Standard Plans Advisory Working Group September 21, 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, Stephen Chuang, Sam Ongwen, Theresa Young, Devi Vijayakumari – Kaiser Permanente (KP)

Paul Speidell – Aetna

Seung Baick – UnitedHealth Group

Kris Hathaway - AHIP

Janice Davis – Producer

Cheryl Fish-Parcham -Families USA

Tammy Tomczyk, Peter Scharl– Oliver Wyman

Mary Beth Senkewicz, Jennifer Libster – HBX Staff

Howard Liebers – DISB

Meeting Notes

Mary Beth: All of you should have received information from our actuaries. Asked them to rerun the AV with RX at 90% and low value services at 50% cost sharing.

These adjustments moved the AV to 72.10%

Also asked actuaries to provide a list of RX that meet 80% vs 90% so we can see what RX might fall out with this adjustment.

Peter:

First update was adjusting prescription drug assumptions from 80% to 90% (of claims being used by patients with a primary dx of Type 2 diabetes).

This brought the AV down, as it removed some RX from the $0 coverage category.

Increasing the threshold to 90% for RX reduced AV from 72.47% AV to 72.14%AV

Other service that had significant impact on AV was spinal fusion. Primary inpatient costs were drivers here. Lowered from 80% coverage to 50% coverage.

Had limited impact overall because not a widely used service. Reduced AV from 72.14 to 72.10%.

Other low value services had very little impact on AV, most coming from RX change and spinal fusion.

Questions? None

Dania:

A few things we need to talk about.

First, talking about specific services for diabetes and eliminating the costs around these services.

Are we talking about eliminating cost sharing for these services or just lowering costs.

There was talk about going beyond diabetes, but giving the discussions, may not get there this year.

Need to talk about, how do we pay for this?

Rob: We are talking about modifying existing cost sharing waiver for IVL market?

Mary Beth: no we are talking about plan year 2023. We are not making changes to plan year 2022.

Dania: we are trying to go beyond the 2022 cost share waivers for 2023. Not just looking at insulin and DME that will be addressed in plan year 2022.

Clarifying they are looking at a broad range of services

Not talking about requiring carriers to cover any specific RX, but where covered must be covered at no cost sharing or reduced cost sharing.

Tammy: we did not assume that all services on the SBC scenario were included. Excluded things where primary DX is not type two diabetes. Limited by DX code, not bringing in all services regardless of DX code.

Rob: level setting. Asking about how?

Would this apply to anyone who has type 2 diabetes, or would it just be limited to treatment specifically related to the diagnosis?

Raising operational issues. How would this be administered by the plans?

Tammy: It's on a claim line basis. Would not mean that all services a diabetic receives would be $0 cost sharing, only services with a primary diagnosis on the claim would be covered with $0 cost sharing.

Dania: we will have to come to consensus in the group. This should be for the treatment of the condition and not co-morbidity.

Would this be at the claim level?

Cheryl: Wondering whether high cholesterol would be included in future years? Whether not considering that as not covered now would get us

Allison: People going to the doctor will have comorbidities in many cases. Concerned that people may try to use this benefit but end up with a copay because the provider treated other conditions during the visit.

Under an equity lens, raising concerns about impact on people with other conditions.

This is a huge benefit over people with other conditions, should look at under an equity lens.

Should look at the evidence based care for early intervention for diabetes.

Stephen: Are the actuaries look at pricing impact or rating impacts of this change?

Peter: Mainly focused on metal AV. With change to AV, pricing for plans would go up a similar amount as AV increase (proportionally).

Possible that the offsets may address the metal av but may not address the rating AV

Seung: Are we concerned about risk selection?

Dania: are we going to do this for the other metal level or just silver?

Mary Beth: we will be doing this for all metal levels, not just silver.

Dania: this will reduce the risk of adverse selection, but since others offer non-standard plans.

Equity lens: we want people to enroll into these plans. But then need to consider the pricing impact.

Mary Beth: Carriers take into account the risk of their market wide enrollment, so the risk for these plans will be pooled across the plans offered. Also our uninsured rate is low.

Dania: less of a concern about people enrolling to newly become insured.

Also people may be picking for other reasons, based on information included in plan match, such as provider network.

Allison: AV impact? Did we expect that the impact will be the same on other metal level?

What off sets are we talking about, for example increase to deductible?

Dania: AV impact will be higher for bronze and lower for gold and platinum.

Mary Beth: this could be a next step, to run this on other plans to see the impact.

Broad cost sharing offsets will be part of this discussion.

Rob: Agree with single risk pool, not concerned with adverse selection that would not be addressed through existing mechanisms

Are we talking about individuals only?

Mary Beth: this will be offered in SHOP as well. Board anticipating that these same plans will be offered in both markets.

Rob: idea that any individual standard plan would be mimicked in SHOP?

Mary Beth: Yes. Forms are not materially different in the two markets.

Rob: Idea to modify IVL market plans and then take the plan and apply to SHOP

Was not clear on how this would be operationalized. Will need a little time on our end to understand how we could operationalize this.

Will probably not have that ready for next week, but will need to look into this on the SHOP side.

Dania: we do have got non-RX including services that have primary dx of diabetes.

Two issued raised; concern that doctors catch on and take advantage of this.

Question – should we be included all services in this discussion, including ER? Is there a reason we are only looking at outpatient services

As a person and not as Chair. From an equity lens it makes sense to include hospital and ER because we are trying to address historical inequities. To get too equity have to address existing inequities.

On the other side, maybe we should be focusing on outpatient services to open up possibility that we don't have to off set costs in the first year or make it easier to move to other conditions.

Really about hospital and ER and non-outpatient services

Asking if people need time to consider these options and how to address this through an equity lens.

Mary Beth; will have actuaries run other metal levels so we can see the impact on all metal levels.

Do we want to start to think about the tradeoffs?

How large a gap is 0.1% on AV.

What is the biggest impact on AV, e.g. Deductible? MOOP?

Tammy: biggest impact will always be deductible.

Mary Beth: maybe see what raising deducible by $500 does to AV.

Dania: I think we always try to build in a small cushion, e.g. .02% to allow for carrier variation.

Rob: Would it be possible to look at excluding inpatient and hospitalizations to see what impact would be.

Peter: Inpatient hospital is only 0.5% so excluding that will not have any real impact on AV.

Skilled nursing – impact on AV is also so small in calculator, so will have a very small impact on AV.

Doesn't think excluding inpatient care will have much impact on AV.

Increasing deducible – might address this though $100 or $200 increase. Will need to do the calculations, but thinks a small deducible increase could offset AV increase.