Standard Plans Advisory Working Group September 14, 2021

Standard Plan WG Members and Attendees

Dania Palanker, Chair

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

Allison Mangiaracino, Denise Barton, Theresa Young, Stephen Chuang, Sam Ongwen, Devi Vijayakumari – Kaiser Permanente (KP)

Paul Speidell – Aetna

Stephen Young, Seung Baick – UnitedHealth Group

Kris Hathaway - AHIP

Tammy Tomczyk, Peter Scharl– Oliver Wyman

Mary Beth Senkewicz, Jennifer Libster – HBX Staff

Howard Liebers – DISB

Janice Davis – Producer

Meeting Notes

Dania: Now we are back and working under a different directive from the Board.

This is a lot of hard work and we are going to try to do this fast. From a personal note, I am excited about this. I have done research on this and DC is the only state doing this work on health equity so far. DC is taking the lead on focusing on cost sharing to address health equity. Excited to see where this takes us. Real desire to improve health equity in the District focusing on cost sharing.

I will read the resolution from the board:

> "Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District."

Should address cost sharing for the condition specified by the Board recommendations. Supposed to create a VBID, supposed to waive cost sharing for specified chronic conditions, understand that we cannot do this all in one year. We are starting with Type 2 diabetes.

Under VBID, while we reduce cost sharing for these conditions, we will need to raise cost sharing on other services.

Before we move forward, if anyone has questions about VBID or the other directives, before we get into the work.

(no questions)

Mary Beth:

Sharing screen to show the CMS SBC Type 2 Diabetes claims scenario. This is what we used as a starting base.

Jenny was at CMS when this was developed. Scenario was developed by clinicians and includes claims for a well-maintained type 2 diabetic.

With that in mind, this was shared with our actuaries to review how this would fit into the AV calculator.

Introduces Tammy from OW and Peter Scharl, who will be our lead Actuary on this project.

Tammy: Showing screen – market scan info results.

One of the first questions in considering $0 cost sharing for diabetes claims is identifying what claims would be covered.

Started with market scan focusing on DMV area to increase the sample size of the data. Started by identifying a type 2 diagnostic code. Showing per member per month costs and a second chart of a % of claims associated with diabetes diagnosis vs non diabetes related claims.

Showing that 14.2 % of claims were for diabetic specific claims. Other 85.5% of claims were not related to diabetes

Broke out into medical claims, DME, and Rx.

How to determine what Rx claims are diabetic vs non diabetes. Harder because no diagnosis code. Included insulin, but also looked at other Rx that were prescribed for this population. May want to consider including other Rx and just treat the Rx as covered with no cost sharing.

Seung: did this data include ESI?

Tammy: large group ESI.

Sueng: I wonder how this would be different looking at a small group population. If we looked at a different population.

Tammy: Doesn't think that this would change. The think that might change is the prevenance of the diagnosis in the given population. Doesn't think that the treatment would change if we looked a different population.

Tammy: Another page of spreadsheet - Broken out claims a little more to show more granularity

How do we determine what Rx we put in the zero-cost sharing because related to diabetes?

Right now this is set to 80%. If there is a drug that is prescribed 80% of the time or more to a diabetic, what % of those drugs shift from nondiabetic claims to diabetic claims.

If we use the 80% standard, 0.3% of the time those drugs would be prescribed to a non-debit

This raises an admin question – how could plans limit coverage to people with a diabetes diagnosis. May want to cover the drug itself at $0 cost sharing.

80% was just selected, but this could be change to another figure. This was illustrative.

Moving to table included in the email to the group.

Looking at claims where the diagnosis code is diabetes or for Rx that meets the 80% standard.

If you look at those claims- shows where the claims fall. 40% of costs are preferred Rx. Almost 80% of total costs are under Rx.

Peter: Tammy did a good job coving the process we used. Once we used market scan data, in next column, looking at within AV calculator grouping, which of those services are for type 2 diabetes.

When determining metal AV, those categories would be higher in the second column, would have a higher impact on AV.

Again, more concentrated in the Rx category.

Tammy: Column 2 does not add to 100% - this represents what % of the claims in this category are represented by these services- for the whole population, not just diabetics.

Dania: we are really looking at Rx being the area where costs will be most directly impacted?

Peter: That is correct

Tammy: Agrees generally but it depends. If this is only a $5 copay, and it goes to $0 20% of the time, still need to look at higher cost sharing items that are used less may still have an impact.

Peter: The amount of $ we would be impacting would be 2.5% on Rx. .7% for medical. In total this would be 3.3%. Most of this would be tied to Rx costs.

From an impact, it would be most concentrated in Rx costs

Tammy: If the impact on AV was too much, could look at the 80% standard and make it stricter to reduce the AV impact.

Mary Beth: Good segway into AV calculators. Started with an existing Standard Silver plan. This is one of the more popular standard plans.

Increase AV by .5%, which puts us over the silver AV by .46%.

Peter: current AV was at 71.96, so any increase would put this above the AV allowable amount of 72%

So they would need to be some slight increase in other benefits to meet AV.

Mary Beth: does anyone else have any questions for Actuaries?

Do the actuaries have thoughts on impact of increasing 80% rule to 90%?

Peter: will take a min to look at this.

Dania: Does anyone have questions for the actuaries?

Stephen from KP: Can you explain difference between diabetics claims vs nondiabetic claims

For members that had at least one claim for type 2 diabetes. For those members, we looked at claims for whole year, any claims that were not for a diabetes dx code, they were put in column c and diabetes related claims are in column b

Seung (UHC): at .5% AV impact. Would that be variable or subject to change, based on a carriers PDL covering certain Rx. For example, if a carrier does not cover all specialty drugs in a category, would that lower the impact of Rx.

Tammy: have to distinguish between pricing AV – if plan does not cover all drugs in a category, meaning it would not have a much of a pricing impact.

Mary Beth: Want to move to talk about low value costs. Under the recommendations will need to think about low level services

SJ WG, they identified low value services- 4 services

Spinal fusions

Vitamin D testing

Proton beam for prostate cancer

Vertebroplasty and kyphoplasty

Are these included in EHB. Asking for input from carriers on whether these are included in EHB?

Specifically, about vitamin D testing, and also proton beam?

If included in EHB, cannot raise cost sharing to 100% for consumer on these services. Internally someone suggested might want to cap consumer cost sharing for EHB at 50% coinsurance to ensure it's a meaningful benefit.

Dania: These are not new services. Think that these are pretty widely known low value services and carriers may already be looking to reduce utilization of these services

Rob (CF): we would have to look into this question.

Dania: these would be for new contracts. Going to make an assumption that we are not going to ID low value services that are discriminatory. Assuming that these decisions are not discriminatory, are there any other legal wrinkles we need to be aware of?

Allison: Assuming we can subsize these services with off sets for low value services. Their conclusion was that its ideal to identify low value services, but may not be enough to offset these changes due to low utilization.

Look at recommendations from SJWG. Mila talked about focusing on one service in the first year. Wondering if we might be looking at other services in later meetings, specifically cardiovascular.

Mary Beth: given the time constrains not sure if we will be able to do this now. But we did talk about pediatric MH, but that is also complicated.

The long term goal is to work through this list, but not sure we can do much more than diabetes for this year.

Allison: Only raised because looking at this proposal, .5% isn't insignificant and we are looking at other consumers financing this change. Wondering if there are other proposals that could meet the goals of the working group.

Dania: Are you talking about proposals that does a small initial set of services?

Allison: yes. Could we look at Rx and outpatient services only?

Dania: we will have to talk through this of course. Will need to consider what the costs of this are.

I want every service to be covered without cost sharing but not trying to create inequity.

Mary Beth: two things we can do now:

1) Have actuaries run 90% scenario
2) Look at raising cost sharing to 50% for the identified lower cost services to see what the impacts are.

Dania: we are running out of time so will wrap up here.