SPWG Notes, Meeting 8, November 1, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Aronin	Alana	Children's National Hospital
Baker	Kellan	Whitman-Walker
Blake	Nikki	CareFirst
Blecher	Keith	UHC
Bream	Cory	CareFirst
Davis	Janice	Living Capital
Dobrasevic	Stevan	Aetna
Hathaway	Kris	AHIP
Kinlow	Tonya	Children's National Hospital
Le	Ky	KP
Liebers	Howard	DISB
Lucado	Dwayne	CareFirst
Mangiaracino	Allison	KP
McAndrew	Claire	Waxman Strategies
Neimiller	Jason	CareFirst
O'Brien	Alexandra	CareFirst
Ongwen	Sam	KP
Scharl	Peter	Oliver Wyman
Speidell	Paul	Aetna
Stoddart	Robert	KP
Sucher	Greg	CareFirst
Weber	Joni	Aetna
Willing	Laura	Children's National Hospital
Young	Theresa	KP
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Leighton: Good Afternoon. We are having our 8th meeting of standard plans working group. We are making great progress and appreciate everyone who has committed hours of your time.

Just to remind you of this, we originally planned for 7 calls, but we are now on 8. And we realized that we don't think we will finish this up today. We are planning a 9th meeting which we hope to be the final call. Friday a noon. If you cannot attend but want to vote, you can send your vote by email to Ellen.

Ellen: yes, we will reach out to anyone who says they cannot attend to figure out the voting process for them.

Leighton: we hope we will have a consensus, but we recognize that may not be the case.

In either case we will send the overall records up in the HBX process. If we do not have consensus, it will go to the insurance committee. They would make a decision about how to process. Then it will go to the board this month.

The goal is to have this finalized this year so plans have time to implement for PY 2024.

We have discussed how folks can vote. Carriers each get one vote and so do other members, you know who you are.

If you cannot attend Friday, please tell the HBX team and they will work though how you can vote.

Today we will go through the issues to see if we have consensus, so we can get this down to a single vote for Friday, up or down.

Any questions?

[silence}

Again, this was all do in support of the recommendations of the SJWG. We did this last year for diabetes related care. Now we are doing pediatric mental health. We all recognize there is a crisis in this area. We have heard people from the President on down talk about how serious this issue is. In our own small way, we are hoping we can help.

There are still issues around access to providers and we hope that our partners will continue to work through those issues.

We asked Peter to do one more round of analysis for us.

The issues we have where we tried to finalized discussion last week.

Age – there are various issues around having an age cut off – legal, ethical, practical. I think last year we found some degree of agreement around age 18 up until the 19th birthday. There is some degree of arbitrariness around this, but this is where we had some agreement here.

Next, we looked at the scope of conditions. We started with a list of the most prevalent conditions. Due to complexities around this, including communicating with the public, we looked at the alternative to include all the f-codes or all mental health conditions.

Av analysis – some of these changes go above the av levels that are allowed under federal law, so we are looking at some off sets.

We looked at the possibility of doing this through changes to low or no value services, but we did not have time to fully review these changes in time, so we look like we are leaning towards addressing AV through changes to the MOOP or deductible. I think there is some preference for addressing through MOOP rather than deductible.

We have agreed we are not changing the HSA standard plan due to legal restrictions around those plans.

I think we have some basic consensus around these issues. Any discussion from the group on these?

[Silence]

Leighton: Ok, another issues that came up is limits on OVs. We have been looking at limits around 20 or 26 visits. But there have bene concerns raised about changing cost sharing after a certain number of visits. Some carriers have stated that this may present operational issues, so we were asked to look at the impact of removing the visits limits.

We ran the AV impact of this change and saw it had a small impact on AV.

The question for the group for discussion is to think about those visits. 20 26 no limits?

Alex (CF): given the high number of visits we are looking at as compared to the low number of visits we are actually seeing, Since it looks like there is a limited AV impact from removing the visit limits. We don't think the visit limit is worth it due

Dave: I support that. The single most important issue for me is the greatest number of visits at no cost sharing. Seeing the limited impact of removing the limits I support no cost sharing without limits.

This will be a meaningful change for consumers.

Leighton: Thank you Dave. We have not gotten to the co pay issues yet, though its related.

The number of providers and patients have some say as to how many visits are appropriate.

Anyone else?

[silence}

I am taking this to mean that the final package would include removing visit limits. Practically, the actual number of visits will be sill be lower than the proposed visits limits. There are still provider access issues, and other limits on care.

I saw this to the carrier where they are seeing abuses, they should let us know.

We also have extended some degree of operational flexibility

Also, we have agreed around limiting this to the primary DX, due to the expanding of conditions to include all MH conditions.

Purvee: Can I ask, are other carriers seeing operational issues and do you think this would help.

Keith: the limit aggregation going across PCP and MH providers could be a challenge. I have this as an open question with my operations people right now. This would help with that questions

Joni: yes, I agree this would be easier

Leighton: There are some trade offs between operational concerns and slightly higher AV

Next, we have the issues of copays. I am opening this up for discussion

Someone is displaying the AV impact based on no copay vs $10 copay

See chart in discussion document 1

Keith: just to clarify that is the only change at this point would be the change in OOP cap?

Leighton: Yes. We thought low no value would be too complicated at this point.

Keith: Ok

Purvee: on low and no value we are putting a pin in that. We can open that issue up in the future as it looked like those could have a pretty significant AV impact

Dave: I believe you said that if you eliminated the visit limit it would have a negligible AV impact.

Leighton: Yes, it looks like it impacts it around 0.1%

Purvee: You did not run the no visit with $0 copay, but can you estimate the likely effect?

Peter: the AV impact would be slightly higher than what we saw for the $10 copayment, but what Leighton is saying sounds pretty in line.

Dave: I want to understand the impact including who would be impact. If we a lot of people are in gold, the impact would be lower, but if a lot of kids are in silver the impact would be greater.

Leighton: I think that we would see an increase similar to what we have seen before maybe another $100.

Peter: Yes, I think the change would be around another $50 or $100 on the MOOP.

Purvee: the MOOP would need to be raised in silver and gold.

Leighton: we are only talking about MOOP, but these changes would also impact premiums. There are tradeoffs for all of these things.

Alex: we have been talking about balancing off improving access for these services vs. the impact on the rest of the community. It will have to be include in rates for 2024. We think $10 copay would help mitigate the impacts across the board and it would still be a big improvement from where the copay is in bronze and silver. Because we have not done this yet, if we find out that its effective, I would rather improve this later on if we see its working than to have to do a big increase if we find it's not working. We support $10 over no copay.

Dave: yes, I hate back sliding. If we are saying that it doesn't work, we are talking about not seeing greater access by children of color, which would not require raising the copays again.

I strongly support no copay because it creates greater access for people

Laura Willing: from a clinical perspective, therapy is the most important, and sometimes the only treatment for these conditions. From what is going to help patients, the $0 copay is more effective

Keith: until we price the rating impact, we will not know the impact on premiums. There will be some impact on pricing, we just don't know what it is.

Leighton: again, I think this could overstimulate demand for care. These are not low-income families. Copays are designed to signal something to consumers. Preventive health is no cost sharing because there sometimes no signal of need. Whereas there are signals for these mental health conditions. I support no copay for low-income children

Claire: I am not taking a strong position on copay as this would be an improvement. I would warn away from keeping a $10 copay as a way to warn people away from services or creating barriers to care. Getting kids to therapy may be a feat already. The idea that people are going to abuse these services is a narrative that we want to avoid. I want to be on the record that we have a lot to balance here in terms of AV and cost impacts. If we go to $10 it should be because we cannot cost this out without cost sharing. Its not easy to get kids to go to therapy regularly. right now, it's hard to get these kids to treatment as it is. We don't need kids to have skin in the game for them to get the care they need.

Leighton; Thank you for that Claire. There are lot of services kids need that they may not want, but there are still copays for those services

Sarah Hoffman: Following up on Dr Willing's comment. If the group does consider $10 copay for visits and no copay for medication, is there a way to monitor for unintended consequences where medications may be preferred over therapy when that is not clinically appropriate.

Kellan: That is an excellent question. The intent here is not to change standards of practice but there is a comment practice of [referring RX over therapy. We support no copay for therapy. If there is a difference between cost sharing for therapy and RX, we should be monitoring for unintended consequences.

Leighton: there are concerns about medications and kids, so I hope that our carriers and others keep an eye out for unintended consequences

Keith: our Chief medical officer does not recommend covered RX at no copay unless therapy is also covered at no cost sharing. This is echoing what others are saying here.

Dr. Willing: Therapy is more important for a lot of these conditions than RX. Early intervention for these kids can help set them up for the rest of their lives sand therapy is crucial for that

Janice: I support the $0 copay. When I say that its free to go for a physical, there is no barrier. It changes the way people view the services. There is no barrier t od it. In our community there are a lot of barriers to care already. Any barrier we can remove for MH care is important, It changes the way people think about it. Unless there is an AV reason why we can't do this, I support the no cost sharing

Tonya Kinlow: One of the reasons we are here is because of the conversations we were having the health equity group, Discussing the ability for people to access these services, as well as growing demands for services. MH services I would just put in another category because its so fundamental to helping children achieve health and wellbeing. If made available, the idea of no barrier as compared to a small cost barrier, this could be a real barrier for these kids. I support what Janice said and would encourage the $0 copay.

Leighton: Others? Other carriers?

Keith: I understand the no cost sharing approach. We are not against it. From our CMO he recommends RX and visits at no cost sharing.

When we talk about barrier to care, premiums can also be a barrier to care as well. Its balancing what that barrier would be.

Allison: We don't have a strong opinion either way, but the impact to the Medicaid population is important. Also, we are not just serving the exchange population, so we fear this could impact access for Medicaid children.

Dave: is the fear that if more children are seeking care that would take up visits so medical kids can get care.

Claire: I think DC is interesting, in other areas have a lack of providers, in DC we have a lot of providers that don't take insurance. We do have providers here, but there are steps that we could take to encourage greater participation in health plan networks.

Leighton: I have concerns that there are limited providers. I worry that Medicaid kids are more likely to be black or brown so we might be harming those kids rather than helping the,

IT sounds like we have more people arguing for no copay. I remain not in favor of $0 copay, but is that correct?

Purvee: We are trying to reach consensus to the extent possible. Does have $10 vs $0 with no visit limits make or break anyone. There is limited compromise that is possible on this issue, so please let us know if this is a make-or-break issue here.

Keith: If we move forward with no cost sharing for RX but $10 copay on OVs that could be make or break issue for us. If you leave it at $0 on RX the $10 copay on visits would be a problem for us

Leighton: we have not really talked about this.

Purvee: others where this is a make-or-break issue.

Alex: we would need to take this back.

I would like to take back Keith's concern about cost share differences between RX and OVs

Keith: I can take this back, but I think this would be an issue for our medical team

Aetna: I think we would have a similar issue to united. I will go back and check

Purvee: I think Allision had to leave, not sure if anyone else is on from KP.

We will have peter run no copays without visit limits to see what AV impact looks like.

We will send that around and please take back to your people for review.

We would like consensus, but if that is not possible, we will have to see where we are.

Leighton: I am opposed to $0 copay on this.

Alex: for generic, a lot of generic medications are already $10 so it doesn't make a lot of sense to leave them at $10. Take it down to $0 its something like a proportional decrease in cost to the reduction for OV copayment at $10

Dave: reiterating my support for no cost sharing for visits

I would like to see the impact of a reduction of $40 to $10 vs down to no copay has on behavior. I don't know that that same improved access will be realized with a $10 copayment

Claire made a good point that getting kids into therapy is already hard, including resistance from kids. I would be curious to see what cultural barriers are also in please, including what the elimination of copayment would have on those barriers to care. I would be open to compromise, if necessary, but I worry that the goal of this work would not be achieve with the $10 copay.

Leighton: Evidence that copays are a barrier to care for MH services is weak. There are many reasons why people don't access MH care.

This is different from preventive health services and even diabetes care where there is evidence that eliminating

Janice: the $10 copay for RX is fine for me.

Seeing barriers to accessing therapy, not seeing the same barriers accessing the RX piece

Dwayne: I am struggling with framing of Free of charge. It's not going to be free. there will be a cost that we will see in premiums.

Leighton: We saw that reduction in premiums with the premiums subsidies recently did impact access to coverage.

Alex: we are going to keep doing this work, which will continue to have impacts on premiums

Purvee: right now, it sounds like we have more votes for no cost sharing. But folks may be open to $0 copay based on AV. So, we will send around that analysis. If that is a no vote for anyone, that could move people back towards $10.

Leighton: we have not really discussed having a $10 copay for RX.

Purvee: we have not done any analysis on this, and we don't know what the operational impacts would be. I think it might be too late in the game to consider changes like that at this point in time

Leighton: it might be worth noting for the insurance committee

Purvee: do we want to talk about the last issue on RX

Leighton: We had heard some concerns about specific medications

Purvee or Ellen?

Purvee: here is the list of RX. The 2 outstanding issues were the class of beta blockers and the coverage of a single antihistamine. One of our carriers had concerns about the issue of those 2 medications for MH conditions in children. Yesterday, the CareFirst pharmacist had a discussion with Children's National. Children's shared some research to CF. We are happy to share with the group. For now, we are leaving hydroxyzine, but CF is still looking at this issue. The beta blockers, we struck metoprolol but leaving propranolol. I want to make sure all the carriers cover propranolol, so we have some coverage in that category. Under Alpha Agonists – we clarified that we cover the short and long acting (ER) forms. So, we clarified that. Any other comments on this from Alex or from Children's?

Alex: I don't. Our team is reviewing the information now and hopefully we will have a response on that shortly.

Purvee: any others? I don't think these are make or break issues but want to clarify that. We will send around where we land on the list of RX. If anyone feels strongly about hydroxyzine, please let us know. I think that was the last open issue.

Leighton: this was a good discussion. We are getting close to knowing the positions, if not necessary consensus.

Peter will run the AV impacts so you can see the impacts of these changes. We will meet again on Friday at noon. Thank you again