STATE OF MARYLAND

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MARYLAND HEALTH CARE COMMISSION

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January 28, 2020

The Honorable Joseline Peña-Melnyk
Vice Chair, Health and Government Operations Committee
Maryland House of Delegates
6 Bladen St., Room 241
Annapolis, MD 21401-1991

RE: Request for Cost Estimate to Eliminate Cost Sharing for Prostate Cancer Screening

Dear Vice-Chair Peña-Melnyk:

The Maryland Health Care Commission (MHCC) is pleased to submit this response to your December 12, 2019 letter requesting a study to estimate the cost impact of eliminating the cost sharing requirements for the prostate specific antigen (PSA) screening test and digital rectal examination (DRE). Pursuant to Insurance Article §15-825, Annotated Code of Maryland, this member out-of-pocket (OOP) cost elimination would apply to all males between 40 and 75 years of age. The MHCC estimates that the elimination of cost-sharing will add about $0.03 per member per month or about $0.35 per year to privately insured health care premiums.

MHCC used the Maryland Medical Care Data Base (MCDB), the main component of Maryland's Multi-Payer Claims Database, as the data source for this analysis. Specifically, institutional files (outpatient only), professional services files, and eligibility files were used. The MCDB population is all Maryland residents who are enrolled in private fully-insured health plans. For purposes of this analysis, only the claims experience for males between 40 and 75 years of age were selected from the MCDB, since the cost elimination would only 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 including those covered in the Federal Employees Health Benefits (FEHB) Program, was used to calculate member exposure. Finally, the CPT codes used in this analysis included: 84152, 84153, G0102, and G0103.

As shown in the table below, the results of our analysis indicate that the cost impact, if the member out of pocket (OOP) cost requirements for the PSA screening and DRE were eliminated, is about $0.03 per member per month (PMPM). We would expect this cost to remain relatively flat with modest increases in utilization for men between ages 40 and 75 since there was little to no variation in the member OOP costs over the last three years (2016 - 2018). The cost per service for the 40 to 75 age range (at about $18) and the PMPM allowed charges across the entire fully-insured population (at about $0.12) have been relatively stable over the last three years despite increases in utilization.

Study Year	No. of Services per 1,000 Members	Utilization Trend	Cost per Service (age 40 – 75)	PMPM	
				Allowed Charges	Member Cost Share
2018	79	5.2%	$17.7	$0.12	**$0.03**
2017	75	8.7%	$18.4	$0.12	**$0.03**
2016	69		$17.6	$0.10	**$0.03**

About 23% (283,036 members per month on average) of the entire 2018 private fully-insured population is between ages 40 and 75 (inclusive). Of that 23%, about 31.8% (or 89,983 males) had a prostate cancer screening during 2018. These 89,983 males are about 7.3% of the fully-insured population.

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"* the estimated 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 the 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 carriers is not available to quantify such differences. Therefore, the same estimated PMPM premium impact for each market was used across all carriers.

MHCC does not believe that the elimination of member cost-sharing will fuel excessive demand for the test because of the emphasis on shared decision making in accessing the value of the PSA screening.

The U.S. Preventive Services Task Force (USPSTF), the organization that makes recommendations about the effectiveness of specific preventive care services for patients without visible related signs or symptoms, gives PSA screening a C rating (there is at least moderate certainty of net benefit) for men aged 55 to 69 years. They advise that the decision to undergo periodic PSA screening for prostate cancer should be an individual one, made in consultation with a clinician taking into account a patient's assessment of benefits and harms and factoring in risks based on family history, race/ethnicity, comorbid medical conditions, and patient values about the benefits and harms of screening. The USPSTF recognizes the test offers a small

potential benefit of reducing the chance of death from prostate cancer but also emphasizes that some men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction.

The American Cancer Society (ACS) takes a more proactive approach to screening but also emphasizes individual decision making in assessing benefits versus risks with the option for screening presented to patients beginning at age 50 or who are at average risk of prostate cancer; beginning at age 45 for men at high risk for developing prostate cancer (including African American men who have a first-degree relative with prostate cancer); and beginning at age 40 for men with more than one first-degree relative who had prostate cancer at an early age. The American Urological Association's (AUA) recommendations largely parallel those of the ACS with the exception that they do not distinguish between men at high and the highest risks.

African American men have a higher incidence of prostate cancer, increased prostate cancer mortality, and earlier age of diagnoses compared to white American men. This observation is attributable to a greater risk of developing preclinical prostate cancer and a higher likelihood that a preclinical tumor will spread. The ACS and AUA believe it is reasonable for African American men to consider to begin shared decision-making about PSA screening at earlier ages and to consider screening at annual intervals. Also of note, none of the standard-setting organizations recommend routine PSA screening for men over age 70 with no symptoms.

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

Sincerely,

Ben Steffen
Executive Director

cc: Megan Renfrew, Chief of Government Relations and Special Projects, MHCC