental health providers through telepsychiatry. Given the mixed results, we have assumed the telepsychiatry would have a similar relationship in costs to telemedicine as mental health services has to medical costs.

Currently, the Illinois benchmark plan does not include the services of telepsychiatry explicitly. The proposed recommendation would add telepsychiatry services.

There are several assumptions we employed in the calculation of the cost impact on health insurance premium rates in the state.

- The cost relativity between telepsychiatry services and telehealth services are similar to the cost relativities between physical health services and mental health services. We used outpatient services only to develop these relativities.
- The modeling does not limit or restrict the type of telepsychiatry services that would be covered (i.e., services do not need to relate to drug addiction or opioid use).
- We used public information that was available for telehealth to estimate the costs for telepsychiatry services.
- Further, we have assumed little to no offsetting costs associated with these benefits for the following reasons:
    - There is little available public information that demonstrates the effectiveness of these programs. The results are mixed.
    - The overall costs of the program, based on current costs of telehealth in general is very small. As such, any assumptions of offsetting costs may misstate the impact on the overall costs.

Research and publicly available information was used to estimate the cost of telemedicine provided in the market today. In general, telemedicine is more widely available with 96% of employers offering this coverage. However, the utilization of services is still relatively small, only about 8% of employees.[24] We also extracted historical behavioral health and physical medicine claims information from MarketScan for Illinois specifically to determine the relativity between

[24] http://www.healthcareitnews.com/news/almost-all-large-employers-plan-offer-telehealth-2018-will-employees-use-it

the cost of physical health and behavioral health. Below are the key statistics based on the research performed, the public information and MarketScan Illinois specific data:

- Behavioral health claim costs are approximately 12% of all physical health claims.
- The average cost per telehealth visit is $79.[25]
- The utilization rate is on average one visit for 8% of the population.

The results show an estimated increase in premiums of 0.01%, in other words this benefit will not increase costs and to the extent treatments are successful, carriers may see a decrease in costs related to opioids.

Other Considerations

There are a couple of other considerations and caveats regarding the financial impact on the rates.

- The impact analysis does not take into account an offset in costs associated with opioid use and/or addictions.
- Insurers may be providing some telepsychiatry services through their telehealth vendor already. We would not have taken these into account in our analysis.

[25] http://www.modernhealthcare.com/article/20170307/NEWS/170309914

8. Distribution and Use

This report was prepared for the sole use of the Illinois DOI for the selecting a new EHB-benchmark plan. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the DOI.

Oliver Wyman's consent to any distribution of this report (whether herein or in the written agreement pursuant to which this report has been issued) to parties other than the DOI does not constitute advice by Oliver Wyman to any such third parties and shall be solely for informational purposes and not for purposes of reliance by any such third parties. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

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9. Considerations and Limitations

The Illinois Department of Insurance, engaged Oliver Wyman Actuarial Consulting, Inc. to assist in performing actuarial analyses as part of their 2020 EHB Benchmark Plan Select application to the Centers for Medicare and Medicaid Services (CMS). The actuarial services we provided consisted of analyses in support of demonstrating that the proposed 2020 EHB Benchmark plan meets the requirements that the plan is equal to or greater than the scope of benefits provided under a typical employer plan and that the plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii).

This report was prepared for the sole use of the DOI. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the DOI. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report was issued. The estimated included within are based on regulations issued by the United States Department of Health and Human Services and the applicable laws and regulations of the State of Illinois. Our work may not be used or relied upon by any other party or for any purpose other than which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

For our analysis, we relied on a wide range of data and information and other sources of data as described throughout this report. This includes studies and information available publicly, which are referenced within this document. Though we have reviewed the data and information for reasonableness, we have not independently audited or verified this data. Our review of the data may not reveal errors or imperfections. The results of our analyses are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised.

All analyses are based on information and data available as of June 1, 2018 and the projections are not a guarantee of results which might be achieved. In addition, the analysis shown in this report are dependent upon a number of assumptions regarding the future environment, medical trend rates, insurer, provider and individual behaviors and a number of other factors. These assumptions are disclosed within the report and have been discussed with the DOI representatives and other consultants assisting the DOI. While the analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections and analyses involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

The sources of uncertainty affecting our estimates are numerous and include factors internal and external to the DOI. The most significant external influences include but are not limited to, changes in the legal, social or regulatory environment surrounding the determination of premiums and the potential change in individual and provider behavior due to new benefits. Uncontrollable factors such as general economic conditions also contribute to the variability.

Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that the DOI secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

10. Acknowledgement of Qualifications

I, Beth Fritchen, am a Fellow in the Society of Actuaries, and a member of the American Academy of Actuaries, and am qualified to provide the following certification to render this opinion. We have utilized generally accepted actuarial methodologies in arriving at our opinion.

Under 45 CFR 156.111 in the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule (2019 Payment Notice) displayed on April 9, 2018, CMS finalized that States may select a new essential health benefits (EHB) benchmark plan for plan years beginning on or after January 1, 2020. If a State opts to select a new EHB-benchmark plan utilizing any of the selection options at §156.111(a), the State is required under §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 applies to the State of Illinois' request for a change in the Federal CMS Plan Year 2020 Essential Health Benefit Benchmark Plan under Selection Option 3: "Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan". Along with the Illinois Department of Insurance, we have used the benchmark as a tool to help address the opioid crisis and improve access to metal health and substance abuse resources. We have determined the edits needed to the current benchmark plan based on the recommendations received.

We have reviewed the recommendations made by the DOI and other assisting consultants, reviewed appropriate data and research to estimate the cost impact on current premiums with regard to the five new recommendations to be included with the current 2019 EHB benchmark plan to generate the proposed 2020 EHB benchmark plan.

Reliance

In performing the analyses outlined in this report and arriving at my opinion, I used and relied on information provided by the Illinois Department of Insurance, recommendations obtained from doctors regarding changes to the current benchmarks using literature review, and additional information published by the Federal government. I used and relied on this information without independent investigation or audit. If this information is inaccurate, incomplete, or out of date, my findings and conclusions may need to be revised. While I have relied on the data provided without independent investigation or audit, I have reviewed the data for consistency and reasonableness. Where I found the data inconsistent or unreasonable, I requested clarification.

Actuarial Certification

In my opinion, the Illinois DOI selection of set benefits that could become the State's EHB-benchmark plan complies with the following requirements.

- Equal to, or greater than, scope of benefits provided under a typical employer plan
- Does not exceed the generosity of the most generous amount the plans listed at §156.111(b)(2)(ii)

This certification conforms to the applicable Actuarial Standards of Practice promulgated by the Actuarial Standards Board.

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