Standard Plans Advisory Working Group October 26, 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, Denise Barton, Sam Ongwen, Theresa Young – Kaiser Permanente (KP)

Keith Blecher, Seung Baick - UnitedHealth Group

Paul Speidell - Aetna

Peter Scharl – Oliver Wyman

Mary Beth Senkewicz and Jenny Libster – HBX Staff

Meeting Notes

Mary Beth (MB): [Showing Screen]

I wanted to clarify two things from the chart. I made two errors. I should have added an asterisk for PCP with a primary DX for type 2 diabetes would be covered without cost sharing.

Any objection to this language?

Rob: Only anxiety is saying PCP visits are provided with no cost-sharing. This could lead people to believe all items and services will be covered without cost sharing. Would like to work through language to make clear that some services might be subject to cost sharing

MB: We can work on that.

Remember that the standard plan template is not something that consumers really look at. Generally only looked at by researchers. But we can work on language to clarify.

Nutritional counseling. This is not a lab service, which Allison pointed out. Allison asked that we just remove the label "lab" from the descriptor.

Allison: You can leave the Lab identifier in and make a change to move nutrition to first asterisk along with PCP visits. PCP visits and nutritional counseling with a primary diagnosis code (DX) of Type 2 diabetes.

MB: I will fix that.

MB: Those were the only comments I got on the chart, leaving aside low value services for now.

Peter can you walk us through the AV impact and what remains to be run through the calculator.

Peter: Items we need to include in AV calculator, most impactful one will be the limitations to Rx codes.

Sounds like the approach we are taking is the specified GPIs. Our data only has NDCs; we would need to map GPI to NDC.

Also would limit the lab codes to the 7 or 8 specified. We think will not have an impact on AV, but want to include for completeness.

Same for office visits. Does not think that will change the AV, but will rerun.

MB: your previous analysis used NDCs not GPIs?

Peter: Yes. I am not as familiar with GPIs and our data has NDCs.

Rob: There is not a clean mapping tool. I made that request to our clinical pharmacist and she said it would take some time to general a comparison list. Asked her to hold off to see if we could work from GPIs.

And, not every carrier will apply GPI at the same level due to formulary differences. The tool I just emailed to the group, I understand you can use that to generate the GPI from the NDC.

MB: Hopefully that will work. If it doesn't work, can you do the same assumptions you did for NDCs?

Peter: Yes.

MB: I believe Allison sent back a list of NDCs.

Allison: Yes.

Peter: do you know how closely that corresponds to GPI list?

Allison: I don't. I would need to consult with Pharmacy team.

Rob: This is going to be variable by carriers, but if there is a list that KP shared, that should be good for estimating AV.

Allison: You can use the Rx in the diabetes class and exclude others.

MB: You will rerun with change to PCP and Rx and see what AV comes out?

Peter: Yes, but we still have the question about low value services.

MB: I left the low values services in the grid at 50% cost sharing. I did that because of our charge to review and develop a VBID to support adherence for patients with chronic conditions.

That is why I kept it in, even though the impact on AV is de minimus except for spinal fusion.

Dania: Yes, anyone have questions or thoughts.

Allison: I appreciate that we are thinking about high and low value services. I thought that by narrowing the proposal that we would not need to change cost sharing for low value services. I don't know if there is a need for change to low value services cost-sharing if it does not impact AV.

The other thing is that if the group does want to move forward with that, will need to run by clinical team.

Dania: Any other thoughts on this?

Rob: I agree with Allison. We have not run by clinical team, but with lower impact on AV, it's not clear that this will drive consumer behavior as designed. Maybe look at this in future years.

Paul: As you think about the report, there is something to be said about supporting VBID. But I agree with Allison and Rob that given the de minimus impact to AV, we should think about it more fully down the road as we add more conditions for VBID design.

Dania: It sounds like people would like to remove the change to low value services where they do not impact AV.

MB: What about spinal fusion, which does have an impact. Allison, I think you said in an email that it was 0.5%. Did you look it up or were you recalling from memory?

Allison: I was recalling AV impact on spinal fusion from earlier meetings.

If there is no any AV impact, we don't see the need for this change.

Rob: I believe these are all off calculator adjustments. These are such granular adjustments, so there may be differences of opinions on the impact of these changes.

MB: 0.04% was AV impact of all the low value services run at 50% cost sharing.

We want Peter to run the AV, but not include any changes to low value services. Correct?

Also don't do adjustment to MOOP.

If we are over AV, I will talk to Peter around running with previously discussed adjustments.

Allison: That sound good. Will you be sending the revised grid out after the AV is run with new assumptions?

MB: Yes.

Keith: I have a few higher-level questions?

Are these replicas of plans offered on the individual side?

MB: Yes, the grid without any edits is what is on the individual market now.

Keith: Are these intended to be in network only plans?

We were looking at the individual plans today and they have plans that have non network coverage?

Rob: I think what is being referenced is that CF has two legal entities in DC. I think you see two plans from CF.

Jennifer: Yes, we have to do a plan for each licensed entity. They have the in-network benefits, and then also offer non-network coverage.

Keith: The non-network coverage is that something that is left to the carriers to define?

Jennifer: Yes.

Keith: Diabetes coverage and a DX driving the benefit - we met with operational team and it's looking promising.

Are we currently looking at services by DX on the individual side.

MB: No. The carriers don't currently do this. They will have to adjust now since the zero cost-sharing is being extended to more services for individual and small group this year. Last year we only added insulin and supplies.

Keith: If a claim come in with a diabetes DX, the service would be covered with no cost sharing. Will that DX always come in with that claim, or would they pre-identify a person as someone with type 2 diabetes and know to cover services with no cost sharing?

Rob: If you have a primary DX for diabetes, that will trigger cost sharing waiver. Rx does not have DX codes, so may have different issues around Rx. This is a common issue around VBID. Rx would be waived across the board, regardless of primary DX.

Keith: I understand the Rx piece, as those drugs would largely be taken only by diabetics. The issues are around the medical services and DX code.

Rob: Can think about this similar to the COVD cost sharing waivers. DC had a cost sharing waiver for treatment, so that would be a good process to think about.

MB: anyone else? We are hoping to wrap this up at the next call, in time for the November Board meeting.

Dania: Thanks everyone.