Standard Plans Advisory Working Group October 19, 2021

Standard Plan WG Members and Attendees

Dania Palanker, Chair

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

Allison Mangiaracino, Sam Ongwen – Kaiser Permanente (KP)

Keith Blecher, Seung Baick - UnitedHealth Group

Paul Speidell - Aetna

Cheryl Fish-Parcham - Families USA

Peter Scharl – Oliver Wyman

Mary Beth Senkewicz – HBX Staff

Howard Liebers – DISB

Meeting Notes

Mary Beth (MB): She went through all the emails, and the summary of CareFirst and Kaiser proposals. The more recent emails amend the proposals contained in the summary. She reported that CareFirst and Kaiser agree that $0 cost-sharing will apply to PCP visits, nutritional counseling, insulin, diabetic supplies, and specified lab services:

- Lipid panel test (1x per year at $0)
- Hemoglobin A1C (2x per year at $0)
- Microalbumin urine test or nephrology visit (1x per year at $0)
- Dilated retinal exam (1x per year at $0)
- Basic metabolic panel (1x per year at $0)
- Liver function test (1x per year at $0)
- Nutrition counseling visits (unlimited at $0)

Any concerns or objections regarding what has been agreed to by our individual market carriers:

Paul: I have no concerns, but I will need to speak with others at Aetna to confirm. As an organization we have been working to do better regarding diabetes care. So philosophically I don't think there will be any concerns but I haven't been as nimble as my colleagues and will need to confirm.

Rob: With respect to small group, will the same plans be pulled into the SHOP market?

MB: It will be the same standard plans in both individual and small group markets.

Rob: So the same benefit design overall, in addition to the new Type 2 diabetes things we have added?

MB: Yes.

Rob: Are there any AV concerns regarding the small group market? Does the calculator drive any differences?

Peter: No, the benefit design is the same, so the AV will be the same.

MB: A few new people have joined, so summarized the above.

Seung: We have been looking at the medical services side. All the services are based off a diagnostic code, correct:

MB: Yes.

Seung: We are researching how to operationalize it. We may have to do some work on our systems. Since it's based on a diagnosis code.

MB: Asking CareFirst and Kaiser, since we have done insulin and supplies in the individual market, don't the carriers just pay the claims irrespective of diagnosis code, since the people making those claims are going to be diabetics? Don't you just pay all the claims for insulin and supplies since the nature of the services are that they are used by diabetics?

Rob: It's the latter.

MB: Will it be the same now that we are adding things?

Rob: No for medical services but yes for drugs. What United was getting at in its email was on drugs, I think. There is no primary diagnosis code for drug claims so it can't be implemented the same way. When the public health emergency was in effect in DC, all carriers had to do a treatment cost share waiver for COVID, which is a primary DX based approach.

Seung: pharmacy side is pretty cut and dried. We just still need to do more research on the medical side.

Keith: We are doing this on the individual market side already?

MB: A subset – insulin, and glucometers and test strips.

Moving on the Rx – CareFirst had sent an email regarding Rx – use GPI not NDC, and it includes generic and preferred tiers.

Rob: Allison had raised a good point, United also, a granular list of drugs is not appropriate here. Use classes instead. CareFirst pharmacy team recommends use of GPI-6. Allison suggested some alternate language and we are fine with it, except steer away from using the word "preferred" since that implicates tiers for some carriers.

MB: Yes, Kaiser had recommended "preferred medications in the diabetic agents drug class as defined by the carrier."

Allison: We use the term "preferred" internally so we understand that word will not work for standard plan purposes.

MB: In the past, we have never drilled down into formularies. So if we remove the word "preferred," does that work?

Dania: Let's add a sentence to the effect that nothing requires coverage of a medication that is currently not on a carrier's formulary.

Keith: So the group agrees we will look at this more categorically rather than granular details.

MB: Correct; that was always our intent, but in wrapping our arms around it we had a lot of emails flying back and forth with a lot of lists.

Dania: Can the actuaries cost this out? Will it affect the AV in that we are limiting the drugs more than what we originally were talking about?

Peter: My thought is that this is more limited. I will need to go back and see if flagging it by GPI changes anything.

Dania: Is the language we have now GPI or is it by class?

Rob: The advantage to this approach is that these categories change over time so we are roughly talking about the same thing. Allison's language is more general so as things change, it is still included.

Dania: That answers my question, thanks. I am good.

Allison: All contingent on mental health parity analysis and nondiscrimination issue.

MB: Jenny is our expert on nondiscrimination. She is very confident that there are no issues with respect to nondiscrimination. She will write something up for it but we are confident we are okay. Let's ask Peter about mental health parity tool.

Peter: We updated our tool to account for the zero dollar cost sharing. We mirrored the categories which was done for the metal level AV analysis. To the extent that there will be changes to drugs and specific labs, we will update it. We are going through peer review now and there is no effect and the plans will pass the AVC.

MB: Cheryl had sent an email requesting some data. She was interested in knowing the number of people who reach the MOOP, and for those that do, their income level (subsidy status), main expensive medical condition, and race. I sent out her request to the carriers and received feedback, which enabled us to narrow the request to the individual market standard plans for now. One thing we learned through the Social Justice and Health Equity Working Group is that race is not identified by individuals, by and large, and the carriers do not have that information. Rob pointed out that trying to figure out the main health condition is a large request and can be subjective, and would require a lot more time to analyze. She asked Rob about identifying the number of people who reach the MOOP and subsidy status – how long would that take?

Rob: I am certain I cannot have it within the next two weeks – it's a process. A data pull must be requested, run, and then undergo a quality assurance review, before then vetting for external distribution. We are happy to do, but in terms of our consideration for this round about what levers to pull, there is not enough time. We need more discussion about specifics of a data call. Speaking realistically, he said, it could be a several months' process.

MB: It sounds like we do not have the time to do it for this round; we are targeting the November Board meeting to present our work.

Dania: If it can't be done, it can't be done. Data pulls can be complicated, I know. We may also want to look at the small group market MOOP data as well.

MB: Agreed. We can think about a lot of things and we discuss more such as what populations we want to target, what exactly we need. We can continue as we work through the recommendations of the SJ&HEWG.

My takeaways from today's meeting: MB to come up with language about the Rx, and how to incorporate into the standard plans grid.

Allison: Question about process. At November Board meeting, the item for approval is the VBID plan design. Then, when the draft AVC comes out later this year or early next year, we need to run the plans through the draft and make any changes necessary at that time to stay within the required AV. Is that correct?

MB: Yes. That is the timeline. The March meeting of the Board for PY 2023 AVC changes.