SPWG Notes, Meeting 10, February 14, 2023

Attendance

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Baker	Kellan	Whitman-Walker Institute
Barlow	Yulondra	CareFirst
Blake	Nikki	CareFirst
Boakye	Osei-Yaw	Kaiser Permanente
Bream	Cory	CareFirst
Chandrasekaran	Dave	Voter Empowerment Project
Chuang	Stephen	Kaiser Permanente
Davis	Janice	Living Capital
Dobrasevic	Stevan	CVS-Aetna
Feleke-Eshete	Lienna	Whitman-Walker Institute
Hathaway	Kris	AHIP
Hoffman	Sarah	Children's National Hospital
Kinlow	Tonya	Children's National Hospital
Lucado	Dwayne	CareFirst
Mangiaracino	Allison	Kaiser Permanente
Metz	Robert	CareFirst
Neimiller	Jason	CareFirst
Ongwen	Sam	Kaiser Permanente
Sucher	Gregory	CareFirst
Vayda	Kerry	CareFirst
Weber	Joni	CVS-Aetna
Adomshick	Mary	Oliver Wyman
Scharl	Peter	Oliver Wyman
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Leighton Ku: Hello, everybody. Happy Valentine's Day. To remind people, this is a meeting for the DC Health Benefits Exchange authority standard plans group, we're discussing some slight changes to the standard plans for 2024. The group consists of a variety of people, including affiliated plans, consumers, and brokers.

Last year we convened, and we held a number of sessions to discuss ways to modify the standard plans for the DC Health Benefits Exchange Authority for 2024. We focused largely on pediatric mental health benefits, and we did great work. And in this case, we are reconvening the group or one maybe two

meetings for some technical changes. They're not the sort of policy that we had to struggle about for such a long time. But we did great work on dealing with pediatric mental health benefits. At this point, the federal government, CMS has put out the draft actuarial value calculator for 2024, and so that necessitates certain changes.

Before this meeting, Ellen O'Brien sent you a variety of documents that reflect what the nature of the changes are that we're discussing. It's conceivable that we'll be able to go through this today and that they'll be quick consensus on it. If not, we may convene again February 23rd. Before we go forward, are there any questions about the operations of this group? If you were a member of the working group, you have a vote.

First, we're going to talk about some of the things that are broader changes that will have to be made in a couple of the plans, the standard gold plan and the bronze HSA plan that are necessitated, because of changes in the AV calculator. And then there are certain technical changes that need to be made. These are largely slight technical fixes that had to do with omissions or slight misunderstandings that we had when we sort of circulated these documents before. I think it's better to start first, with the larger AV changes. I'm go ask Peter Scharl, the actuary of Oliver Wyman, to discuss the changes that need to be made about the gold plan and the Bronze HSA plan.

[Peter hands presentation to Mary Adomshick, Oliver Wyman]

Mary Adomshick: Thanks, Peter. As mentioned with the changes can be actuarial calculator, the gold and HSA plans are now out of the range they need to be within. We can talk about standard Gold plan first. You can see on the screen we have three proposed scenarios, that would all get the AV back in range to about a value of 81.9%. The first option would be to increase the maximum out-of-pocket from $5,900 to $6,500, an increase of $600. The second scenario would be to increase the outpatient surgery copay from $75 to $125. And in that scenario, we would keep the maximum out-of-pocket the same. And then third scenario is a combination of the two where we increase both the maximum out-of-pocket and the outpatient surgery copay, but to lesser amounts than in the first two scenarios. Our opinion is that the second is the least disruptive and has the least impact to the members. But kind of as mentioned, we don't have a vote. And it's so open to people's comments and opinions on these scenarios that we've laid out.

Purvee Kempf. Thanks, Mary. I just want to remind folks that we had moved to an out-of-pocket maximum of $5,900. That was in response to the changes that were made in November, related to the pediatric mental health benefits going to $5. I just want to note in Mary's second option, they're in changing the in the outpatient surgery, physician surgical services copay from $75 to $125, which is a $50 increase, we're able to go back down on the maximum out-of-pocket from $5,900 to $5,800. I think the other thing that's worth adding is this is for the outpatient physician or surgical services copay. There's a separate copay that has to do with the facility.

Peter Scharl: Yes, that's correct. And just it's one thing to stress with this, and it's noted in the email that's on the screen is at that $50 increase that's noted, there is much less than the out-of-pocket

maximum increase. And it appears that it's just a, you know, just call it a quirk in the AV calculator that allows that $50 increase to be more impactful than a $600 increase to the increase to the maximum out-of-pocket. And that's one of the reasons why, like Mary said, that our thought is on option two, since it would be the least disruptive to the members that currently have the plan.

Leighton Ku: Is there any discussion on these options? A broader question is, are we willing to try to take a vote today, in many cases, whether we can take a vote today depends in part on some of the plans, because in some cases, you may need to check inside within your organizations to see if you think that you approve one option versus the other. So far, the initial views that we've heard, seem to be that option number two, seems to be the one that seems to be favored. Again, increasing the copay for outpatient surgery physician or surgical services by $50 from $75 to $125. And this let's us lower the maximum out-of-pocket to $5,800. Again, any discussion that we want to have on any of this? I'm asking the plans, do you think you need more time to discuss this internally and then take a vote next week? Or do you believe that you can go ahead and vote on this and the next issue today?

Keith Blecher (United): I'd agree with the recommendation to go with number two. It does seem like the least disruptive and it's an alignment with a lot of the co pays on outpatient surgery in the market. I would be fine voicing United's recommendation to adopt option number two.

Cherron Milton (Aetna). We can support these options and make a vote today. I'm fine with option two for two, I was in between two or three. Based on the consensus from everyone else, we can support all three options.

Theresa Young (Kaiser Permanente): We're having a little chat here, as I've had my head in our filings for Virginia right now. And I'm just trying to switch my head over to DC. I'm sorry, I joined late. I'm not prepared to answer this question. And I sincerely apologize for that. But it does sound like I just need to look at it again to be able to feel confident about where I would stand. But it does sound like the overall consensus is for option two. And I'm sure my colleagues of the other carriers have reviewed that and I'm sure that will feel good with that too. But I apologize, I'm not prepared for today.

Leighton Ku: We understand you have a lot of a lot of things to do. We'll come back at the end of the meeting just to confirm whether you think you're prepared to vote for that option or whether you think you need more time.

Purvee Kempf: I will also just add, Cheryl Fish-Parcham was not able to join for Families USA but she did send us comments saying that she was in favor of option two in terms of the standard gold plan.

Jason Neimiller (CareFirst): I'm slightly concerned about option two, if we raise that outpatient physician costs, we already have the facility costs pretty high. I believe it was $525 for this. So combined between the facility and the physician at like $600. If we raise that $50, it would be $650. And I feel like that might be a little high. I wonder if anybody else has similar concerns?

Dave Chandreskaran: I guess when I'm looking at these, I think we all know we are assessing trade offs. And frankly, if anyone's hitting the out-of-pocket max, usually it's because they probably had a

pretty big hospitalization. And I just went through surgery myself last year so navigated all these bills. I think it sounds like you know, option two and three because we seem to want to be avoid massively raising the out-of-pocket max, which I fully understand. I think I'd personally be comfortable with option two and to a lesser extent option three.

Leighton Ku: For right now it sounds like the consensus is, is moving towards option two, though noting some possible concerns. But we don't need to finalize that vote, we'll come back to it. Shortly just we wanted people to have a little more time to think about it. Let's go back to Mary for the next discussion of options concerning the bronze HSA plan.

Mary Adomshick: We also have three different options for the bronze HSA to get it to an AV of about 64.9%. The first option would be to increase the maximum out-of-pocket amount from $6,900 to $7,200-- an increase in $300. The second option is to increase both the maximum out-of-pocket to a lesser degree than the first option but to also increase the deductible $350. And then the third option would be to increase the maximum out-of-pocket the deductible and the member coinsurance. The member coinsurance would increase from 20% to 30% and the maximum out-of-pocket deductible would decrease less than in the first two options, but are still increasing. Our recommendation would be to go with option one. Since we're going to need to increase the maximum out-of-pocket in all of the scenarios anyway, we think it's the least disruptive to have that the only thing that has been increased. But we'll leave that up to discussion for the group.

Purvee Kempf: Just a reminder of the bronze HSA plan is not a plan where we reduce the cost sharing for pediatric mental health benefits because of the federal IRS requirements around deductible and fully deductible care. These changes are really specific to the AV calculator. Under the federal law, basically all the cost sharing rules are fairly similar for the benefit of HSA plans aside from the preventive benefits.

Leighton Ku: Any discussion on the bronze HSA options? The actuaries of Oliver Wyman are proposing option one seemed to be the least disruptive.

Joni W (Aetna): I agree with option 1 as least disruptive.

Jodi Kwaciarny: I also agree that number one is probably the least disruptive.

Keith Blecher (UHC): Option number one seems least disruptive. We're saying that going increasing the maximum out-of-pocket from $6,900 to $7,200 a $300 increase? That that gets us back to AV compliance? Increasing? Number two, increasing the maximum out-of-pocket $200. Does not?

Peter Scharl: Yes, that's correct.

Keith Blecher (UHC): That seems odd, because the deductible generally has so much more influence on the overall AV score. If that's what it was, then that's what it was. And, definitely, number one is the preference, I would have expected to see less of an increase needed on that deductible to kind of get

in compliance in that scenario number two, but if that's what the numbers are saying, then that's what the calculator saying.

Peter Scharl: I agree with you. In principle, I think we are encountering some of the things that seem to be quirky things about the AV calculator that we don't fully understand, but that we can follow it for the time being anyway.

Leighton Ku: Anyone else on the bronze HSA option? Is there anyone who favors anything other than option number one? Purvee, do we need to take a roll call vote on any of these or can we simply go by consensus,

Purvee Kempf: you can go by voice vote. If there are no nays, then if you've got consensus, if there are nays, or different options being chosen, then we would need to do the roll call. It really depends on where the group is, if folks are comfortable, and everyone is feeling good enough with option two for the gold plan and option one for the Bronze HSA plan and willing to just do the vote voice vote today, we can finish it off. If you need some more time, we can do a voice vote next Thursday. And if we have any nays, then we would need to do the roll call vote. And I just want to remind folks, this is not a vote on approving the pediatric mental health benefits at $5. Because I know there was a lot of conversation on that when we took the vote last time. This is very specific to these two changes in order to get us back into compliance for the AV calculator.

Leighton Ku: Let me specifically move the question else and hopefully you've had a little more time to think about this at this point. So first, go back to once again, go back to the gold plan option. We are proposing to go with option number two, which would end Increase the outpatient surgery position surgical services copay by $50 from $75 to $125. But this lets us lower the maximum out-of-pocket amount down just a smidgen to $5,800. So that was the option that seemed to have those of you. Is there anyone who opposes option number two?

CareFirst: We prefer option one, for reasons that Jason mentioned.

Theresa Young: My immediate reaction is the same. And simply because I feel like anytime we are increasing that that health patient costs, potentially driving folks to the wrong venue, you know, like, the easier we can make it to drive them to the outpatient. I'm feeling like I would vote for one as well. I didn't hear a lot of those for two or three. I don't mean to derail the whole conversation completely being contrary, but that's my immediate reaction is for number one.

Purvee Kempf: I wonder if someone would make a choice between outpatient surgery and inpatient based on a $50 differential be than $50. Overall, for outpatient versus hospital stay? a $50 differential overall \ for outpatient surgery, you combine those dollar amounts, because there's the facility fee and the physician fee. And for the hospital status, the facility fee and the physician fee. Is that accurate?

The proposal is to move this from $75 to $125. So when it goes up, so the outpatient surgery would be $50 over the hospital stay for one day hospital stay or one night.

That's right. These are two separate benefits. We're talking outpatient versus hospital stay. I mean, I guess that maybe it doesn't make that much sense or to have them aligned. But the two are two completely separate benefits. It's not really going to be it's not like we're tiering on outpatient where you go to outpatient facility, freestanding versus a hospital.

Keith Blecher: We're talking about two completely separate benefits. And this is key, again, given the additional information on this chart. I kind of tend to agree. I think it was maybe CareFirst too. said I didn't realize that the facility fee was so high on the gold plan. So that does kind of push that outpatient fee, you know, copay up really high. I would, I would almost favor option number one based on this information or maybe ask Oliver Wyman, like when we say that if we adjusted upwards of 125, does that make the plan the gold plan right at 82%? Where does it land?

Peter Scharl: The options that were given all three of them bring that gold plan to about an 81.9%.

Keith Blecher: So it's right on that edge there. Yeah, so I was I would vote for option number one given that information.

Leighton Ku: This has been a great discussion. I'm inclined to think that the outpatient combined facility plus physician or surgeon be that it gets to $600. Again, I agree, in principle, it would be nice that it's at least a smidgen less than a day, or a night for a hospital stay. I don't think that's on the table at the moment. It could be something that we consider next year to sort of make it so there's a slight financial incentive to choose outpatient versus inpatient, though again, let's face it, obviously, some of this will have to do with the convenience to the patient, I would rather do something on an outpatient basis and outpatient basis, if the cost are equal.

I really agree with that. I think it's based on diagnosis code types of surgeries. I don't think the members making a choice. I think it's, you know, they either go in one direction or the other based on the procedure they're having.

Leighton Ku: The consensus appears to be moving away from option number two towards option number one. Is there a consensus surrounding option number one?
So option number one is to leave the outpatient service co pays the same at $75. But option one increases the maximum out-of-pocket for $5,900 to $6,500. Option number two would increase that outpatient services copay from $75 to $125. So the total would go, you know, $525 for the facility fee, plus $125. For the service fee, that'd be $650. But the outpatient at a maximum out-of-pocket limit would go down just a smidgen to $5,800. And we see what option number three is, which is sort of a combination of changing both the maximum out-of-pocket as well as a somewhat smaller change the copay.

Janice Davis: from a consumer point of view, honestly, when you when they're evaluating plans and they're looking at plans, and you're going through it, let's say you open enrollment, and whatever, you

have no idea what the difference is, psychologically, for the consumer, when they see something that goes from 550 900 to up upwards. Sometimes when they evaluate the plan, they're not as sophisticated. They wonder what the purposes. So what are they getting for this and you'd have a bow, you go into the hospital, you know, you're going to have to do outpatient and inpatient, they don't even see these things, honestly. I don't like the higher out-of-pocket maximum, because that's what people see. But I really don't find any of these are terribly objectionable in my point of view. I'm just trying to look at it as -- it almost sounds like the bronze plan, we looked at the deductible on there. And again, I think all of them work. So I just think III always make a decision that I've been, I mean, the objective is not to go one or the other. But I'm agreeable, agreeable with any.

Dave: For someone who's been on a gold plan here in exchange for a while. And that's I, I feel like I see these numbers quite a bit. And my sense is someone who got a surgery, you know, you kind of pay whatever you pay. And if it's 50 bucks, plus or minus, it's not that that's insignificant for people, but you're buying a gold plan, chances are, that's not going to make or break your decision or whether or not you get care. But the MOOP being higher, I think does influence where people go and since we have Kaiser has a handful of plans in the fold here and CareFirst has one, I think that means that that it becomes the loop for the whole year. And that's, that's where I'm nervous about increasing the maximum out-of-pocket so high at that level.

Janice Davis: I tend to agree with that, especially with my Kaiser clients who are in that area.

Leighton Ku: This is like my view hearing this is that the discussion of this issue has become a little more complicated. I sort of tend to think we might see if Oliver Wyman can think of some other creative alternatives here. And maybe try again next week. Can we for the moment, shift over to the Bronze HSA option where I think there was less dispute, though, again, we might have we might have some great insights coming in for this discussion. Again, the consensus there appeared to be to change the maximum out-of-pocket from $6,900 to $7,200. Do we have consensus on that option? All these things hurt. I mean, frankly, all these things where we increase these amounts, I find this these tough decisions. So once again, I am calling the question, is there a consensus on option number one for the bronze HSA plan?

Unknown: I joined late but I would vote for that.

Keith Blecher: I'm still on board with option one.

Leighton Ku: any objections? **In this case, unless I hear an objection within the next minute or so, we have a consensus on <u>option number one with the bronze HSA plan</u>. So going once, going twice, or three times. Okay, so we have a consensus on the bronze HSA plan.** We're taking a pause for a moment on the gold plan options. Again, conceivably, Oliver Wyman will do some further thought on this issue.

If you have other ideas that may be better for consumers, if you can just share them. And if we don't end up having any other great ideas, then we may be coming back with the same three options next

Thursday. But if you do, we can definitely have Peter run them for us. But we would need them pretty quickly to get them back to you on time.

We'll take a pause, we'll see if there's some other views that may come through. But otherwise, we're going to sort of hold off on this decision for a moment. Do we want to go over the technical changes that need to be discussed?

Ellen O'Brien: We had just converted the grids that are in the final report in Word to this Excel document to make it easier to review. If you want to study those closely, you'll see the changes we made there noted here. The first one was that this platinum plan, outpatient surgery, facility fee surgeon, physician surgeon fee showed as a merged cell and we just split them out to clarify that it's a $250 facility fee, and no copay on the physician surgeon. And same across all of these that in the hospital stays: mental behavioral health inpatient, substance abuse inpatient, and pregnancy, we clarified the cost sharing by splitting these cells when they were merged.

There was a mistake that we had discussed as we were going through that the mental behavioral health outpatient services copay in the silver plan showed as $40, we've corrected it to what it should have been zero. Same for the substance abuse, copay.

And then this one was truly a typo in the bronze HSA, home health care, showed as 2% in our report and it should be 20%.

This is important here on the bronze copay plan, the SNF, DME, and hospice services coinsurance was shown as 30% in our report, but it should be 40%. Thanks to CareFirst, for helping us understand this in the document, you see that there is some explanation about how this occurred that in plan year 2020, the coinsurance was 30%, when CMS lowered the MOOP it required an addendum to change the coinsurance to 40%. And somehow in our grids in 2021, it flipped back to 30%. All along, Oliver Wyman tells us that they have been using the 40% for the SNF coinsurance in the AV calculations. So, as we correct this error, none of that has any effect on the AV analysis.

I don't know if anyone has questions or comments on any of this.

Leighton Ku: I don't think we're putting these things up for a vote here. We're literally informing the group. That's the technical changes that needs to be made. Hopefully everyone agrees that these are not up for vote. These are corrections or clarifications that were identified.

Purvee Kempf: It's not again, the actuaries were running it using the appropriate numbers. And the splitting of the Merge Cells was really it came through the form review process with DISB last year, to just make sure it's clear what the different pieces are. So those were the different reasons this was done are really sincere apologies for any confusion as these grids have changed over time. We will be maintaining these in Excel and we'll have them up. We'll ask you to keep us accurate as we go over time. But that is our goal, so that we can all keep moving forward with any changes and knowingly make those changes as opposed to accidentally.

Ellen O'Brien: Also note, we had left off some CPT codes, these codes that are shown in red here appeared in the anxiety scenario. So, from the very beginning, these are codes for psychiatric diagnosis and evaluation with and without medical services, psychotherapy services of various length, 30 minutes, 45 minutes. Those were inadvertently omitted somehow through an editing error when we created the final report. We are correcting that and putting them back in.

So this is for information. And just to clarify, when we're going to make these changes in the official documents as well.

Leighton Ku: I think the only remaining item goes back to that gold plan option. Can I make one sort of suggestion of a possible fourth option? Can you go back to the benefits table? I wonder is it possible rather than changing the outpatient rules, change the inpatient costs under goal plan to something like 625 per day for five days. And so this would go across the hospital stay in mental health stay, substance abuse stay a pregnancy stay? Is that a preferable thing, it would leave the outpatient total cost 525 plus 75. At 600, it would slightly boost? Some of the hospital says I don't know that 625 is enough. I suppose another option might be 650, or something.

Theresa Young (Kaiser Permanente): I really appreciated what you said earlier about that. These are all difficult decisions, right? There's no good solution, we're sort of picking the best of the worst, so to speak out of here. Right. And, and I also want to say, you know, Peter, I appreciate that it's nice to know about do to find a better way. And it's hard because there sometimes really are no better ways. I do want to say, for Kaiser, we'd be good with any of the three options. And just since we're talking about the real world and our own experiences, and I totally appreciate that sometimes as this does not translate to the real world, that it is a clinical decision, your surgeon is going to tell you whether this should be done in a hospital or not. And David, I really appreciate your experience that you shared. In my case, I had surgery last year, my surgeon did say to me, you know we have we are able to do this outpatient. And we have, you know, a really great location facility to do it. And but you have the option of doing this is the hospital as well. I decided to do the outpatient surgery. But as a design principle, I would always design a plan to favor outpatient over inpatient from a financial perspective. Not necessarily to drive people to that, but just because it sort of makes more sense. It's the less expensive venue and it should have lower cost sharing in my view. I'll get off my soapbox and just say that you know we can agree with any of the three options, there's been a lot of really lively discussion. I've learned a lot, appreciate the perspectives.

Leighton Ku: It's getting almost close to an hour. HBX staff and Oliver Wyman will see if there's a fourth or fifth option for the standard Gold plan. We'll try to get back to you promptly. We have settled the issue for the bronze HSA plan, and we've notified you about the corrections. Hopefully the next meeting can be relatively brief. We have a meeting scheduled for Thursday, February 23, and it's at 12 noon again. Any final questions? And just again, if you have for other options on Gold, please send them to us. Thank you very much. We appreciate your patience and your time.