Standard Plans Advisory Working Group October 5, 2021

Standard Plan WG Members and Attendees

Dania Palanker, Chair

Robert Metz, Alex O'Brien, Jennifer Storm, Dwayne Lucado – CareFirst BlueCross BlueShield (CF)

Allison Mangiaracino, Denise Barton, Stephen Chuang, Sam Ongwen, Theresa Young

– Kaiser Permanente (KP)

Keith Blecher, Ryan Morgan - UnitedHealth Group

Janice Davis – Producer

Cheryl Fish-Parcham -Families USA

Kris Hathaway – AHIP

Peter Scharl– Oliver Wyman

Mary Beth Senkewicz, Jennifer Libster – HBX Staff

Meeting Notes

Peter: (Showing his screen) reviewing KPs proposal

After OW's review, found that the KP proposal had no impact on AV. Only impact was on specialty medications, otherwise the other services were not impacted by the change. The specialty Rx did not impact the AV.

New, on the silver plan. Brough it back into the AV range by increasing deductible by $200. As an alternative, they eliminated the additional $200 deductible and raised the MOOP by $150.

Mary Beth (MB): question about the Rx, are there generic Rx for type 2 diabetes?

Peter: Based on market scan data, there were not any Rx in the generic or non-preferred that were concentrated for diabetes.

Dania: were there very few specialty Rx, or were they only looking at Rx when they were prescribed for diabetes.

Peter: there were a fair amount of diabetes Rx in specialty Rx, but with AV calculator, that tier may not be a driver for the AV calculations. It didn't impact the AV at all.

Dania: are you applying $0 for all use of the Rx?

Peter: for Rx they are applying $0 based on the concentration of diabetes utilization. Not just for diabetes purposes.

Dania: could you clarify what that means? Will the carrier have to waive cost sharing for everyone regardless of diagnosis, or would it only apply to people with the diagnosis?

Peter: assuming that the drug is being giving $0 every time it is being administered.

Dania: Thank you. Any questions?

MB: Helpful to recap where we are.

First, Platinum does not need any adjustments to meet AV

Gold, increase MOOP $50.

Silver: increase MOOP by $150.

Bronze: increase MOOP $50.

Peter had stated that no analysis was performed on HSA-compatible bronze plan. However, for HDHPs, IRS issued guidance that allows items and services with respect to certain chronic conditions can be considered preventive for purposes of the IRC. This includes insulin and other glucose lowering agents, retinopathy screening, glucometer, and hemoglobin A1c testing, can be included as $0 cost sharing. Should this be discussed? Anyone disagree with this analysis?

Dania: Worth discussing. Should we go as far as we can?

MB: 2022 standard plans, did add diabetes supplies and insulin for HSA-compatible bronze plan.

Peter: clarifying that the 2022 standard plans already cover supplies and preferred insulin are covered at no cost sharing.

MB: correct.

Rob: some of the reason there was the language, as defined by carriers, there is some concern that the IRS guidance is in conflict with previous guidance. Would need to be careful because there are some legal interpretations and would not want to create a conflict with federal law.

Also raise some structural and operational thoughts.

MB: yes, you are on the list, let's get through this discussion first and then you can discuss your thoughts Rob.

Current guidance already includes insulin and other glucose lowering drugs.

Rob: not sure that the IRS guidance lets you waive cost sharing for office visits for example.

MB: that is a good point.

Rob: not sure how much more can be done under that list.

Dani: Let's leave it for now, unless anyone has strong feelings about this.

MB: CareFirst raised some issues in an email. I will summarize then Rob can take over

He expressed concern that the proposals are mandating specific Rx, which is beyond the scope of the work group.

Rob: drug claims do not come with a diagnosis code on them, so insofar as there would be a waiver of cost sharing, it would apply to all enrollees. This would be a problem for VBID, cannot limit to just people with a given Dx. We have to recognize that Rx would apply to any enrollee and just not type 2 diabetics.

Also CF has a limitation on Rx they will need to work through with PBM. Their formularies are applicable to all plans within the jurisdiction, so any change to standard plans would have to be applied to everyone in the individual and small group markets. This may be a CF specific problem

On medical side, they can do this. Some discussion with medical folks to get their input on what the right scope of services should be. Will update after that discussion.

Dania: AV has been estimated assuming that everyone gets the reduced cost sharing. The analysis already assumed this carrier limitation.

Non Rx benefits can be tied to a diagnosis code but Rx cannot. This was already built into the AV calculations we have been working with.

Rob: if that has been included, that is fine.

MB: good to make sure everyone understands that.

KP proposal is lab, primary care office visit, specialist office visit, and preferred brand Rx. CF will be reviewing that proposal and getting feed back on whether that works, or the benefits should be expanded or limited.

Dania: urging all carriers to get feedback to us as well, either privately or on the call.

Asking for Aetna and UHC to review as well.

MB: pediatric mental health. Staff has been discussing this topic. It was on the Social Justice and Health Equity Working Group's short list of things we might be able to add for 2023 plans.

We went ahead and asked Peter to start some analysis around pediatric MH services.

Reading an email from Peter- can start this analysis by pulling claims data to identify the most prevalent services for children using market scan data.

Peter: similar to what we did with Type 2 diabetes, review market scan data. Mental health codes start with F. We would look at pediatric claims in DMV area to determine the most prevalent Dx codes. Would send that info to MB to review and start considering what conditions we want to look at first.

Then would start looking at categories of care and Rx.

MB: Depending on market scan result, potentially a wide range of conditions. We will see if we can include MH in addition to diabetes for this year.

Allison: Pediatric MH, are we suggesting that if we were to adopt this benefit would this be $0 cost sharing? Would diabetes benefit impact parity testing?

MB: Yes we are all keeping in mind that we do parity testing at the end of the process. OW uses the HHS tool and their own tool at evaluate MH parity compliance.

Yes, pediatric MH is the on SJ WG recommendations. And we have other conditions on that list. Including adult MH, in later years.

Since we are look at MH, thought we should look at that first, before running parity tool.

Rob: Raised the same issues as Allison. Pretty sure that some of the Rx will impact MH parity.

Maybe worth looking at that sooner rather than later.

MB: how hard would it be Peter, for you to run that tool now?

Peter: we would have to make some adjustments to what we usually do. Since trying to break a category into subcategories. I can discuss internally about the timing.

MB: Let's have Peter have that discussion with his team and hopefully run the tool.

Dania: that makes sense.

Stephen: sounds like Peter will be looking at this. If now we are waiving cost sharing for office visits, that could impact parity, since MH benefits are matching our other office visits.

Question for Peter: 84% for office visit copay. How was that number calculated?

Peter: there were some adjustments to the inputs. I will double check, but I know that was done for standard plan design. Can't recall exactly. Might involve combining two categories into one, but not sure, will need to check.

Cheryl: Would like some legal guidance about what we can and cannot do under nondiscrimination. Have some concerns about dx codes and age

Dania; this should not fall under discrimination because we are not discriminating against a DX or age, but it's worth looking into. I know there are other areas where pediatric are treated differently. Worth checking on this.

MB: Yes, Jenny and I will talk about this.

Allison: Yes, we should look at this from a policy perspective. Would a child have $0 cost sharing, but would have cost sharing when they turn 19.

Dania: it is hard; equity and equality are not the same. Especially when you talk about racial equity. Sometimes you have things that are not equal that are equitable. Here we are talking about age. We will be doing things that are not equitable to move close to equity. We will not get there, but we will work towards greater racial equity.

Janie: I don't think this is a race-based question, we are looking at economic equity.

Dania: thank you for the clarification. We are not dealing with all inequity, such as gender, but looking at race, ethnicity and economic.

MB: no nothing else for today, so I can summarize what we want to get for next week.

We will be hearing from CF on their feedback on appropriate services. Peter will have an update on pediatric MH market scan data. He will also look at parity testing for the four plans that I outlined at the beginning of the meeting.

Cheryl: will you also give you a legal read on nondiscrimination.

MB; Yes. We will work on that, but we may not have an answer for next week.

Cheryl: raising a 1332 waiver question. Can we look at the cost if we did not offset.

MB: 1332 is beyond the scope of our charge.

Dania: It's not a bad thing to think about, but this is something for HBX to think about through other processes.

MB: we can mention it internally. I think that's it for this week.

Dania: Thank you everyone. I urge anyone with issues to raise them.