MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

January 10, 2024

The Honorable Wes Moore
Governor
State House, 100 State Circle
Annapolis, Maryland 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
H-101, State House
100 State Circle
Annapolis, MD 21401

The Honorable Pamela G. Beidle
Chair, Senate Finance Committee
James Senate Office Building
11 Bladen Street
Annapolis, MD 21401

The Honorable Joseline A. Peña-Melnyk
Chair, Health and Government Operations Committee
Taylor House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: SB0184/Ch. 298, HB 376/Ch. 299(2), 2023 - Health Insurance - Diagnostic and Supplemental Examinations for Breast Cancer - Cost-Sharing – Mandate Evaluation Report (MSAR #14660)

Dear Governor Moore, President Ferguson, Speaker Jones, Chair Beidle, and Chair Pena-Melynk,

SB0184/Ch. 298, HB 376/Ch. 299(2), 2023 - Health Insurance - Diagnostic and Supplemental Examinations for Breast Cancer - Cost-Sharing required the Maryland Health Care Commission to study and report on the financial impact of eliminating cost–sharing for diagnostic image–guided biopsies for breast cancer. The Maryland Health Care Commission (MHCC) is pleased to submit the attached mandated health insurance services evaluation on eliminating cost-sharing for diagnostic image–guided biopsies for breast cancer.

The MHCC contracted with Axene Health Partners, an actuarial consulting firm, to evaluate the social, medical, and financial impact of SB184 (HB376). The attached report provides the results of the evaluation related to the social, medical, and financial impact of eliminating cost–sharing for diagnostic image–guided biopsies for breast cancer.

Axene developed a financial model detailing the legislative impact. The source data used included Maryland's All-Payer Claims Data Base (APCD), proprietary information, and public data. The items labeled assumptions in the report are based on Axene's experience with estimating similar benefits.

The financial model measured three primary effects of the legislation:

- Increase in the Number of Screenings. AHP assumed that because of the legislation there will be an overall number of screenings of 12,306 or 3% of the total. The net result is an increase in the overall claims costs per member per month (PMPM) of $0.21. Presumably, the increase will be driven primarily by providers urging their patients to receive all necessary services without cost-share.

- Elimination of Cost Sharing. The 12,306 additional mammograms imply an increase of 865 additional biopsies. The law's requirement that diagnostic breast screenings and biopsies be covered without cost-sharing will transfer the member's current cost-sharing obligation to the payer, increasing payer costs by an estimated $84.53 per diagnostic biopsy. The net increase in costs PMPM is $0.14.

- Savings Impact. The increase in supplemental breast screenings will result in the identification of some breast cancers in earlier stages of the disease progression, which will result in the more cost-effective treatment of these patients. This effect is small in comparison to the increased utilization of diagnostic screening because only one to two in 1,000 screening mammograms will result in a diagnosis of breast cancer at an estimated savings of $15,000 per detected cancer. The net savings is $0.02 on a cost basis.

- The total cost PMPM is $0.33 on a cost basis. Assuming an 85% loss ratio this translates to a $0.39 premium increase or 0.06% of the total.

Finally, the Commission strongly urges the Legislature to proceed with caution when considering the adoption of additional mandated health insurance services given their cumulative deleterious impact on affordability over time despite a minimal impact on premiums of any single mandate at the time of adoption.

We appreciate your consideration. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at ben.steffen@maryland.gov or

410-764-3566 or Ms. Tracey DeShields, Director of Policy Development and External Affairs, at tracey.deshields2@maryland.gov or 410-764-3588.

Sincerely,

Ben Steffen,
Executive Director

cc:
House Health and Government Operations Committee
Senate Finance Committee
The Honorable Laura Herrera Scott, Secretary, Maryland Department of Health
Marie Grant, Assistant Secretary, Health Policy, Maryland Department of Health
Jonny Dorsey, Deputy Chief of Staff, Governor's Office
June Chung, Deputy Legislative Office, Governor's Legislative Office
Jason Heo, Governor's Office
Sophie Bergmann, Governor's Office
Sarah Albert, Department of Legislative Services (5 hard copies)
Lisa Simpson, Committee Counsel, House Health and Government Operations,
Patrick Carlson, Committee Counsel, Senate Finance
Kenneth Yeates-Trotman, Director, Center for Analysis and Information Systems
Tracey DeShields, Director of Policy Development and External Affairs, MHCC

axene health partners

HEALTH ACTUARIES & CONSULTANTS

Diagnostic and Supplemental Exams and Biopsies for Breast Cancer – Cost Sharing

Maryland Health Care Commission

December 20, 2023

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Section 1: Executive Summary

Introduction

During the 2023 legislative session of the Maryland General Assembly Senate Bill 184/House Bill 376, Health Insurance – Diagnostic and Supplemental Examinations and Biopsies for Breast Cancer – Cost Sharing was enacted into law effective January 1, 2024.

The Maryland Health Care Commission (MHCC) has retained Axene Health Partners, LLC (AHP) to deliver health care related actuarial services to assist the Commission in completing its response to a legislative request to determine the financial impact of eliminating cost-sharing for diagnostic image-guided biopsies for breast cancer.

Key Findings

The Mandate

- Cost -sharing for diagnostic image-guided biopsies for breast cancer will be eliminated

Social Evaluation

- Breast cancer will impact 1 in every 8 women
- Breast cancer is easier to treat and the chances of survival increase when breast cancer is detected early

Medical Evaluation

- Under a biopsy, tissue is removed from the breast and sent to the lab for testing
- Biopsies are performed to confirm a cancer diagnosis when an abnormality is present

Financial Evaluation

- The financial impact for this mandate on claims costs is $0.33 per member per month or 0.06% of total costs, which includes the impact of additional screenings, the elimination of the cost share, and medical savings due to early detection.
- If applicable, the expected costs of defrayals is $4.8 million.

Section 2. The Social Evaluation

Breast cancer is a devastating disease that is projected to impact one in every eight women and one in every 800 men during their lifetimes.[1] The impact of affliction is certain cells growing abnormally, often interfering with the work of healthy cells. The federal government has estimated that there will be nearly 300,000 new cases and 43,000 deaths related to breast cancer in 2023.[2]

The legislation requires payers to cover supplemental breast screenings (i.e. not related to an abnormality seen or suspected from a prior examination, and in individuals with a personal or family medical history or additional factors that may increase risk of breast cancer) without cost sharing. Prior to the legislation, payers were required to provide the United States Preventive Services Task Force (USPSTF) routine screenings without cost-sharing. The USPSTF guidelines describe screening mammograms in individuals with no prior indication (in any previous examination) of breast cancer between age 40 and 75 as preventative, however many payers apply this provision loosely and consider screening mammograms for individuals of any age and/or without restriction on diagnosis code (i.e. previous history of breast cancer) to be preventative (i.e. without cost sharing).[3, 4, 5] This likely means an increase in supplemental breast screenings due to the law prompting Maryland residents to seek more breast cancer screening and biopsy services as a result of heightened awareness of the elimination of cost-sharing (even if a member could have received these services without cost-sharing in the absence of the law).

A key question in analyzing any legislation is whether it can be administered appropriately, including what legal requirements need to be considered. Although no carrier surveys were solicited as part of the analysis, AHP's experience indicates that the key to administering this benefit is the ability to determine which claim submissions should be covered at 100% and which will not. We believe the medical codes listed in Appendix A are the appropriate indicator.

From a regulatory perspective, there are two overarching regulations that must be considered, the Affordable Care Act (ACA) definition of Essential Health Benefits and Internal Revenue Service (IRS) regulations regarding preventive services for a high-deductible health plan.

Under the ACA, each qualified health plan must cover all services in that state's list of essential services. Exception processing is required if a health plan covers services not on the essential benefits list. Biopsies are on the essential benefits list for Maryland, but it is not clear if biopsies are considered preventive. If not considered preventive, then the cost-share portion of the costs could be considered a non-essential benefit. Since that is a legal opinion and not an actuarial opinion, a definitive answer to that question is outside the scope of this paper. That said, a few observations:

- Under Maryland law, preventive services for women include services and screening included in the Health Resources and Services Administration Guidelines.[6]

[1] Breast Cancer Risk in American Women - NCI
[2] Female Breast Cancer — Cancer Stat Facts
[3] UHC Preventative Services Medical Policy, October 2023
[4] Cigna Administrative Policy, October 2023
[5] Anthem Preventative Health Guidelines
[6] essentialbenefitschart.pdf (maryland.gov)

- The guidelines state that preventive services can be obtained through a single visit or a series of visits, which is somewhat consistent with the concept that biopsies are preventive services and not subject to the exception processing.[7]

Many plans covered under the ACA are high-deductible health plans which are governed in part by federal law. Under federal law, all services are subject to cost-sharing except the services designated by the IRS. According to the IRS, services considered preventive under the ACA are not subject to cost-sharing.[8]

[7] Women's Preventive Services Guidelines | HRSA
[8] Section 223 – Health Savings Accounts (irs.gov)

Section 3. Medical Evaluation

Breast cancer is the most common form of cancer among women after skin cancer.[9] One in eight women will have breast cancer during their lifetime.[10] Breast cancer is also deadly. There is a one in thirty-nine chance a women will die of breast cancer.[11] Although breast cancer death rates have decreased significantly in the last thirty years, this trend has slowed slightly in recent years. The decrease in death rates is believed to be the result of greater awareness, increased screenings, and better treatment.[12]

Screening Guidelines

As breast cancer is easier to treat successfully if it is diagnosed before it has begun to spread throughout the body, the United States Preventive Services Task Force (USPSTF) and other reputable organizations recommend routine screenings. The recommended frequency varies by age and other risk factors including family history.[13] If the result of a routine screening indicates a lump or other mass in the breast, the customary next step is to perform a biopsy to confirm or eliminate a cancer diagnosis. In many cases, a sample of the mass is excised from the breast and tested for a malignancy. Image-guided biopsies assist the doctor in removing the sample more accurately.[14]

The USPSTF, the organization designated in the Affordable Care Act to define preventive care, recommends a 3-step screening process for breast cancer:

- Self-Examination. The USPSTF guidelines recommend that clinicians teach women to perform self-examinations to determine if they feel any lumps or other abnormalities.
- Clinical Breast Examination. A clinical breast examination is similar to a self-examination but performed by a doctor or other clinician. This is often done in conjunction with an annual wellness visit.
- Screening Mammograms. A screening mammogram is performed on asymptomatic women. The USPSTF recommends biennial screenings for women between the ages of 50 to 74.[15]

In the discussion regarding this recommendation, the USPSTF notes that some women may prefer to have a mammogram before age 50 or more often than biennially based on family and medical history.

Diagnosis and Treatment

Although breast cancer may begin in the milk-producing ducts, it can also originate in the lobules or other tissue in the breast.[16] If an abnormality is detected through the screening process, a diagnostic

[9] Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society
[10] Ibid
[11] Ibid
[12] Ibid
[13] Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
[14] Image-Guided Biopsy | Conditions & Treatments | UT Southwestern Medical Center (utswmed.org)
[15] Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
[16] Breast cancer - Symptoms and causes - Mayo Clinic

mammogram, a breast ultrasound, or an MRI may be needed to further diagnose the abnormality. The only way to definitively diagnose breast cancer is through a biopsy. A biopsy is a procedure for removing a small amount of tissue from the lump or abnormality for further testing in a lab.[17]

There are several types of biopsies, which vary by the size of the abnormality, the location, overall health, clinical assessment, and personal preferences. The procedure may remove just a small portion of the tissue or an entire lump. Physicians may rely on imaging to more accurately target the tissue to be removed. There are three main types[18] of imaging used:

- Stereotactic (mammogram- or tomosynthesis-guided)
- Ultrasound-guided
- MRI-guided

If cancer is detected, treatment[19] may include:

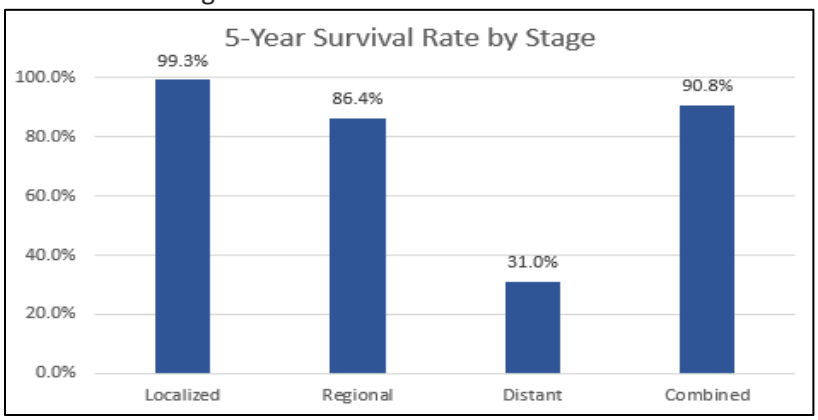
- Surgery to remove just the tumor (lumpectomy), the entire breast (mastectomy), or the lymph nodes
- Radiation, in the form of x-rays or other high-powered beams to kill the cancer cells
- Chemotherapy, which relies on drugs to destroy fast-growing cells like cancer cells
- Hormone therapy to block cancers sensitive to hormones
- Targeted therapy drugs to attack specific abnormalities
- Immunotherapy which uses the body's immune system to fight cancer

Survival Rates

When breast cancer is detected earlier, it is easier to treat and the chances of survival increase. Although there are several ways to define breast cancer stages, perhaps the easiest to explain is the one below.[20] As Figure 1 shows, the 5-year survival rate is much higher if the cancer is localized.

[17] 8579.00.pdf (cancer.org)
[18] Ibid
[19] Breast cancer - Diagnosis and treatment - Mayo Clinic
[20] Survival Rates for Breast Cancer | American Cancer Society

Figure 1. Survival Rates



Section 4. Financial Analysis

The financial impact of this legislation, like most laws related to health insurance benefit mandates, is increased costs in health insurance benefit plans. In this case, the financial model demonstrates that the removal of cost-sharing from some medical services leads to an increase in insurance payer costs. The financial model also reflects savings resulting from earlier detection of breast cancer; the modeling does not reflect expected extension of life or reduced loss of productivity, two key benefits of this legislation.

The Financial Model

AHP developed a financial model detailing the legislative impact and the results are displayed in Appendix 2. The source data includes Maryland's All-Payer Claims Data Base (APCD), proprietary information, and public data as indicated in the 'Comment' column of the financial model. The items labeled as assumptions are based on AHP's experience with estimating similar benefits.

The financial model measures the three primary effects of the legislation:

- Increase in the Number of Screenings**.** AHP assumed that a result of the legislation would be an increase in the overall number of screenings of 12,306 (or 3% of the total) as shown in row c. The net result is an increase in the overall claims costs per member per month (PMPM) of $0.21 as shown in row e. Presumably, the increase will be driven primarily by providers urging their patients to receive all necessary services without cost-share.
- Elimination of Cost Sharing. The 12,306 additional mammograms imply an increase of 865 additional biopsies as shown in row f. The law's requirement that diagnostic breast screenings and biopsies be covered without cost-sharing will transfer the member's current cost-sharing obligation to the payer, increasing payer costs by an estimated $84.53 per diagnostic biopsy as shown in row g. The net increase in costs PMPM is $0.14 as shown in row h.
- Savings Impact. The increase in supplemental breast screenings will result in the identification of some breast cancers in earlier stages of the disease progression, which will result in the more cost-effective treatment of these patients. This effect is small in comparison to the increased utilization of diagnostic screening because only one to two in 1,000 screening mammograms will result in a diagnosis of breast cancer at an estimated savings of $15,000 per detected cancer. The net savings is $0.02 on a cost basis as shown in row k.

The total cost PMPM is $0.33 on a cost basis. Assuming an 85% loss ratio, this translates to a $0.39 premium increase or 0.06% of the total.

Section 5. Actuarial Considerations

This report has been prepared by Gregory G. Fann, FSA, FCA, MAAA, who is also the primary contact. The report has been peer-reviewed by:

- Joan C. Barrett, FSA, MAAA
- Tony Pistilli, FSA, CERA, MAAA, CPC

All members of the team members of the American Academy of Actuaries (MAAA) in good standing and are qualified to perform this work. This report was prepared in accordance with the following Standards of Practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries:

- Actuarial Standards of Practice No. 1, "Introductory Standard of Practice"
- Actuarial Standards of Practice No. 5, "Incurred Health and Disability Claims"
- Actuarial Standards of Practice No. 23, "Data Quality"
- Actuarial Standards of Practice No. 25, "Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages"
- Actuarial Standards of Practice No. 41, "Actuarial Communication"
- Actuarial Standards of Practice No. 56, "Modeling"

Although AHP has performed due diligence in researching the legal implications of this analysis, this report does not constitute a legal opinion and the reader should consult their own legal counsel about specific legal issues.

Appendix 1. Medical Codes Used

Criteria 1) At least 1 CPT/HCPCS code from the list below:			Criteria 2) A primary ICD-10 diagnosis code matching the list below (astrick denotes start of diagnosis code):
10004	19126		C50.*
10005	19281	77063	C79.81*
10006	19282	77065	D05.*
10007	19283	77066	D24.*
10008	19284	77067	D48.6*
10009	19285	88172	Z12.3*
10010	19286	88173	
10011	19287	88177	
10012	19288	88305	
10021	71120	88307	
19020	71130	88309	
19030	76641	0352T	
19081	76642	0353T	
19082	76942	0354T	
19083	77002	0422T	
19084	77012	0546T	
19085	77021	0633T	
19086	77046	0634T	
19100	77047	0635T	
19101	77048	0636T	
19105	77049	0637T	
19110	77053	0638T	
19112	77054	0351T	
19120	77061	0694T	
19125	77062		

Appendix 2. The Financial Model

		2021 Data	2024 No Legislation	2024 With Legislation	Legislative Impact	Comment
Baseline Screening Costs						
a.	Eligible women	1,527,140	1,527,140	1,527,140		APCD data
	Age 25 - 39	*509,818*	*509,818*	*509,818*		
	Age 40 - 49	*332,093*	*332,093*	*332,093*		
	Age 50 - 75	*685,229*	*685,229*	*685,229*		
b.	Member Months	16,798,540	16,798,540	16,798,540		APCD Data
c.	Total screenings in total population	381,747	381,747	394,052	12,306	APCD data, assumption
	Screening rate per 1,000 women age 25 - 39	*7.2*	*7.2*	*7.9*		
	Screening rate per 1,000 women age 40 - 49	*299.5*	*299.5*	*314.5*		
	Screening rate per 1,000 women age 50 - 75	*406.6*	*406.6*	*416.8*		
d.	Allowed costs per screening	$ 252	$ 292	$ 292	$ -	APCD data, 5% annual increase
e.	Allowed PMPM	$ 5.73	$ 6.64	$ 6.85	$ 0.21	(c. x d) ÷ b.
Cost Sharing Impact						
f.	Diagnostic biopsies in total population	26,835	26,835	27,700	865	APCD data
g.	Average cost-share amount	$ (73.02)	$ (84.53)	$ -	$ 84.53	APCD data, 5% annual increase
h.	Cost-share impact PMPM	$ (0.12)	$ (0.14)	$ -	$ 0.14	(f. x g.) ÷ b.
Savings Impact						
i.	Cancers detected per mammogram	0.2%	0.2%	0.2%	0.0%	Published data
j.	Savings per detected cancer	$ (13,000)	$ (15,000)	$ (15,000)	$ -	Proprietary data[1]
k.	Savings impact PMPM	$ (0.53)	$ (0.61)	$ (0.63)	$ (0.02)	(i. x j.) ÷ b.
Net Mammogram PMPM						
l.	Baseline screening allowed PMPM	$ 5.73	$ 6.64	$ 6.85	$ 0.21	e.
m.	Cost-sharing	$ (0.12)	$ (0.14)	$ -	$ 0.14	h.
n.	Expected savings	$ (0.53)	$ (0.61)	$ (0.63)	$ (0.02)	k.
o.	Net Impact to payers	$ 5.09	$ 5.89	$ 6.22	$ 0.33	l. + m. + n.
Net Impact % of Total Costs						
p.	Net allowed PMPM	$ 470	$ 576	$ 576	$ -	Proprietary data
q.	Net Impact on the cost per service	$ -	$ -	$ 85	$ 85	g.
r.	Increase in appropriate use of the service	0%	0%	0%	$ -	Assumption
s.	Substitution effect	0%	0%	0%	$ -	Assumption
t.	Impact on total cost of health care PMPM $	$ 5.09	$ 5.89	$ 6.22	$ 0.33	o.
u.	Impact on total cost of health care %	1.08%	1.02%	1.08%	0.06%	t ÷ p.
v.	Defrayal claims costs PMPM				$ 0.33	t.
w.	Loss ratio				85%	Assumption
x.	Applicable members				922,361	Proprietary data
y.	Total defrayal costs, if applicable				$ 4,287,207	(v. ÷ w.) x x. x 12

[1] Source: What Percentage of Diagnostic Mammograms is Cancer? | Independent Imaging