UPMC LIFE CHANGING MEDICINE

September 1, 2023

UPMC Health Plan
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Ms. Katie Merritt, Director of Policy and Planning
Pennsylvania Insurance Department (PID)
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Submitted electronically to ra-in-policyoffice@pa.gov

Re: Commonwealth Essential Health Benefits Benchmark Plan – Public Comment Period (Notice 2023-14)

Dear Director Merritt:

UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in response to the Pennsylvania Insurance Department (PID or the "Department") July 29, 2023 notice in the Pennsylvania Bulletin regarding updates to the Commonwealth's Essential Health Benefits (EHB) benchmark plan.

UPMC offers a full range of commercial, individual and group health insurance, Medicaid, CHIP, Medicare Advantage (MA), Medicare Special Needs Plans (SNPs), behavioral health, dental, vision, employee assistance, workers' compensation coverage, and third-party administrator services. Since beginning operations in 1996, UPMC has been recognized for its dedication to quality and outstanding customer service across its product lines. UPMC has offered consumers a variety of coverage options as a qualified health plan issuer since the launch of the Marketplace in 2014 and we currently provide coverage to approximately 100,000 individual Marketplace enrollees. Our Medicaid managed care organizations (MCOs), UPMC *for You*, UPMC Community HealthChoices, and Community Care Behavioral Health Organization, provide coverage of physical health, long term services and supports, and mental health and substance abuse services for over 2.2 million Medicaid enrollees in Pennsylvania. Our CHIP MCO, UPMC *for Kids*, serves over 28,000 children in Pennsylvania. In addition, our UPMC *for Life* MA Plans serve more than 200,000 members combined through the MA Part C/D and D-SNP programs. Collectively, our commercial, benefits management, and government programs membership exceeds 4.4 million.

We thank the Department for affording issuers and other stakeholders an opportunity to comment on potential changes to the EHB benchmark plan. UPMC supports PID in its efforts to improve and expand insurance coverage for Pennsylvanians, while also addressing coverage disparities and challenges related to health equity. We applaud the Department for seeking public comments, and we look forward to extensive dialogue among stakeholders in furtherance of our shared goals to ensure the affordability and accessibility of quality health care for all residents of the Commonwealth. It is with this support in mind that we respectfully offer for your consideration the following comments.

Process Considerations

Given that this is the first time Pennsylvania's EHB benchmark plan has been updated using the 2019 guidance established by CMS, as well as the first time that the Department intends to exercise discretion regarding the selection of individual benefits, it is critical that development of the new benchmark be grounded in a robust, transparent process that facilitates meaningful participation among stakeholders at each stage of development. While we appreciate that the Department has initiated the development process through a preliminary solicitation for public input (which we acknowledge is not required under federal guidance), we believe it is also important to establish additional precedential constructs to both guide the remainder of the current process and help ensure that any future changes to the benchmark plan will be effectuated through an equally robust and transparent stakeholder dialogue. Only a handful of States have undertaken updates to their EHB benchmark(s) since release of the 2019 guidance, and we believe that Pennsylvania has an opportunity to demonstrate leadership by establishing and adopting best practices for transparency and stakeholder engagement. To this end, UPMC encourages PID to follow the existing best practices for benchmark updates as put forth by the National Health Law Program (NHLP) in its report "Essential Health Benefits: Best Practices in State Benchmark Selection."[1] Those best practices include taking measures to ensure that the benchmark development process is transparent, is foundationally advanced through a data-driven approach, and creates ample opportunity for meaningful public participation.

Transparency

While the Department's early solicitation of comments is an important first step toward transparency in stakeholder dialogue, we believe there are additional policy decisions

[1] Wayne Turner and Héctor Hernández-Delgado. "Essential Health Benefits: Best Practices in State Benchmark Selection" National Health Law Program. July 2022. Available at https://healthlaw.org/wp-content/uploads/2022/07/Essential-Health-Benefits-Best-Practices-plus-appendix-7.26.2022.pdf.

that the Department can adopt to ensure meaningful transparency through the remainder of the development process. Specifically, UPMC encourages PID to publicly post all comments received during the public comment period(s). Additionally, UPMC encourages the Department to publicly address whether and how it intends to respond to comments. The Department is required to provide opportunity for public comment on the selection of an EHB benchmark plan and has indicated that it intends to provide an opportunity for public comment on the detailed proposal for updating the benchmark plan in early 2024.[2] In its proposal, we recommend that the Department expressly acknowledge and address how it has weighed and evaluated the various stakeholder recommendations.

Transparency should also include the prospective provision of information about the process the Department will use to arrive at decisions, including providing public information in response to the following questions:

- Which of the options for selecting the EHB benchmark plan available under regulation will the Department use to create the new benchmark plan? How was this selection made and what consideration was given to the options that were not selected?[3]
- What weight will be given to public comments? Will there be any scoring, weighting, counting, or other algorithms or quantitative metrics applied during the Department's review and consideration of comments?
- What data will be considered to determine the greatest needs for coverage?
- How will concerns about health equity be addressed?
- How will the Department analyze which benefit adjustments best address the needs identified?
- How does the Department intend to select the typical employer plan that it will use as part of its analysis?[4]
- Does the Department intend to add benefits until the maximum permissible actuarial value of the benchmark is reached, or will benefit additions be limited on some other basis?

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[2] 45 CFR § 156.111(c). The state must provide reasonable public notice and an opportunity for public comment on the state's selection of an EHB benchmark plan.

[3] 45 CFR § 156.111(a). A State may change its EHB benchmark plan by 1) selecting the EHB-benchmark plan of another state; (2) replacing one or more categories of EHBs in the benchmark plan with the same category or categories of EHB from the benchmark plan of another state; or 3) otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

[4] 45 C.F.R. § 156.111(b)(2)(i). A "typical employer plan" is either 1) one of the selecting state's 10 base-benchmark plan options available for the 2017 plan year, or 2) the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the state.

- What data sources will be used to evaluate the actuarial value of new benchmark benefits?
- How will the Department weigh the cost of adding benchmark benefits for subsidized individual market members against potential cost increases for unsubsidized individuals and small businesses?
- Does the Department intend to include coverage mandates adopted since the 2017 benchmark plan was established in the new EHB benchmark plan?[5]

Data Driven Decision-making

Given the likelihood that PID will receive comments supporting inclusion of a wide range of coverage mandates for a variety of healthcare services, it is important that undue weight not be given to those who advocate most forcefully for their point of view. We recommend the Department collect and analyze data from reputable sources to determine what services represent the greatest needs and the best opportunities to address health equity or disparities in the Commonwealth, while also weighing the potential for coverage losses or other market responses to a requisite increase in coverage as new benefits are added (particularly among small employers and individual market consumers that do not receive a premium subsidy). In keeping with our call for a transparent process, those data and analyses should be included in the package of information presented to the public for comments and feedback early next year.

The NHLP report cited above also encourages states to approach their actuarial analysis in stages, first determining, pursuant to regulatory requirements, the value of the most generous plan available on the marketplace in 2017, and then comparing it to the current benchmark, in order determine the net actuarial difference the state can add to the EHB benchmark without having to defray the costs of the additional coverage requirements.[6] UPMC recommends that PID follow this important step prior to development of the new benchmark package; this early-stage analysis should be made available to the public. In addition, because utilization and the cost of medical care can vary widely across regions in Pennsylvania, it is critical that the Department establish, and solicit stakeholder feedback on, its intended data sources for estimating the statewide actuarial value of services in both the current benchmark plan and the most generous plan, as well as, in later stages, the proposed new benchmark plan.

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[5] For example, Act 1 of 2023 requires coverage of certain breast examinations and imaging as well as BRCA-related genetic counseling and testing. https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2023&sessInd=0&act=1.

[6] Turner and Delgado. Page 10. Pursuant to 45 CFR § 156.111(b)(2)(ii), the scope of benefits of the new benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, including 1) the state's EHB benchmark plan used for the 2017 plan year, and 2) any of the state's base-benchmark plan options for the 2017 plan.

Public Participation
It is essential that stakeholders be given the opportunity to respond to all aspects of the decision-making process, and not just provide initial input during this comment period and then respond to a complete proposal created by the Department. Stakeholders should be informed of the end-to-end process and invited to participate at various decision points. For example, stakeholders should be made aware of the actuarial limitations the Department must consider when contemplating additional benefit mandates and invited to review and provide feedback on the Department's data analysis, including the actuarial certification reports the Department is required to submit to the US Department of Health and Human Services.[7] Stakeholders need this complete understanding of the proposal and its impacts in order to provide meaningful and informed public comments.

Conclusion
UPMC encourages PID to rely on the principles of transparency, data-informed decision making, and meaningful public participation to create a durable process that can be emulated in future updates to the EHB benchmark plan. The best practices we outline in our comments above will also help the Department demonstrate how the changes to the benchmark plan will address health equity and existing coverage disparities in the Commonwealth.

UPMC thanks the Department for the opportunity to comment at this initial stage in the process of updating the EHB benchmark plan. We appreciate the Department's consideration of these comments and look forward to continued dialogue and collaboration in the future.

Respectfully submitted,

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Divisional Chief Legal Officer
Vice President, Health Policy & Regulatory Affairs
UPMC Health Plan

[7] 45 CFR § 156.111(e). A State changing its EHB-benchmark plan under this section must submit documents to HHS, including an actuarial certification that affirms 1) that 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, and 2) the new benchmark plan does not exceed the generosity of the most generous plan.