OPIOID RELATED EHB CHANGES - UTILIZATION AND COST ANALYSIS

Illinois Department of Insurance

17 August 2021

CONTENTS

1. EXECUTIVE SUMMARY

Purpose and Scope

This report provides findings from Oliver Wyman's analysis of health plan data related to cost and utilization trends of commonly prescribed opioids, alternative therapies and telepsychiatry care in the ACA individual and small group markets. It also summarizes interviews conducted with health plans about new opioid related benefits in the EHB benefit plan effective January 1st, 2020. Lastly, we provide information about distribution, demographics, cost and utilization of the opioid user compared to non-opioids users in the Illinois ACA markets.

Actuarial Findings

- Most companies stated in interviews that they were already taking a proactive stance against the opioid epidemic, and thus, had already implemented many of the opioids related EHB benefits changes prior to 1/1/2020.
- Most companies offered a general, overall description of where they have seen the biggest impact of these EHB implementations from the interviews. The most common responses were the 7-day limit prescription of opioids and the increase in telehealth visits.
- The combined cost and utilization impact of the services related to the 2020 benefit changes is minimal across ACA enrollees in Illinois except for telepsychiatric care.
- Telepsychiatric care visits utilization increased significantly starting in March of 2020 as did all telehealth services due to the COVID-19 pandemic. Although there has been a drastic increase in the total allowable cost for these services, the overall out of pocket increase on enrollees is minimal due to the issuance of Executive Order 2020-09 and the prohibition on imposing cost-sharing for in-network telehealth services.
- The number of enrollees utilizing prescription opioids has been declining by about 0.5% per year since 2018 in both the individual and small group markets.
- The prevalence of opioids users is highest in the regions outside of the Chicagoland area.
- The rate of prescription opioid utilizing enrollees is significantly higher among higher risk individuals indicating a strong correlation between opioids users and high cost claimants.
- Opioid users are responsible for three to four times more inpatient admissions, outpatient surgeries and emergency room encounters and costs compared to non-opioid ACA enrolees.

2. BACKGROUND

Addressing the opioid crisis has been the focus for national and state level policy and health care stakeholders. Illinois is only one of four states with laws that limit prior authorization for substance use disorder (SUD) services and medications in both Medicaid and commercial plans.[1] However, drug and opioid overdose deaths continue to increase[2] and efforts to end the nation's drug pandemic needs to be monitored and evaluated on regular basis.[3] As part of the CMS "The State Flexibility to Stabilize the Market Grant Program", the Illinois Department of Insurance (DOI) requested from Oliver Wyman Actuarial Consulting (OW) to assess and evaluate recent benefit changes to the Illinois Essential Health Benefit (EHB) Benchmark health insurance plan. The new benefit changes include:

- Coverage of alternative therapies for pain;
- Limit of opioid prescriptions for acute pain;
- Remove barriers to obtaining Buprenorphine products for medically assisted treatment (MAT) of opioid use disorder;
- Coverage of prescriptions for at least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50 Morphine Milligram Equivalents (MME) or higher; and,
- Coverage of telepsychiatry care by both a prescriber and a licensed therapist.

These EHB benchmark changes went into effect on 01/01/2020 for fully insured individual and small group health insurance plans in Illinois subject to EHB benchmark requirements under the Affordable Care Act (ACA).

Specifically, the DOI requested the following information:

- Documentation how private insurance companies offering plans on the individual and small group markets implemented the changes required and describe any variation by geographical area.
- Develop metrics to measure the costs for opioids and alternative therapies to pain before and after the EHB Benchmark changes went into effect. The metrics will vary by the various geographies within the state and will be provided separately for consumers and for the insurance plan.
- Develop metrics to compare the utilization of opioids and alternative therapies to pain before and after the EHB Benchmark changes went into effect. The metrics will vary by the various geographies within the state.
- Creating data request(s), reviewing documents and conducting interviews for the plans subject to the Benchmark EHB changes in order to independently derive the cost and utilization metrics as well as the documentation of how those changes were implemented.

[1] https://www.lac.org/resource/spotlight-on-legislation-limiting-the-use-of-prior-authorization-for-substance-use-disorder-services-and-medications

[2] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[3] https://end-overdose-epidemic.org/wp-content/uploads/2020/12/AMA-Manatt-Health-National-Roadmap-December-2020-FINAL.pdf.

OW has contracted with NovaRest Consulting as a sub-contractor to facilitate the interviews with private health plans related to the implementation of the EHB changes. This report includes a summary of the findings as prepared by NovaRest and reviewed by OW in Section 3.

In addition, this report documents the data sources (Section 4), methodology and description of the cost and utilization metrics (Section 5), and results and findings from the data analysis (Section 6).

3. HEALTH PLAN INTERVIEW SUMMARY

The Illinois Department of Insurance hired Oliver Wyman and NovaRest as a subcontractor to research the impact of the new benefits in the EHB benefit plan in 2020. Oliver Wyman gathered data from carriers to perform a quantitative analysis of claims. NovaRest interviewed carriers to do a more qualitative analysis of the impact of the new benefits.

As part of its interview efforts NovaRest:

1. Developed an interview guide,
2. Contacted Illinois ACA individual and small group market issuers to arrange interview times; and
3. Conducted interviews.

NovaRest interviewed: Humana, Health Alliance Plan, UHC, Medical Associates, Mercy Health, Quartz, Centene, and Aetna. NovaRest received a written response from CIGNA and from HCSC.

None of the companies performed an official analysis on the impact of EHB changes. Reasons for this include non-credible Illinois ACA business and the coverage of all or many of these EHBs before the law went into effect. One company did no cost analysis, but estimated premium impact based on the Oliver Wyman study conducted as part of the Illinois application to CMS for the EHB benchmark plan changes.

Most companies stated they were already taking a proactive stance against the opioid epidemic, and thus, had already implemented these benefits. Most mentioned prior changes in accordance with CDC recommendations.

Most companies offered a general, overall description of where they have seen the biggest impact of these EHB implementations. The most common was in the 7-day limit prescription of opioids. The results are as follows:

- Two companies noticed a decrease in utilization of opioids from a combination of factors such as providers being more conscious about the 7-day limit and overall awareness.
- One company said the change with the biggest impact was the 7-day limit due to difficulty changing prescribing habits prior to the addition of this EHB benefit requirement.
- One company noticed more provider willingness to engage with health plans and more documentation on provider strategy to bring patients down from dangerous levels of opioids. Pharmacies also created best practices by requiring diagnosis codes.
- One company has been monitoring numbers of prescription pills, therapy, etc. and has noticed that distribution has dramatically decreased.
- One company stated that changes were not that impactful. However, they do look at opioid possession by strength, number of pharmacies patients go to, and how many pharmacy scripts per members. They send follow up letters if they notice anything out of the ordinary.

Since most of these new EHB additions were in effect already, some companies had to make just a few minor coding and/or administrative changes to make sure benchmarks were met.

Telepsychiatry was another area where there were some significant differences for some carriers after the new benefits were required. Many did notice an increase in utilization but credit this due to COVID-19 rather than the implementation of new EHBs. The following are some responses from carriers:

- Two companies already covered telepsychiatry and saw no change.
- One company assumed the impact of telepsychiatry was so small when using 2018 experience for 2020 rates that it was not considered. Going forward they believe it will be more utilized largely due to practices during COVID-19.
- One carrier implemented telemedicine in 1/1/2020 but had decided to do this before the EHB changes were in place.
- Three carriers already covered telemedicine/telepsychiatry and saw a tremendous uptake. They expect it to continue to be greatly utilized. However, they credit this uptake to COVID-19.
- One company noted that it had a positive impact on membership.
- One company did not anticipate any cost change since it is compensated at the same rate as in person services. Due to the pandemic, they did also see a huge increase in services (from virtually nothing to 80-90% of services).

4. DATA

Health Plan Data Collection and Reconciliation

We identified 15 health insurance plans with credible individual and small group ACA in force premiums in the state of Illinois from 2018 to 2020 as shown in table 1 below.

Table 4.1: Reported Earned Premium in the Individual and Small Group Market in Millions 2018 to 2020

		2018		2019		2020	
Plan Name	**NAIC code**	**Individual**	**Small Group**	**Individual**	**Small Group**	**Individual**	**Small Group**
Aetna Life Insurance Company	60054	$0.7	$43.4	$0.0	$3.7	$0.0	$0.0
Celtic Insurance Company	80799	$174.2	$0.0	$166.1	$0.0	$129.0	$0.0
Cigna HealthCare of Illinois, Inc.	95602	$136.6	$0.0	$98.5	$0.0	$49.6	$0.0
Health Alliance Medical Plans, Inc.	77950	$300.2	$74.8	$230.3	$70.2	$217.4	$65.9
Health Care Service Corporation	70670	$2,438.0	$2,494.4	$2,310.3	$2,591.0	$2,250.3	$2,612.9
Humana Health Plan, Inc.	95885	$0.0	$14.2	$0.0	$12.7	$0.2	$14.8
Humana Insurance Company	73288	$0.0	$105.4	$0.0	$83.1	$0.3	$58.3
Medical Associates Health Plan, Inc	52559	$0.0	$2.0	$0.0	$1.0	$0.0	$1.2
MercyCare HMO	12195	$0.0	$1.7	$0.0	$1.8	$0.0	$1.5
Quartz Health Plan Corporation	95101	$0.0	$0.0	$5.7	$0.3	-$0.8	$0.3
Quartz Health Benefit Plans Corp	95796	$0.0	$0.0	$0.0	$0.0	$11.8	$1.2

UnitedHealthcare Insurance Company of Illinois	60318	$4.5	$435.7	$0.0	$413.3	$0.0	$345.0
UnitedHealthcare Insurance Company of the River Valley	12231	$0.9	$99.0	$0.0	$88.3	$0.0	$50.5
UnitedHealthcare of Illinois Inc	95776	$0.2	$25.3	$0.0	$22.8	$0.0	$15.0
UnitedHealthcare Plan of the River Valley, Inc.	95378	$0.0	$15.2	$0.0	$12.7	$0.0	$5.1
Other Entities		$42.9	$23.5	$39.0	$0.2	$19.7	$0.7
Total		**$3,098.4**	**$3,334.6**	**$2,850.0**	**$3,301.2**	**$2,677.4**	**$3,172.4**
Market Share of 15 Plans		**98.6%**	**99.3%**	**98.6%**	**100.0%**	**99.3%**	**100.0%**

The credible threshold was determined at $1 million in annual earned premium in either the individual or small group market as reported in the CMS MLR Rebate Reports[4] for the state of Illinois in 2018 or 2019 or in the statutory annual statement Supplemental Health Care Exhibit[5] (SHCE) in 2020. We have cross checked the health plan listing against the other public reports such as the CMS Summary Report on Permanent Risk Adjustment Transfers for the 2018 and 2019[6] Benefit Years as well as CMS Rate Review data.[7] Health plans with less than $1 million in annual earned premium, no premium reported in 2018 and 2019, or with all of them in force in the grandfathered or transitional major medical health plans have been excluded from the analysis. The only exception was Quartz Health Benefit Plans Corp, NAIC code 95796, which switched all their business in 2020 from another reporting plan, Quartz Health Plan Corporation, NAIC code 95101. The 15 health plans represent no less than 98.6% of the earned premiums reported in the individual and small group markets for period from 2018 to 2020. We have confirmed the entity listing with the DOI.

We initiated a data call request with the 15 plans to provide data extracts for medical, prescription drugs and membership information. The requested service dates for medical and prescription drug claims was specified between 1/1/2018 and 3/31/2021, paid through 3/31/2021, for ACA lines of business (i.e., individual and small group excluding ACA transitional plans). This ensured that we could analyze the cost and utilization impacts prior to and after the implementation of the EHB change date of 1/1/2020. The

[4] https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

[5] We utilized S&P Global Market Intelligence Service for 2020 SHCE data: https://platform.marketintelligence.spglobal.com/

[6] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf

[7] https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview

requested claims data was at a claim line level and included detailed claim information (e.g., diagnosis codes, procedure codes, allowable, member cost sharing and health plan incurred claim amounts, etc.) as required for our actuarial analysis. For enrollment information we requested membership records for members enrolled between 1/1/2018 and 3/31/2021 for ACA lines of business along with additional demographic and health plan information. The requested claims and enrollment data fields are listed in Appendix A.

We received data extracts from all 15 entities. We analyzed the data by performing checks for completeness against requested data control numbers and by comparing 2018 enrollment, allowed claims and health plan paid claims data against prior DOI data requests processed by OWA. Complete data has been selected for the analysis in this report which represents 93.4% and 96.2% of the reported earned premium in the individual and small group markets respectively for the period of 2018 to 2020. The final data set includes 3.6 million average members and $15.1 billion in allowed claims cost for period from January 2018 to March 2021. Next, we describe the initial data modifications we performed on the health plan data.

Initial Health Plan Data Modification

We combined all the carrier data submissions used for the analysis and created a working database. The initial data modifications were limited to the following edits:

- Standardize the data for consistency (e.g. ‘M’ for male, ‘F’ for female).
- Remove duplicate membership as necessary in order to assign one enrollment record by month. This impacted less than 0.5% of the membership records for the identified entities.
- Summarized the data down to only variables required for utilization and cost analysis (see Section 5 below).

5. COST AND UTILIZATION METRIC METHODOLOGY

In this section we describe the data and cost model service categories developed for our analysis. We also provide descriptions of the five EHB Benchmark changes and the cost/utilization metrics developed.

Demographic Data Categories

We developed demographic data categories based on the data submitted by health plan entities.

Opioid users were identified based on ICD diagnosis codes typically associated with prescribed opioids and through NDC prescription drug listings associated with opioid analgesics that are normally prescribed in outpatient settings and dispensed by retail pharmacies.[8] The listing of the demographic categories is shown in Table 5.1.

Table 5.1: Demographic Data Categories

Demographic Category	Description
Line of Business (LOB)	Individual (including Catastrophic plans) and small group lines of business as provided by health insurance entities through the data submission
Geographic Areas	1) Chicago/Cook County – ACA Rating Region 1 2) Chicago Suburbs – ACA Rating Regions 2-4 3) Remaining IL – ACA Rating Regions 5-13
ACA Risk Score	Group by deciles in each plan year and by LOB
Opioid User Identifier	Member with medical claim IDC-10 codes related to adverse effects, overdose or poisoning by prescribed opioids (T40.2), analeptics and opioids receptor antagonists (T50.7), opioid related disorders (F11) or NDC prescription drugs identified in CDC's 2020 File of National Drug Codes for Selected Opioid Analgesics in each calendar year

Cost Model Service Categories

We have developed allowable, member cost sharing and plan incurred expenditure and utilization metrics as additional features for our analyses. Both types of metrics were summarized based on medical and prescription drug categories from our internal cost model such as inpatient, outpatient (up to 99 categories), professional (up to 99 categories), other medical (19 categories) and prescription (27 categories). An example of major and detail cost model categories for various claim types is shown in Table 5.2.

[8] CDC's 2020 File of National Drug Codes for Selected Opioid Analgesics: https://www.cdc.gov/opioids/data-resources/index.html

Table 5.2: Cost Model Major and Detailed Service Categories

Major Service Category	Detailed Service Category
Inpatient Facility	Medical
Inpatient Facility	Surgical
Inpatient Facility	Maternity
Outpatient Facility	Urgent Care
Outpatient Facility	Emergency Room
Outpatient Facility	Radiology (Mammograms, CT Scans, MRIs, X-Rays, etc.)
Outpatient Facility	Therapy (PT/OT/ST)
Professional Services	Primary Care Physician/OB-GYN
Professional Services	Specialist
Professional Services	Office Surgery
Other Carve-Out Services	Ambulance
Other Carve-Out Services	Home Health
Other Carve-Out Services	Durable Medical Equipment
Prescription Drugs	Retail Drugs (Generic, Preferred Brand, Non-Preferred Brand, Specialty)
Prescription Drugs	Mail-Order Drugs (Generic, Preferred Brand, Non-Preferred Brand, Specialty)

EHB Benchmark Description

Table 5.3 details how we defined the five EHB Benchmark changes in the data set. We developed cost and utilization metrics for each of the five EHB Benchmark changes separately, which are summarized in section 6 of this report.

Table 5.3: EHB Benchmark Data Description and Identification

Item Number	EHB Description	EHB Identifier
1	Benefits will be provided for at least one intranasal opioid reversal agent prescription for initial prescriptions of opioids with dosages of 50 MME or higher.	NDCs associated with naloxone as intranasal spray (69547-212-04, 69547-212-24, 69547-353-02)
2	Benefits will be provided for topical anti-inflammatory medication including, but not limited to, Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain.	• About 435 NDC associated with Ketoprofen, Diclofenac • Applied AHRQ CCS definitions for pain management identifier (See Appendix A.5.) • Limited to scripts filled within 7 days of medical encounter
3	Short-term opioid prescriptions for acute pain will be provided for no more than 7 days.	CDC's 2020 File of National Drug Codes for Selected Opioid Analgesics with supply days of 7 or less
4	Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder shall not include prior authorization, dispensing limits, fail first policies, or lifetime limit requirements.	CPT codes associated with MAT as defined by CMS guideline[9] and NDC identified with Buprenorphine, Methadone and Naltrexone.
5	Benefits are available for Medical Care visits when: you utilize telepsychiatry care (care may be provided by either a prescriber or licensed therapist).	Psychiatry procedure codes with modifiers of 96 or GT. See Appendix A.6.

Cost Metrics

We developed cost metrics to measure the per member per month (PMPM) allowable amounts, the health plan's portion of the allowable (Plan Paid) and the member portion of the allowable (Member Paid) for calendar years 2018 to 2020. The cost metrics for 2021 were not included since they only consist of the first quarter of 2021 and were inconsistent with other years. The cost metrics were calculated by LOB, opioid vs non-opioid users, geographies and the risk score deciles.

[9] OPIOID TREATMENT PROGRAMS (OTPs) MEDICARE BILLING AND PAYMENT FACT SHEET
https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

Utilization Metrics

We developed utilization metrics using the number of medical encounters (defined as each service by member per day) for EHB item #5 or by the number of Rx prescriptions per 1,000 members for EHBs items #1-4. The utilization metrics were also calculated by plan year, LOB, opioid vs non-opioid users, geographies and risk score deciles.

Consideration for COVID-19 Impacts

The utilization of medical services was significantly impacted by the COVID-19 pandemic starting in Q1 of 2020, which makes the comparison of various cost and utilization metrics difficult between pre and post COVID time periods.

As shown in Chart 5.1, the utilization of services and subsequently overall costs significantly decreased with the onset of the pandemic relative to historical patterns, impacting expected annual trend rates. This impact is largely limited to medical services. Prescription drug spending was less impacted by COVID-19 as shown in Chart 5.2. Outside of telepsychiatry services, the EHBs evaluated in our analyses are strictly related to prescription drug benefits. Since the impact of COVID-19 on prescription drug services is minimal, we have not made any adjustments to the 2020 medical or prescription drug metrics to normalize for COVID-19 impacts. The rate at which telemedicine services are utilized drastically increased. Many elective services traditionally performed in an office setting, such as routine office and mental health visits, moved to a virtual setting due to the pandemic. Chart 5.3 below illustrates the spike in telepsychiatry/telemedicine utilization beginning in Q1 of 2020. Further, Chart 5.4 shows that these services have become increasingly popular as an alternative to an office setting with the expectation that the levels of utilization for teleservices will not retreat to levels seen prior to the COVID-19 pandemic. As a result, annual comparison of 2020 results to 2018 and 2019 should be considered with the impact of COVID-19 in this report.

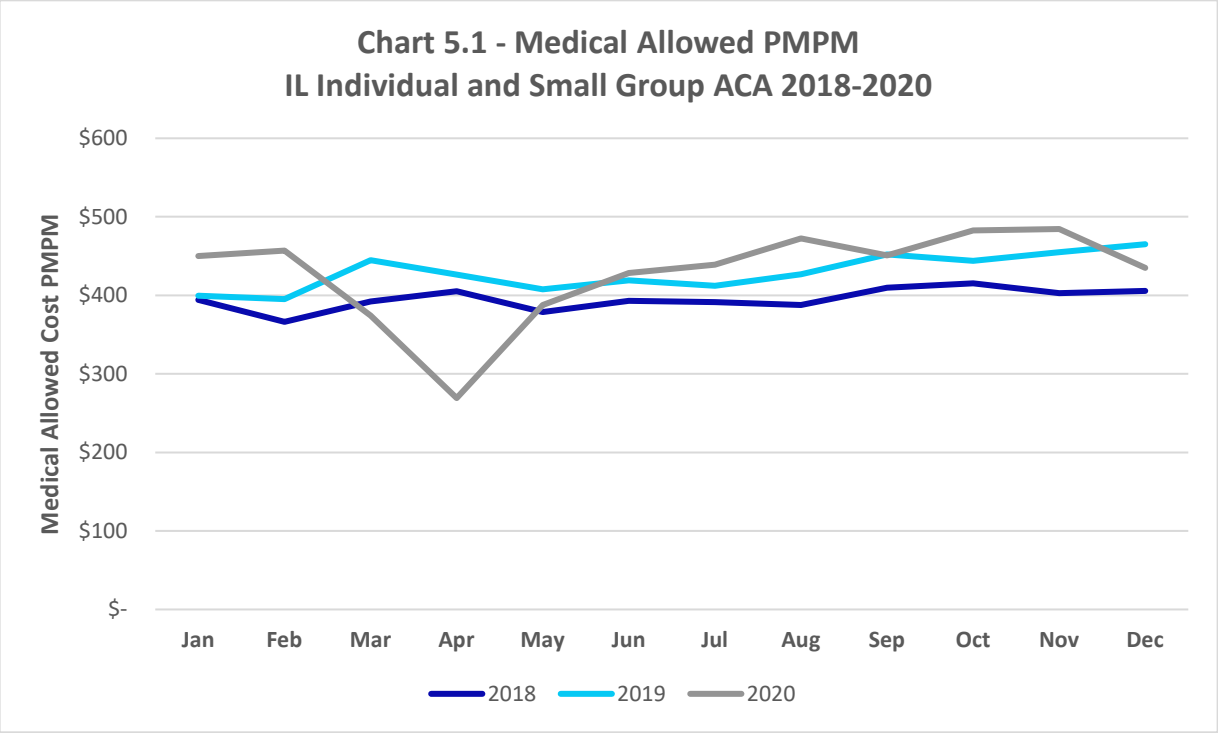


Chart 5.1 - Medical Allowed PMPM
IL Individual and Small Group ACA 2018-2020
Medical Allowed Cost PMPM
$600
$500
$400
$300
$200
$100
$-
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2018
2019
2020

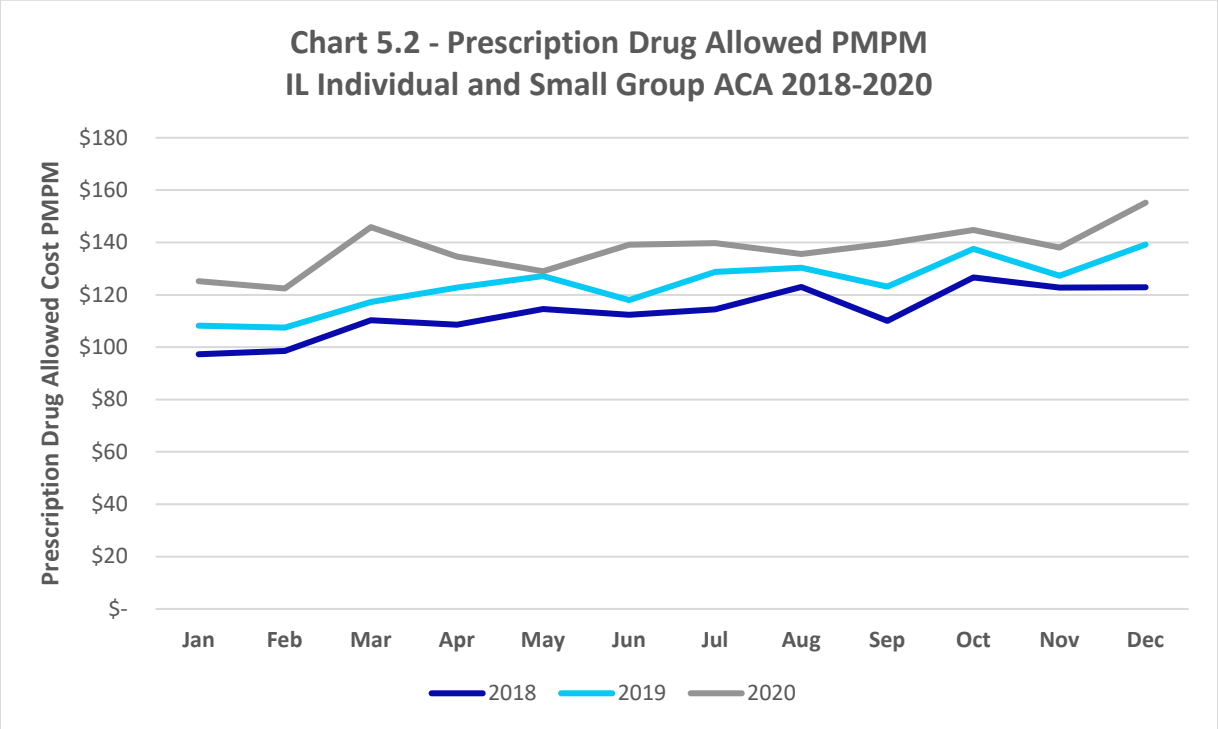
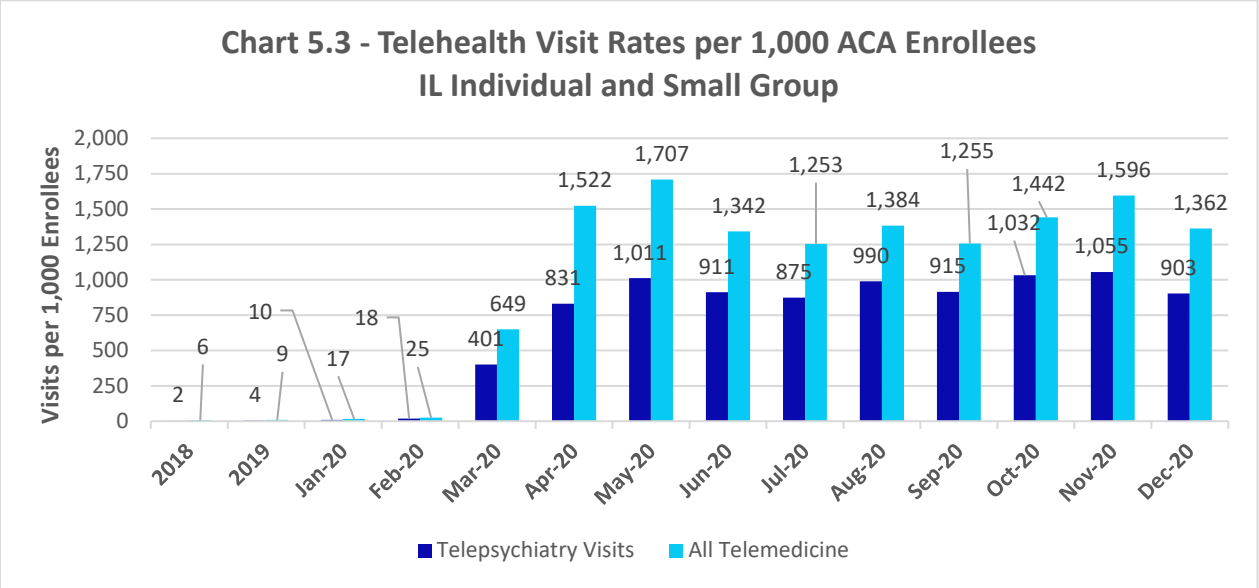
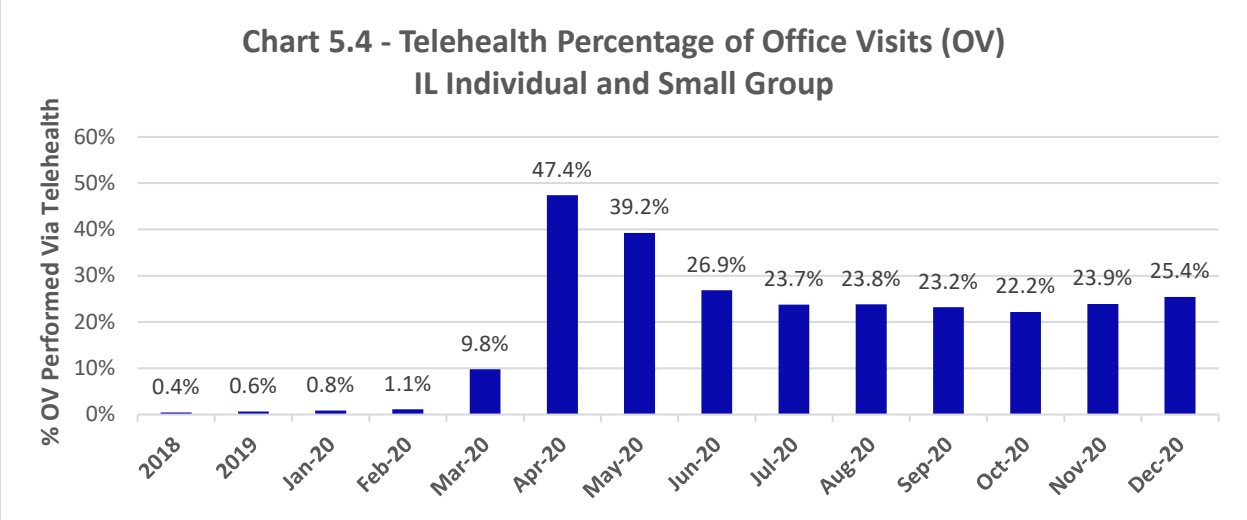


Chart 5.2 - Prescription Drug Allowed PMPM
IL Individual and Small Group ACA 2018-2020
Prescription Drug Allowed Cost PMPM
$180
$160
$140
$120
$100
$80
$60
$40
$20
$-
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
2018
2019
2020





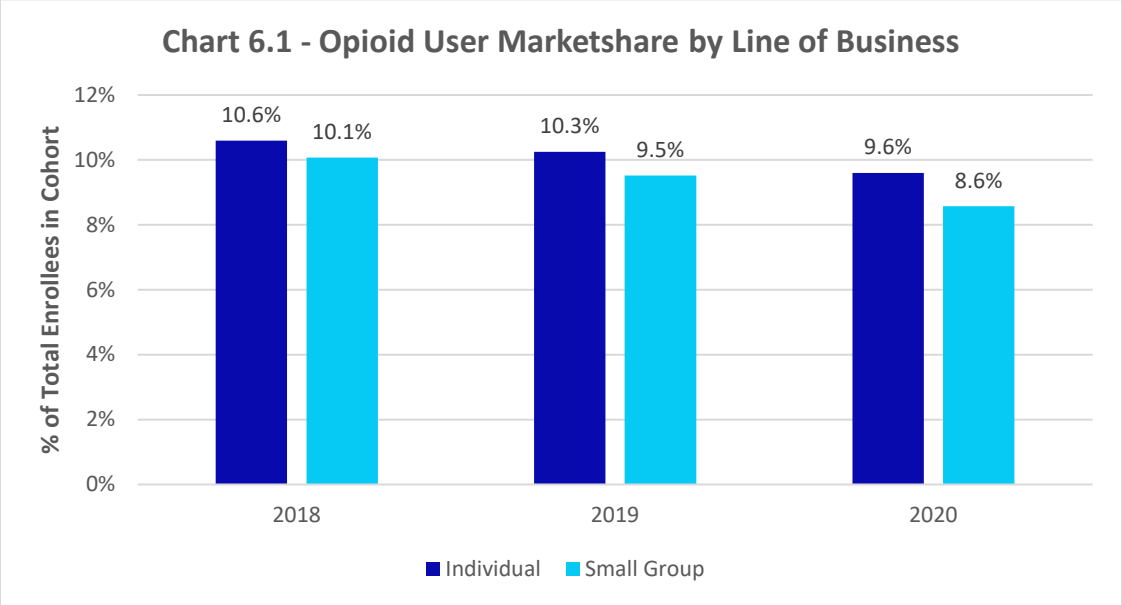
As mentioned above, of the five EHB changes that we evaluated, four are strictly related to prescription drug services. Since the effect of the pandemic on these services is minimal, we have not made any adjustments to account for COVID-19 impacts. Conversely, the drastic increase in the utilization of telepsychiatry services (and telemedicine services overall) in 2020 is likely exclusively linked to the onset of the pandemic.

6. RESULTS

In this section we summarize the results of the various analyses. We start with highlighting general information about the market share and demographic information of opioid users in the individual and small group ACA markets in IL. Secondly, we outline the significant differences in claims cost and utilization between opioid and non-opioid users. Lastly, we discuss the cost and utilization related the five EHB changes. Further detailed data and information is included in Appendix B and is referenced accordingly.

Opioid User Market Share

The number of enrollees utilizing prescription opioids has been declining by an average of about 0.5% per year since 2018 in both the individual and small group markets. Chart 6.1 shows the percent of total enrollees in each respective line of business that utilize prescription opioids from 2018 to 2020. The trend of lower opioid prescription users is in line with general national trend of decreasing number of commonly dispensed opioids[10] even as the number of prescriptions remain high.



Not only does the rate of prescription opioid use vary by line of business, but it also varies by different demographic splits. Below are key takeaways. See appendix B.1 for Charts B.1.1 to B.1.5.

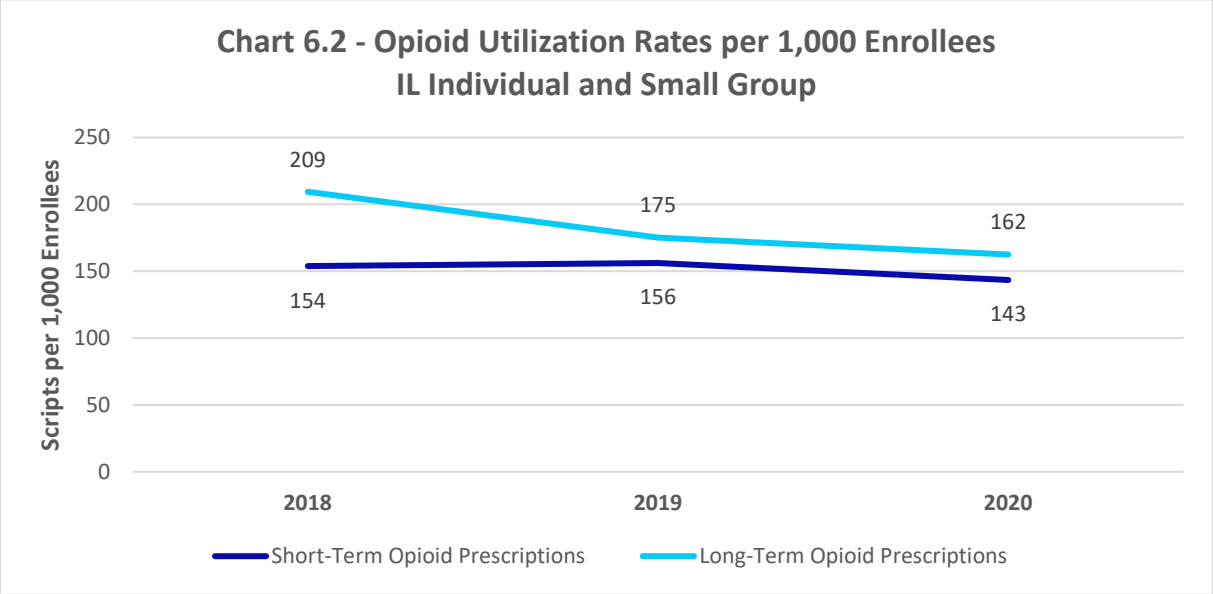
- Region: Chart B.1.1 illustrates that regions outside of the Chicagoland area have an approximate 2% higher rate of prescription opioid utilizing enrollees. The prevalence of opioids users is the highest in the regions outside of Chicagoland.
- Risk Score: As shown in Chart B.1.2, the rate of prescription opioid utilizing enrollees is significantly higher among higher risk individuals (80-100th percentile of risk scores), indicating a strong correlation between opioids users and high cost claimants which is further analysed in the following subsection.

[10] CDC U.S. Opioid Dispensing Rate Maps: https://www.cdc.gov/drugoverdose/rxrate-maps/index.html

- Condition Counts: Opioid utilizing enrollees represent roughly 15% of the total ACA population in Illinois with at least 3 medically diagnosed conditions.[11] This is 5-8% higher than the opioid enrollee market share among enrollees with 1 or 2 medically diagnosed conditions. See Chart B.1.3 for additional information.
- Metal Level: Charts B.1.4 and B.1.5 show that the rate of prescription opioid users is higher for richer benefit plans.
    - Within the individual market, the percentage of enrollees utilizing prescription opioids has been decreasing by about 1% for gold and silver plans. However, this percentage has remained relatively flat for bronze plans.
    - Within the small group market, the percentage of enrollees utilizing prescription opioids has been decreasing by 0.5%-1% across all metal levels from 2018 to 2020.

Opioid User Cost and Utilization Metrics

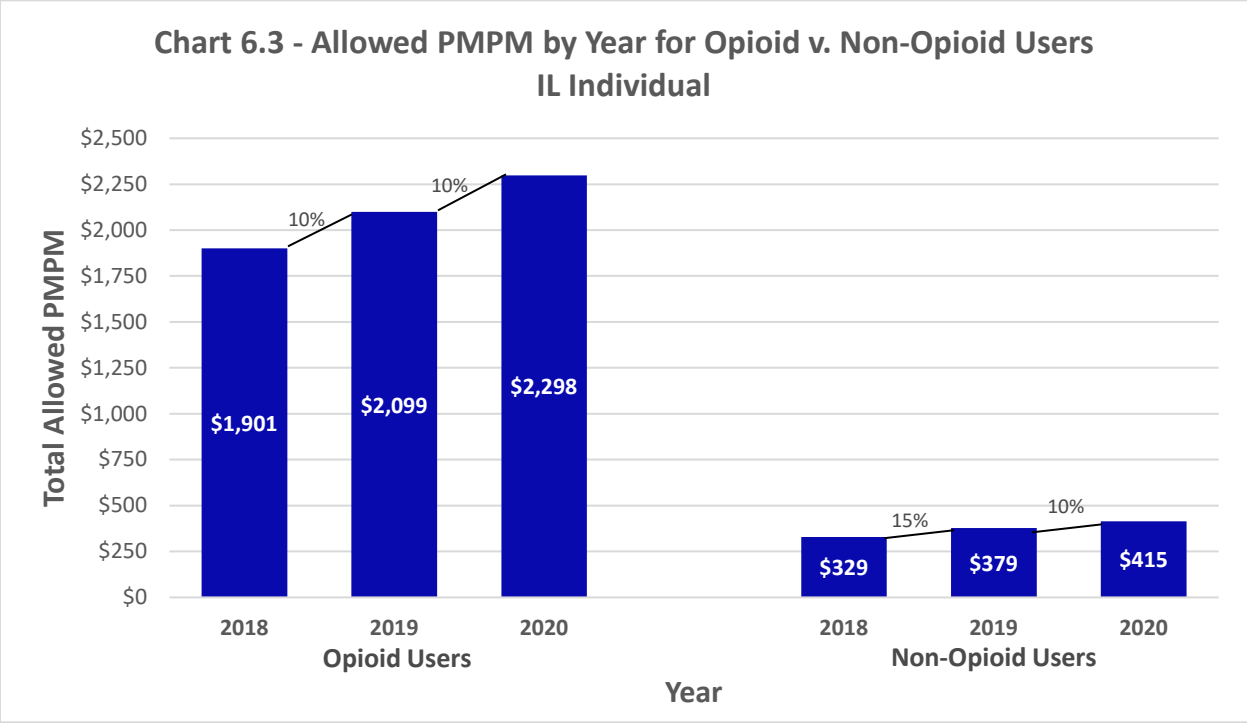
In addition to a diminishing percentage of prescription opioid utilizing enrollees year over year, the overall prescription opioid utilization has also been declining since 2018, as shown in Chart 6.2.



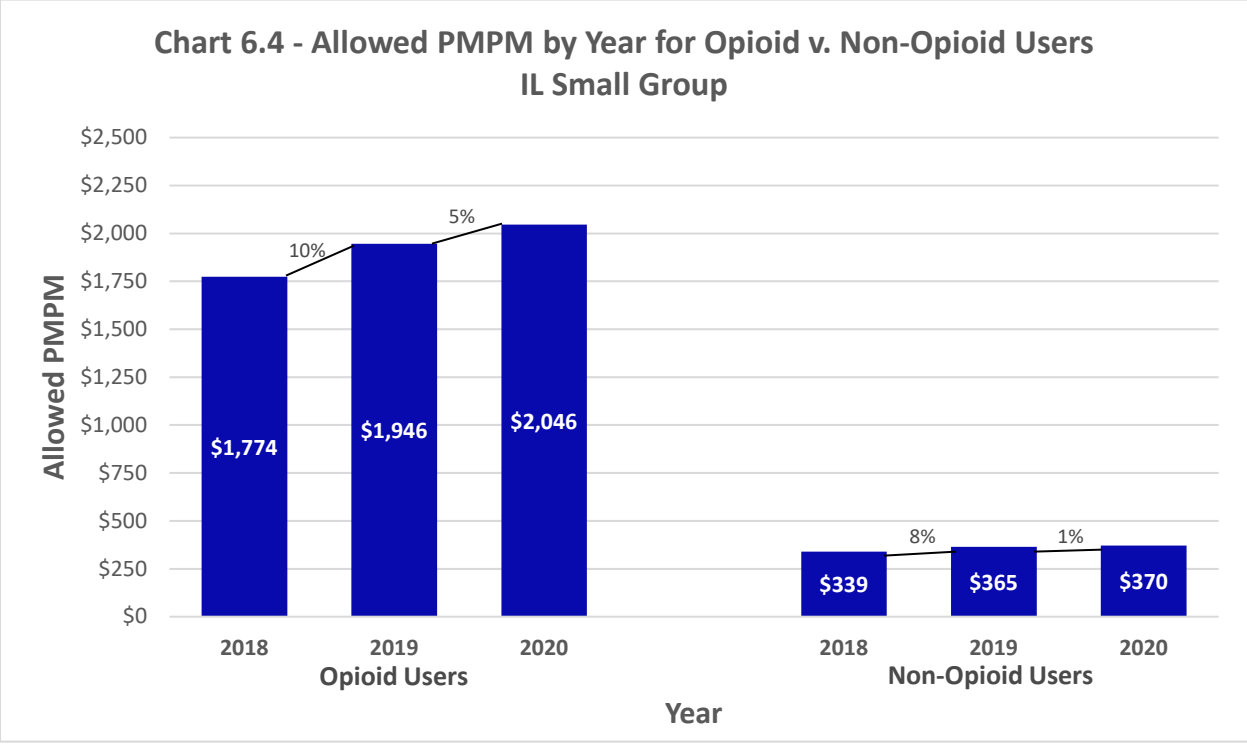
Note: 2020 metrics as reported without adjustment for COVID-19 impacts

While the overall utilization of prescriptions opioids has been steadily declining in both ACA markets, there continues to be a significant gap in cost and the utilization of services between opioid users and non-opioid users. Chart 6.3 and 6.4 below provides insight into total allowable costs for these two populations for the individual and small group populations respectively. Please note that the 2020 utilization and cost metrics have not been adjusted for COVID-19 impacts.

[11] Based on the AHRQ CCS diagnosis grouper: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/dxccsr.jsp



Note: 2020 metrics as reported without adjustment for COVID-19 impacts.



Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Some of the main drivers behind these large allowable PMPM differences are inpatient admissions, outpatient surgery and emergency room services. Charts B.2.1 and B.2.2 and tables B.2.1 and B.2.2 in

appendix B.2 show that opioid users are responsible for three to four times more inpatient admissions, outpatient surgeries and emergency room encounters compared to non-opioid ACA enrollees.

Although there are significant differences in total allowable cost and overall utilization between the opioid utilizing and non-opioid utilizing cohorts, the distribution of major services relative to total utilization are largely consistent across the two populations. Opioid users utilize prescription drug services slightly more than non-opioid users and professional services slightly less.

EHB Change Cost/Utilization Analysis

We analyzed the longitudinal impact of costs and utilization related to the five EHB changes discussed in Section 2 using the ACA enrollment in IL, while breaking out the subset of membership utilizing prescription opioids. Tables 6.1 and 6.2 display per member per month costs (total allowable and member liability, respectively) for each of the EHB changes. Although these changes officially went into effect in 2020, interviews conducted by NovaRest (and summarised in Section 3 above) indicated that all entities contained within this study had all changes implemented prior to January 1, 2020.

Table 6.1 – Total Allowable Cost Per Member Per Month (PMPM) – All ACA Enrollees

Year	#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray	#2 Removal of Barriers to Buprenorphine Products	#3 Limit of Opioid Prescriptions of Acute Pain	#4 Alternative Therapies for Pain	#5 Coverage of Telepsychiatry Care
2018	$0.00	$0.02	$0.06	$0.03	$0.02
2019	$0.01	$0.03	$0.06	$0.05	$0.05
2020	$0.01	$0.04	$0.05	$0.04	$9.65

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table 6.2 – Total Member Liability Per Member Per Month (PMPM) – All ACA Enrollees

Year	#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray	#2 Removal of Barriers to Buprenorphine Products	#3 Limit of Opioid Prescriptions of Acute Pain	#4 Alternative Therapies for Pain	#5 Coverage of Telepsychiatry Care
2018	$0.00	$0.01	$0.03	$0.01	$0.01
2019	$0.00	$0.01	$0.02	$0.01	$0.01
2020	$0.00	$0.01	$0.02	$0.01	$0.07

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Aside from telepsychiatric care, which drastically increased in allowable costs due primarily to the COVID-19 pandemic, the combined cost impact of the services related to the 2020 benefit changes is minimal across all ACA enrollees in Illinois. For telepsychiatric care, although there has been a drastic

increase in the total allowable cost for these services, the out of pocket impact on enrollees is minimal as shown on Table 6.2.

More discernible cost and utilization patterns begin to emerge across various demographic splits when analysing the subset of ACA enrollment utilizing prescription opioids.

Line of Business

Tables B.3.1- B.3.3 in appendix B.3 illustrate that opioid utilizing enrollees' total allowable costs for services related to the EHB changes have been increasing year over year in both the individual and small group markets. At the same time, the member liability associated with these services has either declined or remained relatively flat, while the rate of utilization of services has consistently increased (see Charts B.3.1 and B.3.2 in appendix B.3). Overall, opioid utilizing ACA enrollees are utilizing the services associated with the expanded EHBs at limited additional out of pocket costs.

Geographic Region

There are also distinct cost differences for services related to the EHB changes in Illinois. Total allowable costs for short term opioid prescriptions, alternative therapies for pain, and Buprenorphine products in the MAT setting are higher outside of Cook County and the broader Chicagoland area for prescription opioid utilizing enrollees. Conversely, allowable costs associated with telepsychiatry services for these enrollees, specifically in 2020, are significantly higher in Cook county relative to other parts of the state. This is likely due to network contracting and unit cost differences. While there are distinct overall cost patterns across various geographic regions, member liability for opioid utilizing enrollees does not significantly vary from region to region. See tables B.3.4-B.3.6 in appendix B.3 for additional information.

Utilization of services related to the five EHB changes has been consistently increasing among opioid users in Illinois, with utilization rates for short-term prescription opioids and telepsychiatry services the largest in areas outside of Chicago and its surrounding suburbs. See table B.3.7 in appendix b.3 for additional information.

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8. ACKNOWLEDGEMENT OF QUALIFICATIONS

The authors of this report, Beth Fritchen, Gabriel Rivera and Peter Kaczmarek are members of the American Academy of Actuaries and meet that body's Qualifications Standards to perform this work and render the opinions expressed in this report.

APPENDIX A. DATA REQUEST FIELDS

A.1. Medical Claim Extract Fields

Variable Name	Description	Detailed Definition	Format	Example
CLM_NBR	Claim number	Unique claim identifier	Plan-dependent	
CLM_LN_NBR	Claim line number	Claim-unique line number	Non-zero Integer	14
MBR_ID	Member Identifier	Please ensure member identifier aligns with what would be shown for the member in the membership extract. Ideally this would be a member identifier that could track the same member across plans	Plan-dependent	
CLM_SRV_DT	Claim date of service	Service date of the service rendered for a specific claim line	Date	1/15/2019
CLM_BEG_SRV_DT	Claim beginning date	Service date of the first service rendered across all claim lines associated with claim number	Date	1/15/2019
CLM_END_SRV_DT	Claim end date	Service date of the last service rendered across all claim lines associated with claim number	Date	1/15/2019
ADMIT_DT	Admit date	For Inpatient Claims, the date of the member's admission to the hospital	Date	1/15/2019
DISCH_DT	Discharge date	For Inpatient Claims, the date of the member's discharge from the hospital	Date	1/15/2019
PAID_DT	Paid date	Date of plan payment to provider	Date	1/15/2019
PROV_SPEC	Provider specialty	Code designating the specialty of the provider that rendered the service (for instance, 01 - General Practice or 37 - Pediatric medicine)	Alphanumeric code	01
CLAIM_PROV_ID	Claim Provider ID	Unique provider identifier, for provider who rendered the service	Plan-dependent	

PROV_ZIP	Servicing Provider Zip Code	Zip code for provider who rendered the service	String, 5 digits	78727
PROV_NAME	Servicing Provider Name	Name of provider who rendered the service	String, Variable length	
Servicing NPI	National Provider Identifier, servicing provider	National provider identifier, for provider who rendered the service	10 position numeric code	1234567892
Billing NPI	National Provider Identifier, billing provider	National provider identifier, for provider who submitted the request for payment	10 position numeric code	1234567892
CAP_CLM_IND	Capitated claim indicator	Indicates whether claim represents services covered under capitation arrangement with providers	String, 1 character	Y/N
IN_IND	In-network/out-of-network indicator	Indicates whether claim was in or out of network (In network= Y)	String, 1 character	Y/N
ADMIT_IND	Inpatient admission indicator	Indicates whether claim was associated with an Inpatient admission	String, 1 character	Y/N
DRG	DRG	Diagnosis Related Group	1-3-digit numeric code	796
ICD_VERS	ICD version	Indicates whether ICD Diagnosis codes provided follow the ICD 10 format or ICD 9	2-digit numeric code	09/10
DIAG_CD_1	Diagnosis code 1	First ICD Diagnosis Code on claim	7-character string	
DIAG_CD_2	Diagnosis code 2	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_3	Diagnosis code 3	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_4	Diagnosis code 4	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_5	Diagnosis code 5	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_6	Diagnosis code 6	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_7	Diagnosis code 7	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_8	Diagnosis code 8	Additional ICD Diagnosis detail, 2-20	7-character string	

DIAG_CD_9	Diagnosis code 9	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_10	Diagnosis code 10	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_11	Diagnosis code 11	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_12	Diagnosis code 12	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_13	Diagnosis code 13	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_14	Diagnosis code 14	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_15	Diagnosis code 15	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_16	Diagnosis code 16	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_17	Diagnosis code 17	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_18	Diagnosis code 18	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_19	Diagnosis code 19	Additional ICD Diagnosis detail, 2-20	7-character string	
DIAG_CD_20	Diagnosis code 20	Additional ICD Diagnosis detail, 2-20	7-character string	
BILL_CD	Bill code	Code describing the type of facility, type of care, and sequence of this bill in this episode of care	4-digit alphanumeric code	
REV_CD	Revenue code	Describes location of treatment or type of item received.	3-digit numeric code	450
PROC_CD	CPT/HCHPS code	Current Procedural Terminology code attached to the claim line	5-digit alphanumeric code	99727
PROC_MOD_CD1	Modifier code 1	First modifier code assigned to the claim line	2-digit alphanumeric code	GT
PROC_MOD_CD2	Modifier code 2	Second modifier code assigned to the claim line	2-digit alphanumeric code	91
PLC_OF_SRV_CD	Place of service code	CMS code specifying the location where service(s) were rendered	2-digit numeric code	01
TYP_OF_SRV_CD	Type of service code	Code specifying the type of service rendered	2-character code	IP/OP/PR

UNITS	Service units	Number of units provided	Integer	
ADMIT_CNT	Admission count	Count of admissions associated with the claim	Integer	
ALLWD_AMT	Allowed amount	Amount paid to the provider, including plan paid, member cost share, and other payer paid amount, for all services covered under the plan	Decimal	
MBR_LIAB_AMT	Member cost-sharing amount	Amount paid to the provider by the member	Decimal	
PAID_AMT	Paid amount	Amount paid to the provider by the plan	Decimal	
OTHER_PAYER_PAID	Other payer paid amount	Amount paid to the provider by other plans or Medicare under secondary coverage	Decimal	

A.2. Pharmacy Claim Extract Fields

Variable Name	**Description**	**Detailed Definition**	**Format**	**Example**
CLM_NBR	Claim number	Unique claim identifier	Plan-dependent	
MBR_ID	Member Identifier	Please ensure member identifier aligns with what would be shown for the member in the membership extract. Ideally this would be a member identifier that could track the same member across plans	Plan-dependent	
FILL_DT	Date script was filled	Date script was filled	Date	
PAID_DT	Date claim was paid	Date claim was paid	Date	
NDC	NDC	National Drug Code, a universal product identifier provided for all RX claims	10-digit or 11-digit, 3-segment number	
STANDARD_TIER	Tier indicator	Indicates drug tier - Generic, Brand, Non-Preferred Brand, and Specialty	G, B, NPB, S	

DAYS_SUPPLY	Days supply	Number of days for which drug was prescribed to be used	Integer	
MET_QNTY	Units	Number of units dispensed - i.e., number of pills in the bottle	Integer	
FORM_IND	Formulary indicator	Indicates what formulary the drug is under in the plan	Plan-dependent	
BRAND_IND	Brand indicator	Indicates whether the script is for a drug that is brand name or generic	Y = brand, N = generic	
MAIL_IND	Mail order indicator	Indicates whether the script is for a mail-order claim	Y = mail-order, N = not mail-order	
ALLWD_AMT	Allowed amount	Amount paid to the provider, including plan paid, member cost share, and other payer paid amount, for all services covered under the plan	Decimal	
MBR_LIAB_AMT	Member cost-sharing amount	Amount paid to the provider by the member	Decimal	
PAID_AMT	Paid amount	Amount paid to the provider by the plan	Decimal	

A.3. Membership Extract Fields

Variable Name	Description	Detailed Definition	Format	Example
MBR_ID	Member Identifier	Please ensure member identifier aligns with what would be shown for the member in the claims extract. Ideally this would be a member identifier that could track the same member across plans	Plan dependent	
SUB_ID	Subscriber ID	Unique policyholder identifier. Should be the same for all members receiving coverage under the same policy	Plan dependent	
GROUP_ID	Group Identifier	Policy or employer health plan identification. For individual ACA coverage, GROUP_ID = SUB_ID	Plan dependent	

MBR_EFF_DT	Member Effective Date	Date member entered the policy	Date	
MBR_TRM_DT	Member Termination Date	Date member terminated the policy	Date	
ACTMO	Activity Month	Month of member activity on the plan	Date - please use XX/01/XXXX format for all activity months	
RENMO	Renewal Date			
RELATIONSHIP	Relationship to Subscriber	Please indicate if member is Subscriber/Spouse/Dependent	I = subscriber, S = spouse, D = Dependent	
DOB	Date of Birth	Member date of birth	Date	
GENDER	Gender	Member gender	M/F	
LOB	Line of Business	Small Group/Individual	SG/IND	
INDUSTRY	Industry	For small group - indicate the industry of the member's account	Plan dependent - please include mapping if code is used	
ZIP_CODE	Zip code	Member zip code	5-digit numeric code	
RATING_STATE	Rating State	ACA Rating State	2-character string	IL
RATING_COUNTY	Rating County	ACA Rating County	Variable length character field	Nassau
RATING_REGION	Rating Region	ACA Rating Region	Numeric code	
PROD_TYPE	Product Type	Indicate product type	HMO/PPO/POS	
HIOS_PLAN_ID	HIOS Plan ID (ACA compliant plans only)	Health Insurance Oversight System number that uniquely identifies each new qualified health plan approved by CMS	14-digit alphanumeric code	
PLAN_NAME	Plan Name	Name of medical plan member is enrolled in	Plan dependent	
RX_PLAN_NAME	Drug Plan Name	Name of RX plan member is enrolled in.	Plan dependent	
METAL_LEVEL	Metal Level	ACA Metal Level of plan member is enrolled in - Bronze, Silver, Gold, Platinum	B, S, G, P	
CSR_VAR	CSR Variant	Indicator for ACA Silver Metal Cost Sharing Reduction Plans (73%, 87%, 94%)		
MARKETPLACE_IND	Marketplace Indicator (ACA	Indicator whether the ACA plan was purchased on-exchange (Get Covered Illinois	String, 1 character	Y/N

	compliant plans only)	for individual coverage or SHOP for small group) or off-exchange. For transitional plans set to N.		
SEP_IND	Special Enrollment Period Indicator (ACA compliant plans only)	Indicator whether the ACA coverage was purchased during special enrollment period. Set to N if coverage was selected during regular open enrollment period.	String, 1 character	Y/N
ACA_IND	ACA Indicator	Indicates if member plan is ACA compliant (Y = ACA compliant, N = Not ACA compliant)	String, 1 character	Y/N
GF_IND	Grandfathered Indicator	Indicates if member plan is Grandfathered (should always be N for this request)	String, 1 character	N
TOBACCO_USER_IND	Tobacco User Indicator	Indicates if member is a tobacco user (Y = tobacco user)	String, 1 character	Y/N
MED_IND	Medical Coverage Indicator	Indicates if member is covered under the medical plan (Y = covered under medical plan)	String, 1 character	Y/N
PHARM_IND	Pharmacy Coverage Indicator	Indicates if member is covered under the pharmacy plan (Y = covered under pharmacy plan)	String, 1 character	Y/N
HHS_Risk_score	HHS risk score	ACA risk score for the member used for risk transfer program	Decimal	1.3
Telehealth_indicator	Telehealth Indicator	Indicate whether Telehealth is administered by a third party (Y if administered by third party)	String, 1 character	Y/N
Medical_Claims	Medical Claims Indicator	Indicate whether member has medical claims included in extract for activity month	String, 1 character	Y/N
Pharmacy_Claims	Pharmacy Claims Indicator	Indicate whether member has pharmacy claims included in extract for activity month	String, 1 character	Y/N

A.4. Data Control Fields

Table Name	Variable
Medical Claims	RowCount
	Paid
	Allowed
	MemberLiability
Pharmacy Claims	RowCount
	Paid
	Allowed
	MemberLiability
Membership	RowCount

A.5. Clinical Classification Software ICD10-CM Pain Groupings

CCS Code	CCS Code Description
MUS010	Musculoskeletal pain, not low back pain
MUS038	Low back pain
NVS019	Nervous system pain and pain syndromes
SYM006	Abdominal pain and other digestive/abdomen signs and symptoms

A.6. Telepsychiatry Procedure Codes

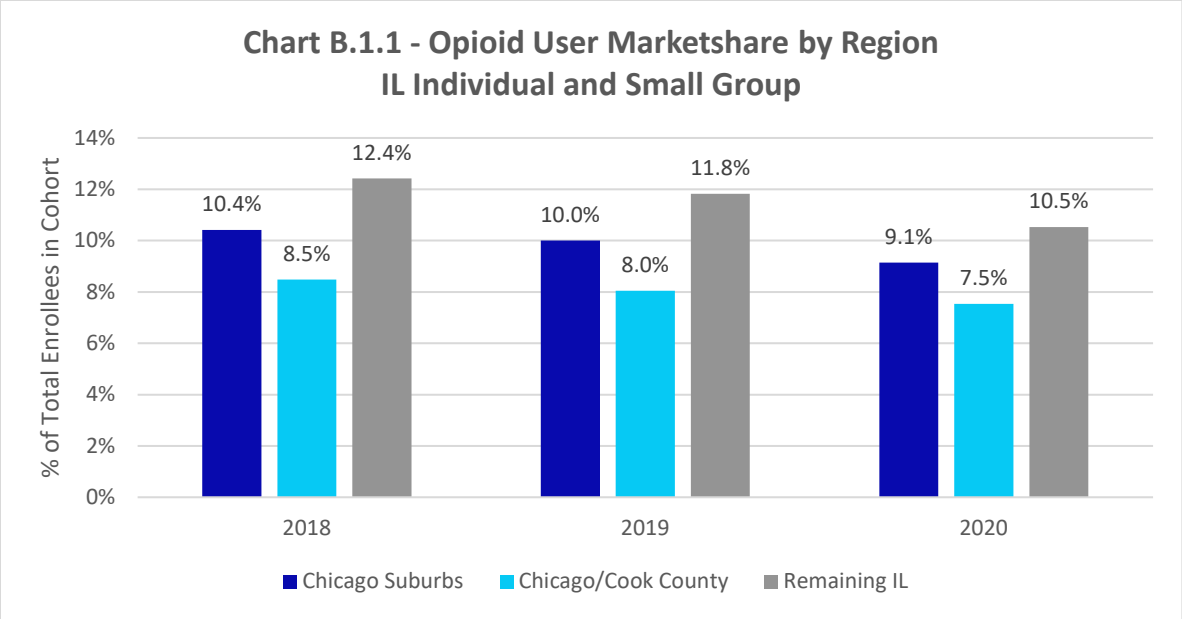
Procedure Codes			
90785	96132	97152	99212*
90791	96133	0362T	99213*
90792	96136	97153	99214*
90832	96137	97154	99215*
90833	96138	97155	99231*
90834	96139	97156	99232*
90836	96156	97158	99233*
90837	96158	0373T	99354*
90838	96159	90875	99355*
90839	96164	96170	99356*
90840	96165	96171	99357*
90845	96167	90849	
90846	96178	90863	

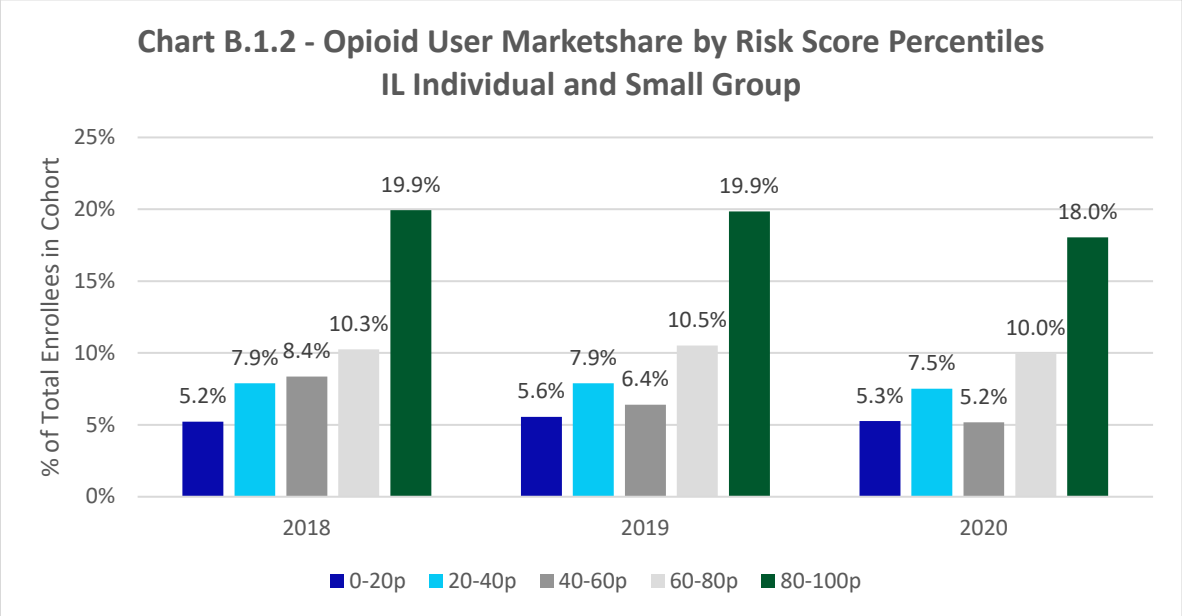
90847	96127	96146	
96116	G0396	99201*	
90853	G0397	99202*	
80940	96110	99203*	
96121	96112	99204*	
96130	96113	99205*	
96131	97151	99211*	

*General Evaluation and Management codes; included only if associated with a psychiatric speciality

APPENDIX B. RESULT EXHIBITS

B.1. Opioid User Market Share Charts





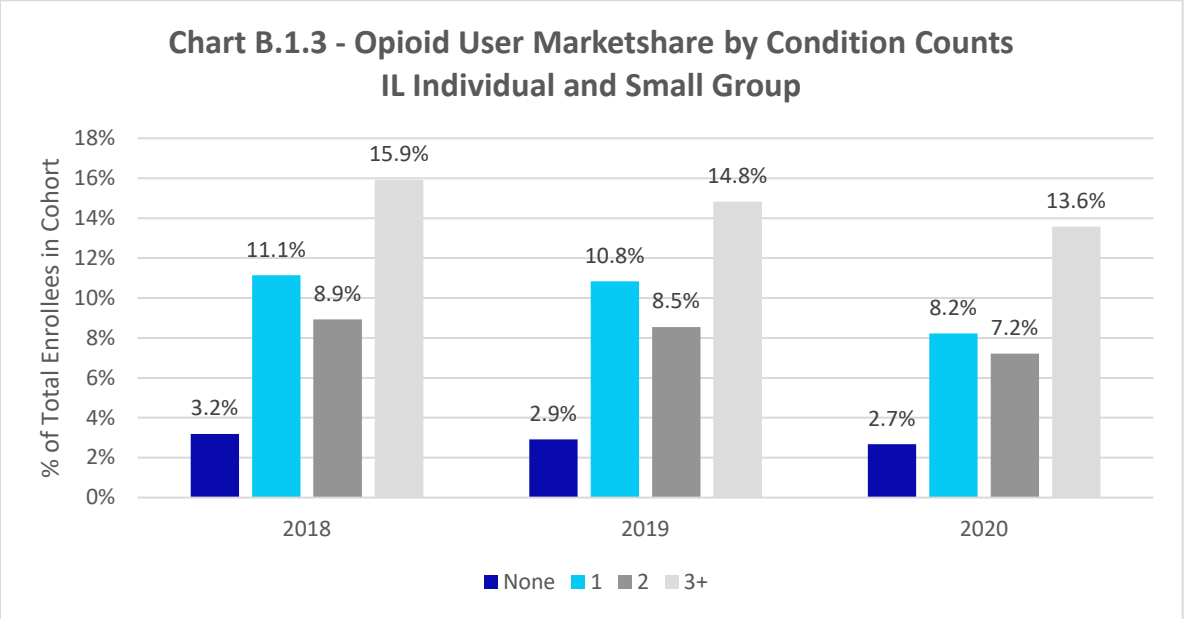


Chart B.1.3 - Opioid User Marketshare by Condition Counts
IL Individual and Small Group
% of Total Enrollees in Cohort
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
3.2%
11.1%
8.9%
15.9%
2.9%
10.8%
8.5%
14.8%
2.7%
8.2%
7.2%
13.6%
2018
2019
2020
None
1
2
3+

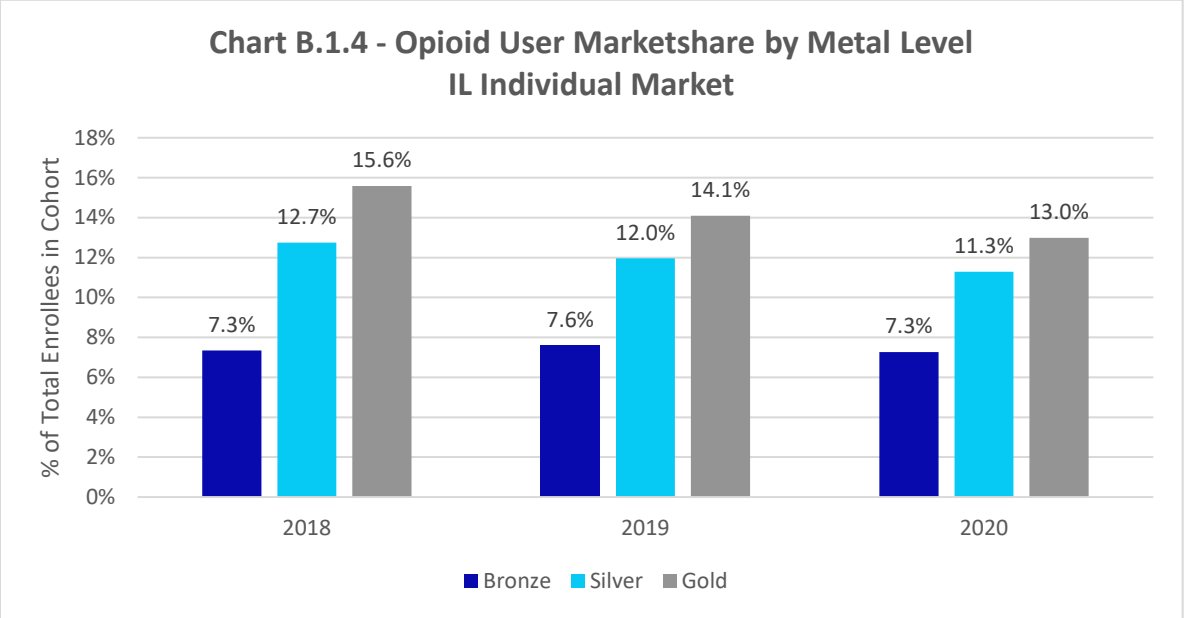


Chart B.1.4 - Opioid User Marketshare by Metal Level
IL Individual Market
% of Total Enrollees in Cohort
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
7.3%
12.7%
15.6%
7.6%
12.0%
14.1%
7.3%
11.3%
13.0%
2018
2019
2020
Bronze
Silver
Gold

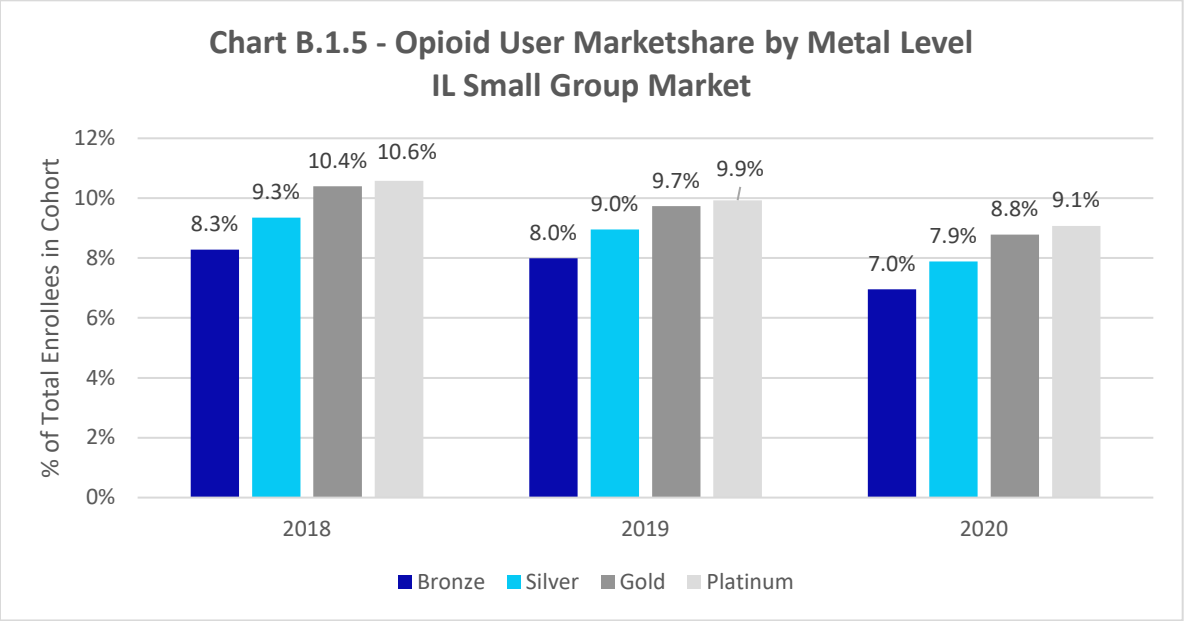
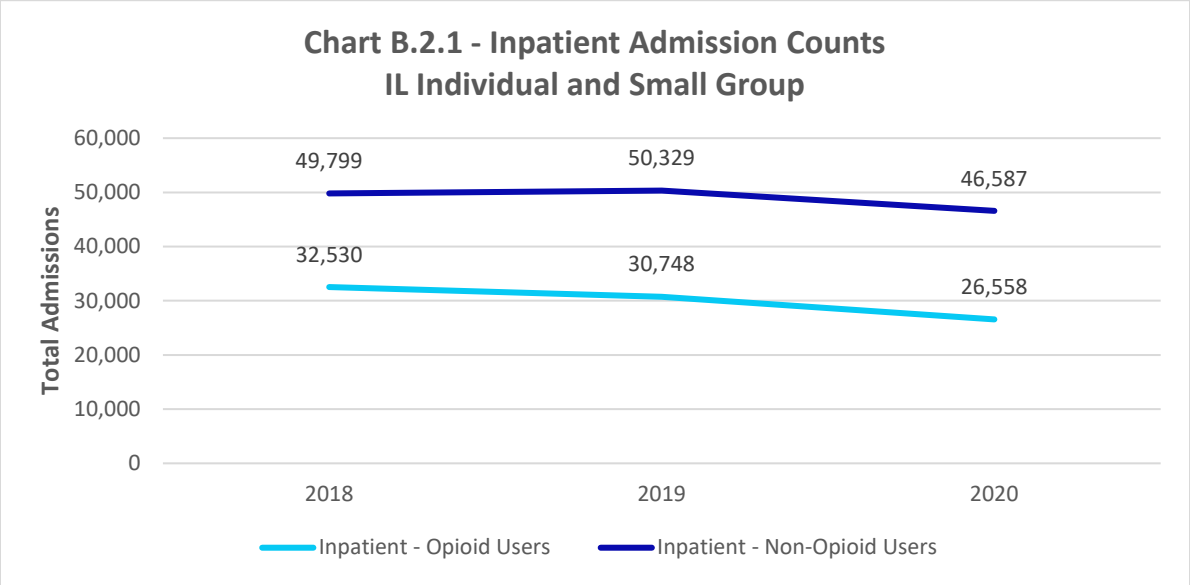
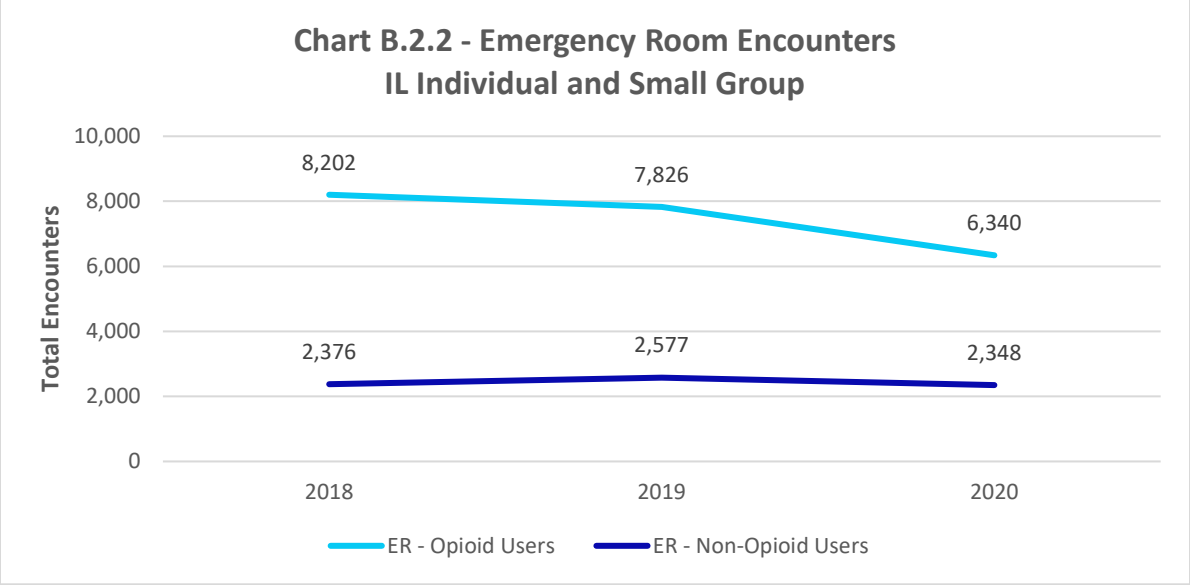


Chart B.1.5 - Opioid User Marketshare by Metal Level
IL Small Group Market
% of Total Enrollees in Cohort
12%
10%
8%
6%
4%
2%
0%
8.3%
9.3%
10.4%
10.6%
8.0%
9.0%
9.7%
9.9%
7.0%
7.9%
8.8%
9.1%
2018
2019
2020
Bronze
Silver
Gold
Platinum

B.2. Additional Opioid User Cost/Utilization Metrics



Note: 2020 metrics as reported without adjustment for COVID-19 impacts



Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.2.1 - Utilization Hot Spots for Opioid Users - Individual Market			
	2018	**2019**	**2020**
	Opioid Users		
IP Total Admits per 1,000	441	443	425
OP Surgery Services per 1,000	1,299	1,381	1,438
Emergency Room Encounters per 1,000	622	632	594
	Non-Opioid Users		
IP Total Admits per 1,000	101	106	97
OP Surgery Services per 1,000	224	255	285
Emergency Room Encounters per 1,000	123	129	117
	Percent Difference		
IP Total Admits per 1,000	337%	318%	341%
OP Surgery Services per 1,000	479%	442%	405%
Emergency Room Encounters per 1,000	405%	392%	407%

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.2.2 - Utilization Hot Spots for Opioid Users - Small Group Market			
	2018	**2019**	**2020**
	Opioid Users		
IP Total Admits per 1,000	344	352	345
OP Surgery Services per 1,000	1,345	1,419	1,465
Emergency Room Encounters per 1,000	598	608	545
	Non-Opioid Users		
IP Total Admits per 1,000	57	58	57
OP Surgery Services per 1,000	279	314	330
Emergency Room Encounters per 1,000	145	146	121
	Percent Difference		
IP Total Admits per 1,000	502%	502%	506%
OP Surgery Services per 1,000	382%	352%	344%
Emergency Room Encounters per 1,000	312%	318%	350%

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

B.3. Key EHB Cost/Utilization Metrics

Table B.3.1 – Total Allowable Cost Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Line of Business	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Individual	2018	$0.04	$0.08	$0.47	$0.13	$0.05
Individual	2019	$0.07	$0.20	$0.52	$0.25	$0.10
Individual	2020	$0.10	$0.21	$0.41	$0.36	$10.99
Small Group	2018	$0.03	$0.08	$0.56	$0.10	$0.04
Small Group	2019	$0.05	$0.07	$0.63	$0.15	$0.07
Small Group	2020	$0.07	$0.12	$0.63	$0.14	$14.07

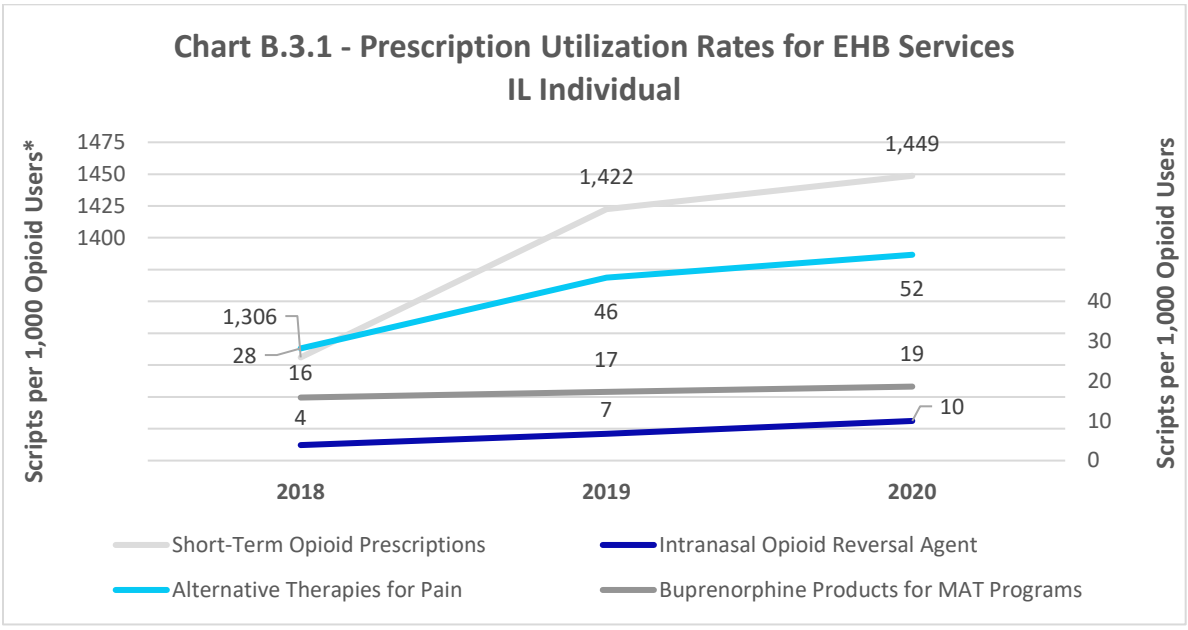
Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.2 – Total Plan Liability Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Line of Business	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Individual	2018	$0.03	$0.06	$0.21	$0.10	$0.03
Individual	2019	$0.05	$0.18	$0.33	$0.18	$0.06
Individual	2020	$0.07	$0.18	$0.25	$0.27	$10.45
Small Group	2018	$0.03	$0.07	$0.30	$0.08	$0.03
Small Group	2019	$0.04	$0.06	$0.43	$0.12	$0.06
Small Group	2020	$0.06	$0.11	$0.46	$0.11	$13.65

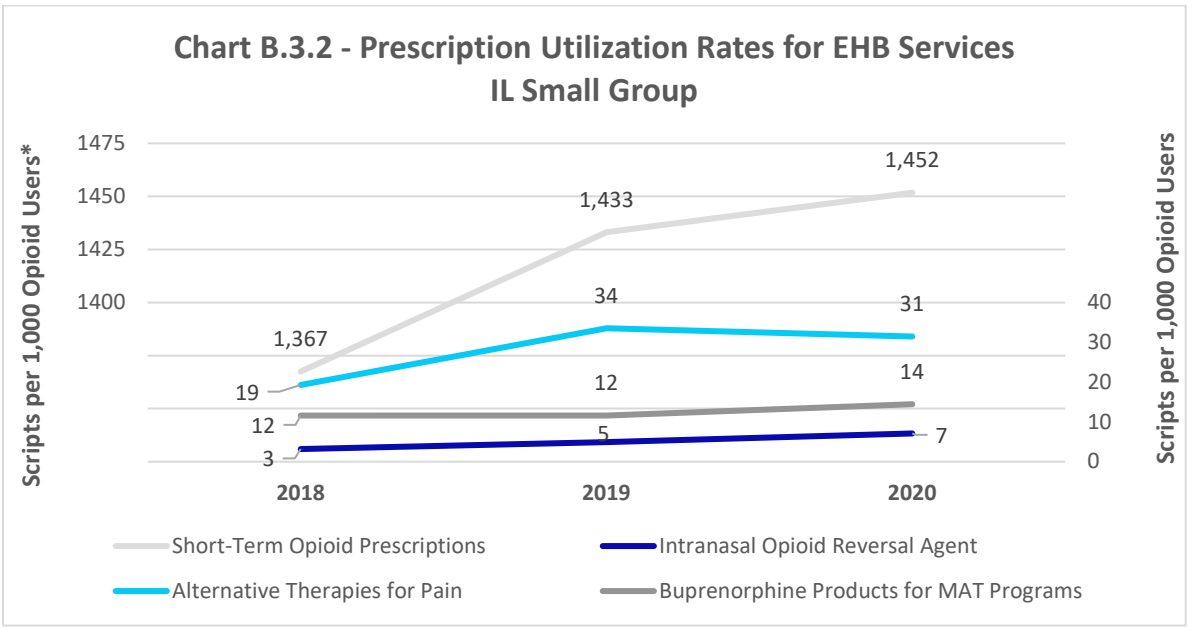
Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.3– Total Member Liability Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Line of Business	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Individual	2018	$0.01	$0.02	$0.24	$0.02	$0.01
Individual	2019	$0.01	$0.02	$0.19	$0.06	$0.03
Individual	2020	$0.02	$0.03	$0.16	$0.07	$0.05
Small Group	2018	$0.01	$0.02	$0.26	$0.02	$0.01
Small Group	2019	$0.01	$0.01	$0.20	$0.03	$0.01
Small Group	2020	$0.02	$0.01	$0.18	$0.03	$0.09

Note: 2020 metrics as reported without adjustment for COVID-19 impacts



*Left-side axis for Short-Term Opioid Prescriptions only. 2020 metrics as reported without adjustment for COVID-19 impacts



*Left-side axis for Short-Term Opioid Prescriptions only. 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.4 – Total Allowable Cost Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Geographic Region	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Chicago/Cook County	2018	$0.03	$0.10	$0.45	$0.11	$0.06
Chicago/Cook County	2019	$0.06	$0.11	$0.59	$0.21	$0.05
Chicago/Cook County	2020	$0.07	$0.16	$0.50	$0.18	$21.31
Other Chicago Suburbs	2018	$0.04	$0.05	$0.53	$0.08	$0.01
Other Chicago Suburbs	2019	$0.07	$0.11	$0.56	$0.13	$0.08
Other Chicago Suburbs	2020	$0.09	$0.12	$0.52	$0.14	$12.99
Remaining IL	2018	$0.04	$0.10	$0.55	$0.15	$0.06
Remaining IL	2019	$0.06	$0.15	$0.59	$0.25	$0.12
Remaining IL	2020	$0.09	$0.21	$0.58	$0.38	$5.24

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.5 – Total Plan Liability Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Geographic Region	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Chicago/Cook County	2018	$0.03	$0.07	$0.21	$0.09	$0.05
Chicago/Cook County	2019	$0.04	$0.10	$0.38	$0.16	$0.03
Chicago/Cook County	2020	$0.05	$0.14	$0.38	$0.13	$20.53
Other Chicago Suburbs	2018	$0.03	$0.04	$0.29	$0.06	$0.00
Other Chicago Suburbs	2019	$0.05	$0.09	$0.39	$0.10	$0.05
Other Chicago Suburbs	2020	$0.06	$0.09	$0.36	$0.10	$12.58
Remaining IL	2018	$0.03	$0.08	$0.27	$0.12	$0.04
Remaining IL	2019	$0.04	$0.14	$0.39	$0.19	$0.09
Remaining IL	2020	$0.07	$0.20	$0.37	$0.30	$4.96

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.6 – Total Member Liability Per Member Per Month (PMPM) – Opioid Utilizing Enrollees						
Geographic Region	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Chicago/Cook County	2018	$0.01	$0.02	$0.22	$0.02	$0.01
Chicago/Cook County	2019	$0.01	$0.01	$0.20	$0.04	$0.01
Chicago/Cook County	2020	$0.02	$0.01	$0.12	$0.04	$0.10
Other Chicago Suburbs	2018	$0.01	$0.01	$0.21	$0.02	$0.00
Other Chicago Suburbs	2019	$0.01	$0.02	$0.16	$0.03	$0.02
Other Chicago Suburbs	2020	$0.02	$0.03	$0.15	$0.03	$0.06
Remaining IL	2018	$0.01	$0.02	$0.32	$0.03	$0.01
Remaining IL	2019	$0.01	$0.01	$0.22	$0.06	$0.03
Remaining IL	2020	$0.02	$0.02	$0.24	$0.07	$0.07

Note: 2020 metrics as reported without adjustment for COVID-19 impacts

Table B.3.7 – Prescription Drug Utilization per 1,000 Opioid Utilizing Enrollees						
Geographic Region	**Year**	**#1 Coverage for One or More Intranasal Opioid Reversal Agent Spray**	**#2 Removal of Barriers to Buprenorphine Products**	**#3 Limit of Opioid Prescriptions of Acute Pain**	**#4 Alternative Therapies for Pain**	**#5 Coverage of Telepsychiatry Care**
Chicago/Cook County	2018	2.94	15.10	1,313.46	24.35	3.22
Chicago/Cook County	2019	5.33	15.25	1,400.83	40.77	4.38
Chicago/Cook County	2020	7.01	20.15	1,381.13	42.83	1,561.70
Other Chicago Suburbs	2018	3.92	15.41	1,372.27	16.48	1.04
Other Chicago Suburbs	2019	6.39	15.87	1,446.38	32.06	4.97
Other Chicago Suburbs	2020	8.74	17.64	1,473.28	33.33	1,056.72
Remaining IL	2018	3.62	10.65	1,326.54	29.57	5.56
Remaining IL	2019	5.44	11.49	1,433.46	44.67	10.23
Remaining IL	2020	9.04	11.51	1,485.42	45.17	442.13

Note: 2020 metrics as reported without adjustment for COVID-19 impacts