SPWG Notes, Meeting 7, October 25, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Aronin	Alana	Children's National Hospital
Baker	Kellan	Whitman-Walker
Barlow	Yuolondra	CareFirst
Blake	Nikki	CareFirst
Blecher	Keith	UHC
Bream	Cory	CareFirst
Chandrasekaran	Dave	Voter Empowerment
Davis	Janice	Living Capital
Daymont	Mary	Children's National Hospital
Hathaway	Kris	AHIP
Hoffman	Sarah	Children's National Hospital
Le	Ky	KP
Liebers	Howard	DISB
Lucado	Dwayne	CareFirst
Mangiaracino	Allison	KP
Milton	Cherron	Aetna
Parcham	Cheryl	Families USA
Scharl	Peter	Oliver Wyman
Speidell	Paul	Aetna
Storm	Jennifer	CareFirst
Weber	Joni	Aetna
Young	Theresa	KP
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Leighton: Hi everybody, its noon and everyone is joining in so we should be ready to start soon.

An old friend of mine said you can judge how good a meeting is by whether or not you need to offer food for people to attend. This must be a good meeting as we cannot offer you food on a virtual meeting.

We are now on meeting number 7 for SPWG. We are working on modifying plans on pediatric MH benefits. We have had some good discussions so far

The game plan, next week will be our final meeting. We hope we can get consensus or at least clear votes, so we can take this to the exec board at HBX in November.

IF we have consensus, this will go to the board. If we do not have consensus, we will take this to the insurance regulatory committee and then to the board.

The goal is to have the recommendations in place so carriers have a year to plan and implement this in PY 2024.

Do we need to talk more about the process for voting? If we have consensus, we will not need a roll call vote.

If we do not have consensus, does HBX want to describe the process?

Purvee: we are hoping or consensus in which case we can do a voice vote. If we have someone who cannot vote on the agreement the group reaches at the end of this, we will need to do a roll call vote.

Reach out to any of us, Ellen, Jenny or if you would like to discuss more.

Leighton, I understand that carriers each have one vote, even though they may have more people on these calls.

WWC, Children's and OW would not have a vote as our advisors.

Purvee: That is correct.

Leighton: we went through a number of alternatives and asked OW to run some of these alternatives for us

Peter:

Version 4 of AV analysis – based on what we discussed last week on our call. And include the changes we discussed.

This uses version 3 as a starting point, with some changes.

We removed the 2 drug classes indicated on the slide and ran with $0 co pay for 20 visits and $10 copay for 26 visits. We ran these for 4 different age ranges up to 21.

You will see that this pushes both Gold and Silver over AV for the no cost sharing option. Pushes over for Silver for all age various and gold is over for age 20 and 21.

Leighton: can you clarify what age 18 means, does that include through the end of the 18th year.

Peter: yes

Impact of these is to push gold and silver over the AV limits, so some changes would be needed to bring the AV back. Could be done thought changes to the MOO P or deductible

Gold doesn't show a deductible change due to AV calculator having a quirk for gold plans. Increasing the deducible actually increases the Metal AV in the calculator so we did not provide an option with this change.

Leighton: when you are showing deductible and MOP changes are these either or, not both?

Peter: Yes, these would be one change or the other, not both.

The variations you see here are based on the most extreme option, including age 21.

In chat: Dave C: Do we have any info on how many people hit the deductibles or OOP max at silver level over the past few years?

Purvee: Peter, do you have any information on this?

Peter: we do not have any actual DC data on this. I would need to look to see if there is anything in the AV calculator.

Purvee; if you have it, could you send around?

Peter: Dave clarified that he wants to know about DC data -- which we do not have.

Leighton: HBX would not have that information, the carriers would.

Cheryl in Chat: So if we go to age 20 max with MOOP change only, any guesstimate for what the MOOP would be?

Purvee: do you a sense of how much we would need to change the Moop if we went down a year.

Peter: I think it would be maybe $50 -100 less.

Leighton; Let's try to go thought all the variations now

Peter:

Version 5 – based on discussion last week. This scenario is only based on age 18, but updated to include all ICD-10 codes beginning with F rather than the subset we looked at last week.

The impact of expanding the scope is about 0-0.2% depending on the metal level and copay amount.

The box at the bottom shows the offsets which are similar to what you saw above on changes to MOOP and deductible to get the plan back in compliance with AV.

Leighton: Kaiser Permanente raised these concerns, and I think CareFirst did as well. Wanted to simplify this to just include all MH and BH conditions. I did ask Peter what he thought about the impact on utilization. Peter thought 7-8% increase maybe.

Peter: to clarify that was the increase at the lower copay. Not a direct increase in utilization

Sarah Can you clarify that $10 copay scenario is $10 for services/visits and $0 for drugs, or is it $10 for visits and $10 for drugs?

Leighton: Yes, still no cost sharing for RX

Joni: Are any other carriers vetting whether or not their claims systems can administer different levels of cost-sharing by diagnosis, age?

Joni: we were told by our claims team that this would be something we struggle with.

Keith: I will need to go back and talk to our claims teams. We do have some cost sharing based on age already, and some on DX code already under diabetes, but I am cautiously optimistic we can do this.

CareFirst: I will need to take this back to our team. Our bigger concern is the visit limit

Allison: the visit limit is a challenge. We have removed some of the complexities here. The more complexity here the more risk of error.

Leighton: I am surprised, since plans have visit limits for benefits now.

Jen: It's not the visit limit, it's the change in cost sharing after the limit.

Alex: Yes, that is the issue.

Dave: I know many plans have the 3 free PCP visits. So that is common. Why would this not be doable for another category of service?

Jen: It might be national vs local plans that have different capability. This not something we have done in this area for heavy use.

Keith: it might be built into the plan design. Here is with additional conditions. So starting to make this more complex.

CF/Phone 5: might be harder to do this accurately

Leighton: go back to your teams to get more information on this. But again on diabetes, we did do a combination of dx and visit limit of care under that scenario.

P phone 5- I would need to go back and check on that.

Leighton: Peter can you go on

Purvee: I want to clarify that none of the RX was changed here. We added the F codes but did not check for other RX based on those conditions. To the extent that the current RX are useful that would be included, but if other RX are needed that are not included

Keith: Is this based on age limit or is the DX code being included as well?

Peter: there is no option to include specific ages or conditions, but we calculated weighted average copays based on these decisions.

We estimated based on the specifics of the proposal with the lower cost sharing.

Keith: the issue of ID the DX at the P of sale. Would the AV be impacted by DX codes.

Peter: No the way we modeled this. If you are 18 and under and have one of the RX, it was covered at zero in our estimates because there is no way to tie to DX code.

Keith: that's helpful

Leighton: that was one of the reasons why we put some limits on RX because some are used for other conditions more frequently. WE hope that

This is why carriers still have flexibility under their plans as they did with diabetes

Keith: as a carrier this leads me towards the simplest option which is just to cover the RX on the list with no cost share to avoid admin issues for the member

Peter: that was the last one we had to go over

Ellen: removing the 2 RX classes had little to no impact on AV is that right?

Peter: I would need to go back, but I don't think it would have had a significant impact

Alex: do we have any data on % of population with 20+ visits

Leighton: we heard from the clinical experts that relatively few people were getting up to 20 visits, but can they confirm

Kellan: it was hard to pin down. The ranges are wide, but the median is around 6-10, but that also is impacted by the barriers to care we are trying to remove though this work

Sarah: we agree with Dr Baker. WE had some concerns about just basing on claims data due to barriers to care. Cost may be a significant barrier to care for people which may be a reasons for lower visits in claims

Cheryl: the copays we are looking at 40 pre-deductible for these plans

Leighton and Peter and Elle; They vary by metal level

Leighton; These would be substantial reduction on copays, even going to $10 is a reduction.

We wanted to turn to discussion about the issues before us today. I thought the easiest would be the scope of conditions.

It may be easier to communicate this and maybe easier to administer. It does increase the AV at least a modest amount

Speaking solely for me, I thought this was a reasonable trade off. What do others think?

Allison: first, thank you for modeling this. Its helpful to understand our options. I think it would help with some of our concerns around admins issues. Whether its limited or broader, we are still looking at an increase to deductible or MOOP. People with more health conditions would be required to pay more for their services. So when we are talking about equity we are lowing costs for some but raising costs for others in a similar population. This is a hard tradeoff.

Ideally we would make these changes without a trade off, but the impact on solver is hard.

Leighton that is a good point. Even in gold and platinum the premiums may go up.

Allison: we don't know what kinds of increase we would need to make.

Cheryl: We should ask Council if they are willing to pay the difference.

Leighton: I think that would be a difficult ask

Cheryl: I Feel like I would like to vote conditionally today

Purvee; even if there were other sources of funding, it would be very difficult to do. Eg in another program we are implementing (for OSSE, childcare workers and their teams), the amount of work to administer free coverage is challenging.

Cheryl: Would it be possible to talk to the NM exchange where they have legislation on this?

Leighton: we do not have legislation here.

Purvee: we also look at what other exchanges are doing, but the operational lift for 2024 would be hard we can take a look for the future.

Leighton: is there some consensus to shift to all F codes vs the limited DX we were working with, recognizing the av impact of this? Is there any opposition?

[silence}

We will need to see what the whole package looks like. I am taking silence that people are ok with this approach.

Allison pointed out that everyone will need to bear the offsets for this benefit for children.

But that is what the SJ WG asked for.

Are we ready to move to the next issues?

The next issue is age limits: we had been working with the proposal to go thought age 18. We had discussion about raising to a higher age. Is the 19th bday cut off arbitrary and should we raise this age cut off up?

The age 18 cut off was cut off with other exchange policies and some Medicaid eligibility. MH issues go up, so it's a little arbitrary to pick an age

Cheryl: I think we should go thought age 20. These people are going through changes and they face financial challenges.

Janice: thought go up to age 19 as a compromise to be consistent with other policies

Leighton: so you mean up to age 19?

Janice: Yes

Leighton: others?

CF: It would be good to be consistent with the ACA

Leighton: do we have consensus around age 19 cut off?

Cheryl: I do feel strongly about this

Purvee; peter do we have any idea what the F codes would do on AV if we went through age 20?

Peter: [ ]

Leighton: every time you add a year you add 0.1 or 0.2 to the AV

Cheryl is saying she wants this to go higher. Where are others? It doesn't sound like we have a clear consensus around up to the 19th birthday (up to in including n18)?

Alana in Chat: For clarification, DC Medicaid coverage for children is through 20. It has been pointed out that transitioning 18 and 19 year old to adult care is difficult, and can be difficult to find providers talking those ages.

[silence]

I think that is right. For now we will put a pin in that, recognizing we do not have consensus

The last issue we can go through today is the copay issue $0 to $10. I have expressed my preference for $10 copay with no copay for RX. My reason is the limited number of providers. Squeezing out Medicaid kids

$0 is better from a consumer perspective, but we charge fees to have consumers recognizing the cost

I will open this up to the group:

Alana: when we look at our provider base there is a difference between providers that focus on Medicaid populations vs those taking private pay. There is not as much overlap as you might think

Laura: I would recommend the no copay because this is a big barrier to access to care. We are not going not going to solve the provider issuer here so we should do the best that we can for the exchange consumer

Kellan: WW would concur with the no copay

Leighton: any carriers?

CF was leaning towards having a copay. And maybe varying copay by metal level to minimize the deductible increases

Leighton: We were thinking $10 across the board but are you thinking of varying copays across metal levels.

CF: gold and platinum would end up having lower copays

Purvee: around simplicity its easier to have a single copy amount. Varying by metal level is not something we were contemplating for this specialized program. Be easier to make it the same.

CF: I get that point

Leighton: We are almost at 1 so we will write up of were we are not so you can take it back to your colleagues for hopefully final decisions next week.

Purvee: I know people have said they are talking inside their organization. We really need the feedback next week

We will need the next meeting to get a 2-hour block to try to get to the end on this

Can folks send where they are on the copay issue, that would be helpful for us to see where a draft might land at this point.

Leighton: we will get you the write up as soon as we can and we will see you again next week.

Purvee: Please let us know if you have any conflicts next week so we can make sure we have everyone represented. Proposing 12-2 next week. And please send your feed back