Standard Plan Working Group – PY2024

Meeting 1

Tuesday, September 13, 2022

Attendance:

Chair: Leighton Ku, HBX Executive Board

Baker	Kellan	HBX Contractor (Whitman-Walker Institute)
Barlow	Yuolondra	CareFirst
Blake	Nikki	CareFirst
Blecher	Keith	UnitedHealthcare
Chandrasekaran	Dave	Voter Empowerment Project, HBX Standing Advisory Board
Davis	Janice	Living Capital
Dobrasevic	Stevan	CVS Aetna
Hathaway	Kris	AHIP
Hoffman	Sarah	Children's National Hospital
Keepes	Joshua	AHIP
Kinlow	Tonya	Children's National Hospital
Kwarciany	Jodi	NAMI, HBX Standing Advisory Board
Le	Ky	Kaiser Permanente
Lucado	Dwayne	CareFirst
Mangiaracino	Allison	Kaiser Permanente
Neimiller	Jason	CareFirst
O'Brien	Alexandra	CareFirst
Ongwen	Sam	Kaiser Permanente
Parcham	Cheryl	Families USA, HBX Standing Advisory Board
Speidell	Paul	CVS Aetna
Stoddart	Robert	Kaiser Permanente
Tomczyk	Tammy	HBX Contractor (Oliver-Wyman)
Willing	Laura	Children's National Hospital
Young	Theresa	Kaiser Permanente

Staff:
Ellen O'Brien
Purvee Kempf
Jenny Libster

WELCOME

Welcome back. I'm Leighton Ku, stepping in as chair for Dania Palanker who is on leave.

We have a large group and so I don't think we will use our time with formal introductions.

TODAY'S AGENDA

Leighton:

The charge is to provide advice to DCHBX about ways to modify standard plans to deal with a recommendation from SJWG. As part of the hard work from this group and the SAB, we developed a social justice initiative was to consider how to modify benefits on DCHL that would improve social justice, with a focus on reducing disparities.

First, we dealt with diabetes, working with our health plan partners to eliminate cost sharing for insulin. In the next phase we are eliminating cost sharing for more items and services related to diabetes care. We are really ahead of the country on this work and there is interest from around the country in this work. Now we are trying to move forward again.

We are seeking to gradually and incrementally make changes in benefit design in standard plans. We are now focusing on mental health issues. We will be discussing potential changes to plan design around cost sharing for certain pediatric mental health benefits. This is an area that was identified as an area with health disparities. Burdens are falling disproportionally on minority children.

We have 2 components on DCHL, IVL and also the SHOP market where small group plans are offered to employees of DC business, including people who live outside the District and their families

That is the scope of what we are talking about this year. We are hoping we can finish up in the next several weeks and then plan to bring this to the Exec Board in November to consider our recommendations around changes in cost sharing for pediatric mental health benefits.

These changes, if adopted, must be considered by our s and will go into effect for PY 2024.

We are grateful for the changes under the inflation reduction act, keeping premiums down for people.

Purvee and Ellen, am I leaving anything out?

Ellen: No, we can come back to the timeline at the end.

Leighton: another clarification, we offer standards plans, as some other states do as well. We do not dictate benefit design for all plans offered on DCHL, but we also require the offering of standard plans, where benefits design is standardized. Consumers still have choices to select non-standardized plans, but standard plans have been relatively popular.

The recommendations from here will not impact necessarily non-standard plans, but these changes might influence designs in other plans in nonstandard plans or off exchange plans.

This work might be picked up by other states as well.

Are there any questions, and then we will turn this discussion over to experts that we engaged including from Children's and Whitman-walker Institute. They are advising on mental health conditions and benefits as experts.

Questions: . . . . [Silence]

No questions, as a reminder this is the first of several meetings. We have 7 meetings planned, so this will play out over the next several weeks.

One of the final elements is we are asking the people involved, including our experts from Oliver Wyman, to weigh in on cost issues under AV. We will ask the carriers to also weigh in on AV impacts.

AV has been the painful part of standard plans; every year we find the AV calculator comes out with new issues and every year we need to tighten things up. This is particularly challenging in bronze level plans.

We have staff from DCHBX, experts from Children's and WW Institute, we have members of the working group including AHIP, CAP, Families, Living Capital, and some folks from SAB, Jodi (NAMI) and Claire McAndrews might be joining. She is now at Waxman Strategies.

Anyone else who wants to introduce themselves?

Dave: this is Dave and I can't believe your forgot about me (joking). I am working at a small nonprofit but also now enrolled through DCHL again so he is a consumer again.

Purvee; He is also on SAB.

Leighton, Cheryl, and Janice who is a broker and brings that perspective.

Janice: Hi, I'm a broker, a resident and a small business owner. So, I wear 3 hats.

Leighton: We also have actuaries on from OW who are working with us on this project

Are there questions or comments about our purpose, process, and timeline?

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Let's move on to our first presentation.

First, we have Tonya Kinlow, Vice President, Community Engagement, Advocacy & Government Affairs, from Children's National Hospital to discuss the prevalence of mental and behavioral health conditions among communities of color in the District.

Tonya: I just want to take DCHBX for inviting us to serve on the SJ working group where I gave a presentation on health disparities they are seeing for children in the District. Specifically seeing disparities in mental health. Seeing a 4X increase in demand for pediatric mental health services. I presented on the need and demand and made several recommendations on how Children's National, looking at benefit design and some of the rules governing access to this care, could help improve access to care and reduce disparities.

Of course, we are seeing disparities amongst Black and Hispanic communities in their need. Also seeing disparities in their ability to access care.

Dr. Laura Willing and Sarah Barclay Hoffman are here today with me to talk about the benefits needed in this area to help reduce disparities in children's mental health services.

Turning this over to Dr Willing.

Dr Willing: Thank you for having us.

Sarah Hoffman: I manage our mental health policy strategy with a focus on DC. I have 20 years of experience in children's health policy, recently focusing on mental health needs. This is a personal and professional privilege to be doing this work.

We have been doing work since August identifying conditions that disproportionally impact communities of color and we have initially identified 3 conditions, and we are continuing to work on identifying more.

We started with Anxiety, PTSD, and gender dysphoria

Turning over to Dr. Willing to talk about the importance of these conditions.

Dr Willing: I am a child and adolescent psychiatrist. One of 2 gender development specialists.

Starting with Anxiety. This is not one disorder, but includes a range of diagnoses, including selective mutism, adjustment disorders and OCD, as well as generalized anxiety disorders.

You might start with an unspecified anxiety disorders when starting diagnosis and care, so it makes sense to treat as a category.

It could be years from when someone has symptoms and diagnosis.

We also see minority communities are under diagnosed and there is no reason to believe there is lower prevalence. Believe this is based on lack of access to services.

Consistently see anxiety show up in the top 10 diagnoses in children, and when combined into one category, there is high prevalence.

These dx are also highly treatable. Strong evidence-based treatments.

Medications used are SSRI and SNRIs frequently, and some other rx are common. And treatment is therapy, family therapy (if separation anxiety and some other disorders), and group therapy (e.g., for things like social anxiety disorders).

Any questions on anxiety disorders?

No, ok trauma related disorders including PTSD. PTSD is a good term for this category, also covers acute stress disorders, which is shorter term (less than 30 days).

These conditions are also highly treatable.

We think this is an important category to include due to the pandemic, which create a universal trauma and disproportionately impacted communities of color, specifically children.

There is CBT which his very effective in this category, and medications. Trauma focused CBT which has a strong evidence base.

Finally, gender dysphoria is important to include for several reasons. Under an equity lens, this community is under attack nationally. There are many barriers to access to care. Black and brown communities are under-represented in who is turning up for care for this type of care, but no reason to think there is less prevalence.

Also, a lot of issues with access to care. In DC luckily there is better access to providers, but there are still barriers to care. Black and brown populations significantly underrepresented in treatment, but there is no reason to think there is lower prevalence in these populations.

Any questions?

Sarah Hoffman: We are continuing to look at our data and turning up new data. Seeing things like ADHD showing high prevalence so we will be following up with additional data when we complete this work.

Dr. Willing: yes, the 3 we are talking about today all show up in the top 10, but we will have more information. These three conditions are slam dunks.

Leighton: I am glad you mentioned ADHD. When I saw these, I was wondering about depression and ADHD. Depression and anxiety are frequently linked. What about depression?

Dr. Willing: Yes, seeing reporting on people going to the hospital with suicidal thoughts, so we expect to come back with something more on that.

Cheryl: is DC doing mobile crisis? Is there a need for private insurance to play a role in that?

Dr. Willing: DC has CHAMP. I will leave it to someone else to talk about the role of private health insurance.

There is work to do in implementing 988 in DC and work coming out of the Dept of behavioral health. There is still significant demand, even with those services, so there is still a need to address the need across various partners and agencies.

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Leighton: Thank you very much. We look forward to hearing more from you in the future. In the interest of time, we will move onto Dr. Kellan Baker from Whitman walker.

Because of their longstanding presence in the District and clinical expertise, HBX has contracted with the Whitman-Walker Institute to develop the clinical scenarios for pediatric mental health conditions.

Dr. Kellan Baker: Hi everyone I have am the Executive Director of the WW Institute, the research arm of Whitman Walker

We are an FQHC that provides services

We looked at 4 different sources looking at prevalence for anxiety. Looking at publicly available data, our own EMR and discussion with our clinical health providers.

Approx. 1/3 of US population has met diagnostic criteria for these anxiety disorders.

Median onset is 11 years old

Important to remember that LBGTQ and racial minority communities are not distinct and there is significant overlap around access and equity issues for these communities

Review of clinical guidelines – Primarily these studies are conducted on white communities and generally LBTQ communities are not specifically considered

Analysis of EMR

Used this data to identify DX codes for prevalence and appropriate care.

Medications: SSRIs SNRIs anticonvulsants, other antidepressants, Benzos and one allergy medication that is commonly used to treat anxiety

Visits: New visits, with referrals, Seeking a lot of range in visits, including the frequency, provider type and location (in person / telehealth)

We are interpreting this information in context of other information, specifically access issues impacting communities of color.

We are expecting these are under counts for communities of color.

Purvee: we will share these slides so people can review this in more detail.

Dr. Baker: Qualitative interviews with Providers most frequently providers recommend a combination of medications and therapy. Having both potions on the table is critical, especially for this pediatric community. Important to include both individual and group options, we well as a range of modality's including in person and telephone/video.

Recommend at minimum of 26 therapy visits per year. This is essential for care for pediatric patients. Cost is a common barrier to regular therapy visits.

Thank you and I am happy to take any questions:

Allison: Are you making recommendations on age up to 18.

Ellen: yes, we are limiting to age 18

Janice: most of my clients raise access as the issue. Telehealth is not working, cannot get appointments, not enough providers. This is a common reason people seek to change plans mid year

Leighton: We can address certain things in standards plans including what benefits are covered and cost sharing. We recognize that access is a real issue and there may be suggestions we have in this process, but this is a problem that s need to think about. I look forward to discussion about this, because this is a real challenge and barrier to care for people.

Janice: I understand that, but in terms of alternatives. Maybe we can emphasize alternative options for people. This is from a customer POV, but please have this in mind that some consumers do not understand the alternative options. I do understand the scope. Thank

Dave: I help friends and colleagues finding therapists. I found that the provide search directory is harder for MH providers than for other types of providers. Can we work with providers on improving these tools for consumers. Are there IT improvements we can work on to improve access from an equity perspective.

Purvee: we did some work on this a few years ago. This is very difficult for consumers, but we have an opportunity here to follow through with the SJ recommendations to eliminate cost sharing for pediatric mental health issues. This will take all our time. I'm not saying this is not important, but we do need to focus on getting this specific work done.

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Leighton, I am mindful of the time. We are getting close to the hour.

If anyone has comments, please email to ellen.obrien2@dc.gov.

Purvee: Dr. Baker presented on visits and RX details. What we ask is for you to review those materials and send comments and questions. s, please have your clinical teams review these materials and send comments/recommendations. We want to be able to arrive at agreement here for a care scenario that covers this broad category of anxiety

Please let us know by Friday. We plan to turn those around with WW so we can continue this discussion next week.

If you can let us know about your thoughts on telehealth visits.

Leighton: how easy is it to set up co-pay limits that differ by age? Here we are carving out a smaller population for $0 cost sharing.

Allison, I will follow up in email with my question.

Leighton: we are moving along. We will consider proposals from WW. This has been tremendous. We will speak against next week. Same time.

Ellen: Thank you Leighton.