Standard Plans Advisory Working Group October 12, 2021

Standard Plan WG Members and Attendees

Dania Palanker, Chair

Robert Metz, Alex O'Brien, Jennifer Storm, Cory Bream– 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

Paul Speidell Aetna

Cheryl Fish-Parcham -Families USA

Kris Hathaway – AHIP

Peter Scharl– Oliver Wyman

Mary Beth Senkewicz, Jennifer Libster – HBX Staff

Howard Liebers – DISB

Meeting Notes

Mary Beth (MB): Rob Metz did send out CF medical recommendations as promised.

To start, we should talk about MH parity and what Peter has done so far, then we can talk about pediatric MH.

Peter: The email he sent was in response to a question raised last week about bronze and silver to see if the proposed changes would impact parity compliance.

MB: can you explain the impacts of inpatient and out patient MH visits.

Peter: Outpatient office visit setting has different copayments, so its not a round number. It comes to something like $37.50l0 because it's a weighted average based on different cost sharing for different settings.

MB: next step would be applying the cost sharing for other metal levels.

Peter: was talking about the AV calculator, not the parity tool.

Would make the necessary updates for $0 diabetes services and then review the parity tool.

MB: MH parity testing would be the next step. And after today you can do that, correct?

Peter: correct, we can do this for next meeting.

MB: any questions?

None.

Next issue is Rob's email with recommendations from his medical team on $0 cost sharing for diabetes. Rob can you discuss your email.

Rob: We had discussion with medical directors and pharmacists about what appropriate services and Rx would be to look at for treatment of diabetes. Their perspectives are outlined in the emails. In addition preferred insult and supplies, it would include PCP office visits.

Diabetes is about treatment and trying to control the condition, important to have continuity of care, so the PCP is the appropriate person for this.

We have concerns about specialists because they are involved when there are complications. Concerns about endocrinologist because there are not enough to care for Diabetics. Concern about $0 cost sharing.

He mentioned some drugs they have concerns with including are klonopin and immunosuppressants, which are not primarily for diabetics.

They are identifying lab yests they think are recommended and the quality of testing that are recommended.

Nutrition counseling is important for this population.

MB: compared CF to KP proposal. KP was PCP, specialists, labs, generic and preferred Rx.

Are there generic drugs for diabetes?

Rob: Yes there are generics for treatment of diabetes and there is now one generic insulin with FDA approval.

MB: Clarified that CF proposing that specialists are not included.

Rob: we have used the term Labs, but have not defined it. So the goal here is also to provide granularity to this benefit.

Allison: We agree with CF's input and appreciate the granularity.

How it would be applied in standard plans. Don't agree with specifying Rx in the standard plan grid. Still supporting including preferred drugs without naming specific drugs.

Rob: agree that we do not want to specify drugs. Clarified that the list they included were all generics. Want to focus on generics as well as preferred drugs would be a better direction.

MB: In terms of terminology, generic and preferred drugs as defined by the carrier.

Dania: I think we have two lists now. We still have a list, and the idea is that we would have a list of drugs that would be covered by the carrier without cost sharing,

MB: we have had a lot of lists. But they are more about educating ourselves.

Dania: There is a difference between saying there is a list of Rx that must be covered vs 1) generic or preferred to treat diabetes as defined by the carriers vs 2) we have a list of categories of drugs that are used to treat diabetes that the carrier must cover at $0 cost sharing.

So we don't have carriers that cover certain categories of Rx for diabetes and other carriers that do not cover that same category and class of drug for treatment of diabetes.

Just want to put out these options.

Rob: I think the concern they have with the existing list is that there are a lot of drugs that are included in that list that are not indicated for treatment of diabetes. GPI6 class is a potential approach.

GPI 6 is the class of drugs. Would need pharmacist input to identify the correct category and class.

Dania: there is a list of RX for treatment of diabetes under UPS. Would this list be something to consider.

Diabetes may not be something that is actually listed. Doesn't look like it is.

IF we are going to pick categories and classes, might make sense to look at UPS. Might be a way to ensure we are not going beyond what is already covered.

Might be helpful if the carriers go back to check with their pharmacists to see if that approach might make sense.

Also we do have two proposals generics only or generics and preferred.

Allison: To clarify KP s proposal means the Rx is preferred by the carrier, not referring to a specific tier level.

Rob: happy to invite the medical folks to a call if helpful. Insulin is important because it manages and controls diabetes. Other drugs are for treating diabetes when its not well maintained. Medical folks think they should be focused on managing and controlling diabetes rather than treating uncontrolled diabetes.

Dania: WG clarified that we would not be covering comorbidities, but did not clarify excluding complicated diabetes.

Everyone is very quiet, but we are going to have to move forward with some recommendations.

Maybe for next week we can put together a summary of the two recommendations to see where people are.

MB: we haven't heard anything from United or Aetna.

I am going to pick on you today Paul. If I summarize, can you discuss with your teams and come back with feedback?

Paul: yes. A summary would be helpful to start getting some feedback from Aetna.

Peter: clarifying how they were discussing labs.

Rob: would some of this framing mute the AV impacts?

Peter: at a high level, I agree with that, the proposals would limit the services eligible for $0 cost sharing. By limiting the eligible services, it might reduce impacts on AV.

MB: Peter is going to run against parity tool.

Last thing was we asked Peter to do was scan market data for pediatric MH .

Sharing screen. Did market scan to identify the most prevalent diagnosis code. Autism was most prevalent.

In the Social Justice WG, autism was not mentioned, but Tonya Kinlow from Children's National did a presentation on pediatric MH and she focused on prevalence of depression amongst black and Hispanic youth.

Dania: I did a little research (not exhaustive), the disparities issues in this area are largely in access to care rather than in diagnostic rates.

We recognize that there is an access to providers issue. Standard plans cannot address the access to providers issue, but can remove cost as a barrier to care.

There was a question about age discrimination. Have we gotten an answer yet.

MB: No. Jenny and I will talk about this after the call today.

Dania: should we be looking at diagnostic codes or identity services to eliminate cost sharing?

No response

Dania: taking my chair hat off, I think I would lean towards selecting services, rather than diagnosis code, because barriers are to access to care. However, could see an argument about picking diagnoses to address the racial stress/trauma that exists. The effects of COVID also increases need for services.

Rob: question on timing. When are we trying to bring things to the board? Would need to talk to medical folks internally. But trying to be sensitive about timing given there is still work to be done on diabetes.

MB: trying to wrap up by end of October with next board meeting in November.

Rob: From a timing side, would need more input on the AV side on diabetes. Not sure they can work through MH work done in the next 3 weeks.

Allison: agree on the timing. Also need some time to think about how to address the inequity issues. Not sure how cost sharing will impact equity in MH. Access to providers, side effects of Rx. It's more clear on diabetes, but need more time on MH.

She asked if there are examples of how MH have bene addressed through VBID design.

Dania: good to think about that but it maybe we are leading the way on VBID. Also noting that we are taking about VIBD not to promote just high value services, but VBID to promote health equity not just promoting high value services. Important to note that equity issue here was in access. Also increased equity issue because of impacts of covid and racial trauma. There have been increased stressors on children of color. Want to make sure that is in everyone's mind as we move forward.

Want to make sure this would not violate 1557 or other nondiscrimination laws, which HBX will look into.

MB: Peter will run plans through Parity tool.

Jenny and I will prepare a summary of where we are and have folks get back to HBX with their thoughts.

Jenny and I will look at nondiscrimination

Dania: Thank you everyone. We are slowing getting there I think.