SPWG Notes, Meeting 6, October 18, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Aronin	Alana	Children's National Hospital
Baker	Kellan	Whitman-Walker
Blecher	Keith	UHC
Bream	Cory	CareFirst
Chandrasekaran	Dave	Voter Empowerment
Davis	Janice	Living Capital
Dobrasevic	Stevan	Aetna
Feleke-Eshete	Lienna	Whitman-Walker
Hathaway	Kris	AHIP
Hoffman	Sarah	Children's National Hospital
Kinlow	Tonya	Children's National Hospital
Le	Ky	KP
Liebers	Howard	DISB
Mangiaracino	Allison	KP
Parcham	Cheryl	Families USA
Scharl	Peter	Oliver Wyman
Sucher	Greg	CareFirst
Willing	Laura	Children's National
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Leighton Ku: Thank you for coming to the ongoing discussion on standard plans updates for pediatric MH for PY2024. Last year we did diabetes care so this year we are doing pediatric mental health. This time we are going to try to be more specific and look at some recommendations. I regret we just got them out to you before the meeting [see discussion document].

There has been a lot of news about pediatric mental health this past week. The AAP and other medical groups have renewed a call for action on the pediatric mental health crisis. A year ago, these groups declared a national emergency and this week, on the one-year anniversary of their initial declaration, they renewed their call for action in a letter to the White House. This is a situation of serious concerns. Also, last week, the USPSTF issued new screening guidelines (B rating) for anxiety and depression screening for children. These services will be covered under EHB preventive health services with no cost sharing. We are trying to go beyond that now with no cost sharing for additional services and drugs for the treatment of pediatric mental health conditions.

Since our last meeting we tried to create a single set of recommendations on this issue. Including Peter's analysis on AV. We are open to hearing other recommendations and thoughts today. We are hoping to get specific recommendations out of this meeting. We know some groups may need to take this back for internal discussion, so we will continue this discussion next week, with the goal of wrapping up 2 weeks from now.

Are there any questions? If not, I will go through the recommendations

Cheryl: I have a question: when is it appropriate to discuss the age cut-off? There is a lot of evidence that adolescents and young adults (age 18-25) are at risk for onset of psychosis, for example. I would like us to consider going to age 21.

Leighton: Yes, of course we can discuss raising the age limit. Another area we expect to come up is concerns raised by KP related to the limitation of $0 cost sharing to specific conditions.

Let's turn to the recommendations document shared with you just prior to this meeting.

The first issue is the list of conditions we want to include. You see the conditions listed on the screen. You can also see the ICD 10 codes. Allison, do you want to talk about your concerns with limiting to this list of disorders?

Allison: Yes. We have concerns about favoring some conditions over others in this design. For the sake of exploring all options, it would be worth understanding the AV impact of including all MH conditions, including SUD. I am guessing the AV impact would be severe, so this is hard. We would likely need to increase cost sharing anyway based on the new AV calculator and other increases costs. So, these changes would be on top of other changes.

Laura Willing: We were asked to come up with the top 10 conditions. If we did not have to worry about the AV, we would love to include all conditions and would love to go to a higher age.

Cheryl: do we know prevalence on Substance Use Disorder?

Purvee: as a reminder our charge is to address health disparities for communities of color, which was the reason for identifying the most prevalent conditions. I would be hesitant to run the full DSM.

Leighton: we will pause the discussion on scope of benefits. We got a revised list of Autism. We did not include the full scope of that in the AV we ran.

Going through the list of services included. Of note, the RX are color coded based on what they are most frequently used for. Not always possible to know what DX goes with which medications. There is some discretion for the plans to determine what specific medications are covered, provided the cover the class of medications. Carriers may have slightly different lists for example under the SSRIs. I think we had some general agreement around this approach to RX.

Keith Blecher: this is how it was handled last year. The carriers didn't modify their RX coverage, just update the cost sharing based on classes of medication they cover.

Leighton: any thoughts on this issue?

Purvee: CareFirst sent some recommendations on prescription medicines. Specifically, they included information in their comments on the medications that are used for non-mental health conditions. We made a column of CF's comments and UHCs on medication coverage. This is important to lock down here. If you are taking out classes of medications, we need to hear from the medical experts on the impact of removing medications.

Dr. Willing: Hydroxyzine is used for other purposes (other than for mental health conditions), but it is frequently prescribed for the treatment of anxiety in children. If we are trying to increase access to care, including this medication is important. Benzodiazepines are less evidence-based for children, and they are addictive; I will let Whitman-Walker weigh in on that as well. If we extend the age limit to age 21, benzodiazepines would be evidence-based.

I am concerned about gender-affirming care hormones and medications. I am not sure why those are being questioned. Those are clearly based on the standard of care for the pediatric population. I strongly believe those need to be included. I know there will be cuts, but I don't think this is a cut we should make. It would remove the whole category for gender dysphoria. There are no other drugs.

Dr. Baker: This is a serious barrier to care for this population with gender dysphoria. I would not recommend cutting any of the medications for this condition. I strongly support including hydroxyzine. And benzodiazepines are used in this population, though it is less evidence-based. That is a reason we recommended close medical supervision for this medication.

Leighton: How expensive is hydroxyzine?

Dr. Willing: It is generic.

Leighton: Here is my proposal. We remove benzodiazepines, and we include gender-affirming medications and hydroxyzine. That leaves some of the issues on the table: the anti-convulsant medications and beta blockers on the table for discussion. People with more clinical expertise than me can then weigh in on anti convulsants and beta blockers. Is that a tentative proposal people could agree to? Benzos out and gender dysphoria care medications in?

Keith: we could do a rereview of the list

Leighton: anyone else?

Purvee: can we take a few minutes to talk about beta blockers?

Dr. Willing: Beta blockers can be very helpful for anxiety. But they are used much more often for other conditions.

Purvee: is that true for children? In children, they are used for conditions other than mental health conditions?

Dr. Willing: Sometimes, it's not very common for beta blockers to be used for conditions other than mental health conditions in children. The older the patient, the more likely they would be used for other conditions. Clinically, it makes sense to include these medications. But I understand the cost impact is a factor if you have to cover for children with high blood pressure. Regarding anticonvulsants:

Yes, you can use for a variety of mental health indications. But they are not used as commonly for anxiety and depression as SSRIs. Clinically, they are indicated. But a question about how frequently they are used.

Dr. Baker: We see a lot of utilization of beta blockers, but we do not feel as strongly about these classes of medications as the other medications.

Leighton: we will put a question mark around beta blockers and anti-convulsants, so others can consider this issues.

Issue 2: Ages Covered

Leighton: Zero to age 18 – current recommendation. Do we want to discuss EHB age issues? Jenny Purvee?

Purvee: We should focus on raising the age if folks have thoughts on that.

Leighton: Cheryl?

Cheryl: We should be consistent with Medicaid -- which is up to age 21. I also feel like, practically speaking, kids at 18 are making major life changes at that point in time. Onset of psychosis frequently occurs between 18-25.

Purvee: Medicaid goes up to age 21, but does not include 21. We also should clarify we are not talking about inpatient care only outpatient services.

Leighton: I think Medicaid goes up to age 19 for kids generally. It's hard to decide where to draw this line, but we need to draw the line somewhere. USPSTF recommendations for screening went to age 18.

Cheryl: I would still like to go to age 20 if we can.

Purvee: for DC Medicaid, there are different income limits for the different age cut offs.

Cheryl: would it impact AV if we raise it?

Leighton: it would raise it, but by how much? Peter could you run this to age 21?

Peter: Yes.

Cheryl: I would be interested to hear from the doctors and Jodi on this.

Dr. Willing: there is not a clinical reason to cut off at age 18.

Dr. Baker: We concur. There is no clinical reason for 18. But there are other factors at play, so we defer to the working group here.

Leighton: there are pediatric dental benefits. And such

Janice: its age 19 for pediatric dental.

Leighton: we will run the AV analysis to review the consequences of increasing to age 19 or 21.

Cheryl: Thank you

Issue 3: **Cost-Sharing and Visit Limits**

Two alternatives are highlighted:

- $0 copays for up to 20 total visits in Treatment Scenarios. $0 copays for relevant medications.

Plan	Current Metal AV	20 Visit Limit
Platinum Plan 2023	89.89%	89.93%
Gold Plan 2023	81.92%	82.01%
Silver Plan 2023	71.95%	72.11%
Bronze Copay Plan 2023	64.91%	64.97%

- $10 copays for up to 26 total visits in Treatment Scenarios. $0 copays for relevant medications.

Plan	Current Metal AV	26 Visit Limit
Platinum Plan 2023	89.89%	89.92%
Gold Plan 2023	81.92%	81.99%
Silver Plan 2023	71.95%	72.09%
Bronze Copay Plan 2023	64.91%	64.96%

Leighton: You will see we go over a little on AV in both examples. I personally think a $10 copay is reasonable. These are middle-income kids. There is a limited supply of providers so I think that reducing cost sharing for these services will make it harder for Medicaid kids to get access. However, $0 corresponds to the SJWG recommendations and is consistent with the diabetes work we did.

Janice: I confirmed: Pediatric dental goes up age 19.

Dave: I know the difference between $0 and $10 is better than $40. But I am thinking about when there is $0 cost sharing, it flagged for the consumer that there is a reason for that decision. It flags the service as important. This is not just lowering a cost sharing barrier but also flagging these benefits as important. There may be cultural reasons why some people may not seek these services, so this flag matters. For myself as a consumer, no cost sharing does impact my behavior and gets me to get services more quickly. I think its worthwhile to have this be no copay.

Sarah Hoffman (sharing in the chat): regarding smaller copays vs medications: Just as zero cost share sends a clear message that the care/treatment is important and valued, the message behind a $10 treatment copay + $0 medication copay may send the wrong message that medication is more valued than treatment. In reality, this may not be best practice for various conditions, or at least should be determined by practitioners.

Keith: I had a question. These calculations are made based on copays and rx, but no other changes.

Purvee: Yes, that is correct.

Allison: At some point we will need to explain this to consumers. Not on the portals and no space in the SBC. This could drive complaints to someone who does not get this benefits.

Dave: yes, since the majority of kids in the exchange are in SHOP. This could be a teachable moment to work with brokers so they can educate their clients about these issues. I think this is a workable issue.

Janice: I tend to agree. Even when you explain this to employers or even elected officials When you actually explain it to them, it does address the issue. $10 is good, but I like the $0. When you include telehealth, you should tell people about that. Some people may not want to go in face to face. We should talk about the option for telehealth too. I think this is a valuable benefit at no cost sharing.

Leighton: Raising the possibility of blocking access to Medicaid kids. Re-raising this issue. I feel strongly about this. I am generally a support of no or low cost-sharing generally.

Its 1 PM so the final issue today. We do have some AV offsets.

AV offset alternatives offered by OW, increases in either deductible or MOOP.

Below are independent options on increases to the deductible or maximum OOP to bring the silver and gold plans' metal AV into the necessary range. These changes would bring the metal AV to roughly the same level as the current plan, which is about 0.1% below the upper limit.

	Deductible – Current	**Deductible – Adjusted**
Gold - $0 Copay	$500	N/A
Silver - $0 Copay	$4,850	$5,150
Silver - $10 Copay	$4,850	$5,100

	MOOP – Current	**MOOP – Adjusted**
Gold - $0 Copay	$5,800	$5,900
Silver - $0 Copay	$8,850	$9,100
Silver - $10 Copay	$8,850	$9,050

Leighton: These are the proposal from AV on possible offsets. How many visits?

Peter: these examples were based on 26 visits. A different visit limit would require slightly different adjustments to the deductible or MOOP to get within the AV ranges.

Leighton: I think we agree we would not touch bronze HDHPs.

Leighton: Next week we may be ready to take some preliminary votes.

Thank you.