House Bill 376
Position: Support
Health and Government Operations Committee
February 16, 2023
Jenna Massoni, Cornerstone Government Affairs

Chairwoman Pena-Melnyk, Vice Chairwoman Kelly, and Members of the Health and Government Operations Committee,

Thank you for the opportunity to provide written testimony in support of House Bill 376. My name is Jenna Massoni and I work with Cornerstone Government Affairs as a representative of Susan G. Komen.

The purpose of this legislation is to eliminate out of pocket costs for Diagnostic and Supplemental Imaging Examinations for Breast Cancer. From passing this bill in 9 other states, Komen believes that this legislation will have a profound impact for eliminating healthcare barriers for Marylanders.

To address the concern of cost implications, in a Maryland Health Care Commission study, we were sent a report (see below) indicating the estimated cost impact from this legislation. MHCC estimated that the elimination of cost-sharing for diagnostic imaging examinations would add about $0.07 cents per member per month, or about $0.83 cents per year to privately insured health care premiums. Additionally, the fiscal notes from the 9 states who passed this legislation have shown negligible impacts on insurance premiums.

We respect the work of Maryland's private health insurers and spoke with each private insurer during the interim. This bill does not create a new coverage mandate, it addresses cost-share requirements for health plans that already provide coverage screening and diagnostic services. The bill ensures that patients who need this follow up for medically necessary reasons, do not forego the test due to unaffordable out-of-pocket costs.

Breast Cancer is one of the most diagnosed cancers in MD. In fact, Maryland has ranked among the top states in breast cancer mortality. It is extremely necessary to address this issue at the state level until it's passed in Congress by Komen's legislation that has been introduced at the federal level.

Thank you for your time and I request a favorable report for House Bill 376.

Jenna Massoni
Cornerstone Government Affairs, representing Susan G. Komen

STATE OF MARYLAND

Andrew N. Pollak, MD
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

February 7, 2022

The Honorable Sheree Sample-Hughes
Speaker Pro Tem, Health and Government Operations Committee
Maryland House of Delegates
6 Bladen St., Room 313
Annapolis, MD 21401-1991

RE: Request for Cost Estimate to Eliminate Cost-Sharing for Diagnostic Screening for Breast Cancer and Diagnostic Evaluation of the Breast

Dear Delegate Sheree Sample-Hughes:

The Maryland Health Care Commission (MHCC) is pleased to submit this response to your January 11, 2022 letter requesting a study to estimate the cost impact of eliminating cost-sharing requirements for diagnostic imaging examinations for diagnostic evaluation of the breast. **MHCC estimates that the elimination of cost-sharing will add about $0.07 per member per month or about $0.83 per year to privately insured health care premiums.** It is important to note that mammography screening is considered an essential health benefit under the Affordable Care Act and a preventive health care service in the fully-insured large group market; therefore, mammography screening is not subject to cost-sharing. As a result, this analysis is an estimate on the elimination of cost sharing for diagnostic testing only.

The results of our analysis indicate that the cost impact, if the member out of pocket (OOP) cost requirements for diagnostic imaging examinations or diagnostic evaluations of the breast were eliminated, is about $0.07 per member per month (PMPM). We expect this cost to remain relatively flat with modest changes in utilization for women ages 30 and older, since there were slight variations in the member OOP costs over the last four years (2017 - 2020). However, after a modest decrease (-6.3%) in 2018, the cost per service shows a steady increase through 2020, ending up at about 14.5%. The PMPM allowed charges across the entire fully-insured population have been relatively stable (averaging about $0.19) over the last four years, despite slight volatility in utilization (decrease in 2018, increase in 2019, and then a decrease in 2020).

Analysis of the Utilization and Costs of Diagnostic Screening for Breast Cancer and Diagnostic Evaluation of the Breast

Study Year	No. of Services per 1,000 Female Members (age ≥ 30)	Utilization Trend	Cost per Service (age ≥ 30)	Unit Cost Trend	PMPM			
					Allowed Charges	Member Cost Share	Premium	Member Cost Share as a % of Premuim
2020	20	-2.9%	$196	14.5%	$0.21	$0.07	$569	0.01%
2019	20	1.0%	$171	4.4%	$0.18	$0.07	$526	0.01%
2018	20	-7.4%	$164	-6.3%	$0.17	$0.06	$485	0.01%
2017	21		$175		$0.20	$0.06	n/a	n/a

Using the average 2018 PMPM premiums by market ($547 for individual, $448 for small group, and $485 for fully-insured large group) from MHCC's "*Study of Mandated Health Insurance Services as Required Under Insurance Article §15-1502"* premiums were projected out one year to 2019 and two years to 2020 using annual PMPM allowed observed medical trends by market. Results show in the above table that the cost for eliminating the member cost-sharing is about 0.01% of premium across all markets (individual, small group, and fully-insured large group). Although costs for the illness burden for the privately fully-insured population, level of benefit coverage, and medical management will vary by insurance market due to differences in health insurance carrier medical management and care coordination, information from health insurance carriers is not available to quantify such differences. Therefore, the same estimated PMPM premium impact for each market was used across all health insurance carriers although the percent of premium would vary slightly across the individual, small group, and large group markets.

MHCC has been charged with conducting a systematic assessment of potential changes in health benefits through added mandates under Insurance Article §15-1501, Annotated Code of Maryland. Typically, MHCC would contract with an external actuarial consulting firm to complete the analysis and formulate estimates. Given the urgency of this legislative request and the current limits of the MHCC budget, an experienced actuary at MHCC conducted the work. I am satisfied that MHCC completed this analysis with similar rigor as if MHCC had contracted with an actuarial consultant.

If you have any questions about these findings, please do not hesitate to contact me at 410-764-3566 or ben.steffen@maryland.gov.

Sincerely,

Ben Steffen
Executive Director

Technical Attachment

MHCC used the Maryland All-Payer Claims Database (APCD) as the data source for this analysis. Specifically, institutional services (outpatient only), professional services, and eligibility files were used. The APCD population includes all Maryland residents enrolled in private (commercial) fully-insured health plans. For purposes of this analysis, only the claims experience for females 30 years of age and older were selected from the APCD since the cost elimination would apply to that cohort. However, when calculating the per member per month (PMPM) costs, the entire fully-insured population (i.e., no age restriction), including the individual market, the small group market, and the large group market, was used to calculate member exposure. However, the insurance carrier Kaiser (no fee-for-service claims for professional services due to capitation) and the Federal Employees Health Benefits (FEHB) Program (Federal decision to exclude all FEHB data from State APCDs including Maryland) populations were excluded in this study. Finally, the CPT and ICD codes used in this analysis included CPT: 76090, 76091, 76499, 76641, 77046, 77047, 77048, 77049, 77051, 77061, 77062, 77065, 77066, 78800, G0279, G0204, G0206; and ICD 10: Z12.31, N63, R92.0, R92.1, R92.2, R92.8. We excluded all mammogram CPT screening codes. These services are covered under the Affordable Care Act (ACA) list of essential health benefits (EHB) and under preventive services for large fully-insured employers.

About 33.8% (252,732 members per month on average) of the entire 2020 privately fully-insured population are female and are at least thirty years or older. Of that 33.8%, about 2.7% (or 6,908 females per month on average) had a diagnostic imaging examination or diagnostic evaluation of the breast claim during 2020. These 6,908 females are about 0.9% of the entire fully-insured population in the APCD.

In 2019, about 33.3% (255,116 members per month on average) of the entire privately fully insured population were female and at least thirty years or older. Of that 33.3%, about 3.1% (or 7,800 females per month on average) had a diagnostic imaging examination or diagnostic evaluation of the breast claim during 2019. These 7,800 females are about 1.0% of the entire fully-insured population in the APCD.

Premium Projections

Year	Market	Premium PMPM	Member Exposure	Premium Dollars	Allowed Medical Trend
2018	Individual	$547	1,750,412	$957,475,364	
2018	Small Group	$448	2,898,261	$1,298,420,928	
2018	Large Group	$485	4,777,154	$2,316,919,690	
2018	Total	**$485**	9,425,827	$4,572,815,982	
2019	Individual	$601	1,680,357	$1,009,169,174	5.4%
2019	Small Group	$479	2,882,757	$1,381,820,320	6.4%
2019	Large Group	$528	4,617,604	$2,439,143,827	5.3%
2019	Total	**$526**	9,180,718	$4,830,133,322	5.6%
2020	Individual	$547	1,945,662	$1,063,653,917	
2020	Small Group	$533	2,760,457	$1,470,576,572	
2020	Large Group	$602	4,268,221	$2,567,815,637	
2020	Total	**$569**	8,974,340	$5,102,046,127	

Notes: (1) Source of 2018 premium PMPMs by insurance market is
MHCC's "Study of Mandated Health Insurance Services as Required Under Insurance Article §15-1502"
(2) Premium dollars for base year 2018 are calculated as premium PMPM times member exposure
(3) Premium dollars for base year 2018 are trended one year to 2019 using the 2019 annual allowed medical trends
(4) Premium dollars for base year 2018 are trended two years to 2020 using the 2019 annual allowed medical trends
(5) Source of member exposure and allowed medical trends is the Maryland APCD.
(6) Population is Maryland residents enrolled in privately fully-insured health plans. This population excludes Kaiser and FEHB

Description of CPT and ICD 10 Codes

Codes	Description
CPT:	
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
76499	Unlisted diagnostic radiographic procedure
76090	Mammography; diagnostic, unilateral
76091	Mammography; diagnostic, bilateral
77051	Mammogram unilateral CAD Diagnostic
77066	Diagnostic mammography, producing direct 2D digital image, bilateral, all views
77065	Diagnostic mammography, producing direct 2D digital image, unilateral, all views
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
78800	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77048	Magnetic resonance imaging, breast, without contrast material; unilateral
77049	Magnetic resonance imaging, breast, without contrast material (s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral
77046	Magnetic resonance imaging, breast, without contrast material (s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral
G0204	Diagnostic mammography, including when performed; bilateral
G0206	Diagnostic mammography, including CAD when performed; unilateral
ICD 10:	
Z12.31	Encounter for screening mammogram for malignant neoplasm of breast
N63	Unspecified lump in breast
R92.0	Mammographic microcalcification found on diagnostic imaging of breast
R92.1	Mammographic calcification found on diagnostic imaging of breast
R92.2	Inconclusive mammogram