SPWG Notes, Meeting 5, October 11, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Adomshick	Mary	Oliver Wyman
Baker	Kellan	Whitman-Walker
Blecher	Keith	UHC
Bream	Cory	CareFirst
Chuang	Stephen	KP
Dobrasevic	Stevan	Aetna
Feleke-Eshete	Lienna	Whitman-Walker
Hathaway	Kris	AHIP
Kempf	Purvee	HBX
Kinlow	Tonya	Children's National
Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Le	Ky	KP
Liebers	Howard	DISB
Mangiaracino	Allison	KP
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
Clausson	Elyssa	Children's National
Young	Theresa	KP
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Leighton: Thank you for joining us. This is the 5th meeting of the working group. Before we go ahead, I want to recap where we are. We have extended the timeframe. We wanted to meet 7 times originally, but we added one more meeting on the 1st of November to give us a little more time. Once we have recommendations from this group, we will take the recommendations to the HBX Executive Board for a vote in November—to give plans sufficient time to update their plans for PY 2024.

Because we have a tight schedule, I want to lay out what we plan to do today, so people have sufficient time to consider these proposals and take issues back to their teams. We want to have a final set of recommendations by next week. We will send the final proposal around for next week so you can take it back to your teams and get your feed back on the final proposal.

In the 7th meeting, we will go over changes that people would like to make. Goal is at the 8th meeting we can take a vote on the recommendations and hopefully arrive at a consensus.

If there is not a consensus, then we will take a vote and see where the majority is and report the vote back to the Executive Board along with the concerns the minority votes had.

One of the critical thing is what happens on the AV impact based on the proposed changes. Oliver Wyman (OW) will be running these to show what the AV impacts would look like. OW cannot do that for today, but they will do this in the near future based on the changes. I asked that the AV be run in lower cost sharing, say $10, to see what the impact of that will be.

Today we want to focus on the comments we have received so far, both in the meetings and via email after each meeting. We will go over those today. There are some other issues that have come up:((1) impact of this proposal under EHB discriminatory benefit design rules. We are checking on that and we will circle back when we have completed that work. Hopefully we can set that aside for today. (2) in the next meeting, OW will present the AV impact.

Today, I hope we can discuss the comment that we have received so far. For next week we will have specific recommendations in writing for the group to consider. We will have the recommendations cleaned up by next week, so you have one set of recommendations to consider. We take the comments from the carriers seriously because they implement these changes.

Any general comments folks want to raise now?

[silence]

Ok, then we will ask CF, UHC, KP, and Aetna to raise their comments with the group for discussion.

Is there someone from CF?

Alex O'Brien: I wanted to summarize some of the comments our team has been sending.

One is that we think the VBID design should apply to non-HSA Plans -- similar to what we did for 1/1/23 plans to ensure compliance with the IRS rules for HDHPs

I did receive concerns around the number of visits at $0. With opening up the scenario to more conditions, we would support reducing the number of visits or just going with a lower cost share that isn't $0. The clinical team provided that the average number of visits is lower than what is proposed.

The AV team still needs to make sure that the AV remains in range.

We were interested in the no value care presentation. We should explore how we can offset these benefits by raising cost sharing for no value services.

Visit categories - we hare KPs concerns about not being able to differentiate types of visit. Support combining all visits into one bucket including all types of visits.

Leighton: can we stop there for a minute. Your point is that is hard from an insurance perspective to determine visit types. You cannot keep track of which is which. Clinical experts think there is a reason to distinguish between visit types. Can clinical folks weigh in on this?

Dr. Willing: they are different codes but as long as all types of visits are covered, I don't think it matters. As long as initial visits and follow up is still covered.

Kellan: there are several CPT codes that overlap. Some are unique but several codes overlap between the 2 categories of visits.

Purvee: Dr. Willing, were you saying it was ok for you as long as they are all covered?

Dr. Willing: Yes. As long as they are all covered. Dr. Baker do you agree?

Kellan: Yes.

Alex: There were some concerns about covering labs and procedures for gender dysphoria. They did not think those should be covered at no cost sharing.

On prescription medications, similar to last year, we want to make sure we come to consensus around classes and making sure we have flexibility within classes to include the medications included on their formularies

Leighton: to clarify. We think certain SSRIs should be covered. So, you are saying that SSRIs should be covered but carriers have flexibility to cover the medications in each class that are included in the formularies?

Keith B.: We did that last year for diabetes. We left flexibility for carriers to cover the specific medications in each class that are in included in the formularies.

Leighton: how does that sound to the clinical experts?

Dr. Willing: I always like to be able to choose the medications I think are appropriate for my patients, but I think it's reasonable to allow flexibility.

Keith B.: we can share what specific medications are included, that is not secret!

Dave C.: we are essentially creating a sub tier, but this should not be different from how tiering generally works already. We are creating a new copay level for certain Rx which I think is new. Just adding a new segmentation.

Dr Willing: I hope this would not be more restrictive than the current plans. But hopefully this would open it up.

Leighton: Hopefully clinicians would know what is covered under the plans.

Purvee: Are the categories for medications shown in the scenario generally what classes you are using?

Keith: Yes. We cover the classes but there are differences between carriers around what specific medications are covered by each carrier.

Alex: the classes make sense. But there are some specific medications within the class that may be used for other (non-mental health) diagnoses.

Keith: There are operational challenges. There is no visibility into why someone is getting a specific medication. That is not handled at the point of service. We could just cover the medication regardless of DX, but that would go against the spirit of what we are doing. WE could impose limits on that at the point of sale based on diagnosis. Could process with standard copay and then later reimburse. Diabetes was easier, this year is harder given the medications are used for other conditions.

Leighton: there is some consensus that there are medications used for multiple purposes. Do we want to just exclude these, such as anti-convulsant. Or would we cover it just for the specific DX we want to include

Purvee: Dr. Baker could you help clarify that for anti-convulsant we only included a specific medication, not the whole class

Dr. Baker: yes, that is correct. There were a couple of RX where we just included specific medications and not the class, anti-convulsant, antihistamines and antihypertensives.

Dr. Willing: Yes, there is one antihistamine that is used for children with anxiety. There is a lot of evidence for the use of these medications. I'm less concerned about the antihistamine (and one other).

Keith: I don't know the cost of the medications, so maybe that is something we can consider.

Purvee, are there benzos that are generic?

Dr. Willing: yes, they are generic

Dave: yes [naming 2 medications that are generic].

Leighton: I cam concerned that we will lose the rest of the hour going into this level of detail.

Dr. Willing: Could we hear more from Alex about the proposal not to cover gender affirming care. That was concerning to me.

Alex: it was just about covering at no cost sharing

Dr. Baker: I recall some concerns about some of the gender affirming care no being prescribed by mental health providers. But under the law, including parity, this is a mental health condition, including the gender affirming care. So I think this should be covered.

Leighton: Alex do you have anything else?

Alex: no, I think that's it for me.

Purvee: it seems like everyone was in agreement to bundle up the total number of visits into one bucket. We will be running different variations based on AV, but if you have specific recommendations on visits limits for $0 cost sharing, please share that. At this point, we will be looking for one number, including all types of visits.

Purvee: sorry one more thing. You did provide a comment on no value care. We have asked OW to run low and no value care. We are having it run with the consumer paying the full amount to get an idea of the outer limits of that AV impact.

Purvee: we can resend the services around. There was something like 35 no value services in the report and we asked OW to rerun the low value services we ran last year.

Leighton: One concern I have is that the low and no value services are looking at are mostly for adults, where we are focusing on lowering costs for children. Aetna/United anything to share?

Keith: Alex covered some of the issues we have. Including the point of sale RX issue. And the potential for age discrimination. I talked to Jenny this week, and I think I have less concern after that discussion. Those are our main 2 issues.

Leighton: Alison?

Allison: I will start with low value services. This is a report on VBID focusing on exchanges. I attached the report (http://vbidcenter.org/wp-content/uploads/2019/09/VBID-X-White-Paper-92019.pdf). It's hard that some services are low use so limited impact on AV. Some services have a high level of clinical heterogeneity and claims systems cannot pick up on that nuance.

We stlll have concerns around age discrimination and chronic conditions. We think the preamble is clear on the clinical evidence we would need. Regarding the ICD codes there are conditions that are excluded here, including eating disorders, etc. These conditions may not be as prevalent, it doesn't mean that they would not be diagnosed in this population. Also think this has the potential to disrupt care. Challenge of identifying types of Office Visits.

Member experience –Someone with other DX that is listed first would not receive the $0 benefit, or they could have the chronic condition and the ICD10 code is not included in the plan design. This will impact provider coding behavior where these conditions maybe should not be listed in the first position. We would like to just reduce cost sharing across the board in silver and bronze. No distinction based on age or condition. The age 18 cut off has the potential to be disruptive.

Leighton: Purvee, Jenny do you want to weigh in on discrimination?

Purvee: we are talking to the regulators about this, so give us a little more time and we will follow up on this next week.

Leighton: there may be moral issues with imposing a cut off even if legal. But we have to make decisions around this in policymaking. Part of me thinks that why should MH get this benefits and not another condition, but the social justice WG identified these conditions as being of particular concern. Raising concerns about not considering lower income families in Medicaid.

Allison: It seems unfair that someone with a SUD or eating disorder has to pay cost sharing but others do not. We are picking and choosing chronic conditions and we don't see a clinical basis for this distinction.

Purvee: you were part of the SJWG so you were there when the working group identified conditions of particular concern. Children's ran this based on prevalence. The idea is to address more locally the

challenges our population faces. We understand we cannot do this on all outpatient MH services, given AV. We are looking at whether these changes will have an impact on access to care for these children.

I am hoping that all the carriers are looking at what the impact is of these changes. Starting with diabetes care. We don't know what the results will be, but the goal is to have some evaluation of these types of changes. WE go through standard plans annually, so this can come back up if there is an evaluation component that shows this is not having the intended impact.

Leighton: I always support evaluation. We would want to understand the impacts, including on consumers in the care setting or point of service.

Joni (Aetna). We agree with the comments from the other carriers. Only thing I would add is that we are meeting internally. We would need to make some internal changes to implementing this proposal. We struggled to get our plans to meet AV in 2023, as well as meeting parity, so those are our concerns.

Leighton: I think we made some progress today, so that is great. By next meeting we will try to have some specific recommendations for you to consider.

IF you have more comments, please send to Ellen.