November 2, 2023

Recommendations of the Standard Plans Advisory Working Group to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Standard Plans Advisory Working Group (SPWG), Dania Palanker, Chair. The Working Group's charge was to modify the standard benefit plan design for appropriate metal level tiers to continue to implement the recommendations of the Executive Board's Social Justice and Health Disparities Working Group.

Background

For Plan Year 2025, the SPWG was tasked with continuing to implement the recommendations of the Social Justice and Health Disparities Working Group (SJHDWG) (as approved by the Board in its July 14, 2021 Resolution). In the first year of implementation of the SJHDWG recommendations, the SPWG developed -- and the Board adopted -- the recommendation to eliminate cost-sharing for certain services, medications, and diabetic supplies for people with Type 2 diabetes [SPWG Report of March 7, 2022; Board Resolution adopted March 9, 2022].[1] A resolution also was adopted to make standard plans available in the small group market. In the second year of implementation, the Board adopted the resolution to reduce cost-sharing for pediatric mental health services [SPWG Report of March 6, 2023; Board Resolution adopted March 8, 2023]. The relevant recommendation is as follows:

> Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and copayment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.

[1] This recommendation built on the $0 cost-sharing for insulin and diabetic supplies implemented in individual market plans in Plan Year 2022 [SPWG Report of February 5, 2021; Board Resolution adopted February 10, 2021].

- HBX Standard Plan Working Group to review and develop for consideration a Value Based Insurance Design to support adherence for patients with chronic conditions. The Social Justice and Health Disparities Working Group recommends the following prioritization of conditions to be assessed for AV and premium impact by the HBX Standard Plans Working Group: (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and (2) for pediatric population-- mental and behavioral health services.
- Waiver of cost-sharing is only for the underlying condition and does not include comorbidities. For example, for an enrollee with diabetes, heart disease treatment would continue to have cost-sharing. Additionally, cost-sharing may be waived for HSA compatible, high deductible health plans only to the extent permitted by federal law. Insurance plan design changes are limited to AV standards approved under federal law.
- Health plans are encouraged to evaluate impact of design changes on enrolled population and provide periodic updates on trends to DCHBX. Furthermore, health plans are encouraged to expand their current health equity support and pilot programs to include patients for whom there will be no cost-sharing for treatment of certain specific conditions. Because product design changes will require provider education, DCHBX shall include in their budget funding for provider education in consultation with the health plans.
- New insurance design should apply to standard plans in the individual marketplace. DCHBX must also develop new standard plan design, which must include this new insurance design, for the small group marketplace to be offered for plan year 2023.

SJHDWG Final Report, pp. 35-36.

In this third year of implementation of the social justice recommendations, the SPWG was charged with making recommendations to modify the standard plan designs (for plan year 2025, in both IVL and SHOP) to eliminate cost-sharing for cardiovascular disease (CVD).[2] Specifically, SPWG's goal was to impose no cost-sharing for CVD prescription generic drugs and certain CVD services for standard plans starting in PY25.

Over the course of 7 meetings in the fall of 2023, the SPWG considered treatment scenarios CVD based on prevalence in the District.

All of the working group's documents, including meeting notes for the 7 meetings held in the fall of 2023, can be found on the SPWG page on the HBX website.

[2] The Social Justice and Health Disparities report lists both cardiovascular disease and cerebrovascular disease. The workgroup included both conditions, noting that cerebrovascular disease is a subset of cardiovascular disease.

Introduction

Actuarial Value Calculator

HBX is committed to addressing health disparities and getting to equity in health coverage and care. The SPWG is the group trying to implement HBX' vision. Although SPWG is supportive of efforts to reduce health disparities regarding CVD and would like to continue to transform the standard plans to equity-based benefit design, the reality is that implementation of the actuarial value standards of the ACA through the actuarial value calculator (AVC) requirements is a major problem. CMS developed the AVC a decade ago before there were focused efforts by states to address disparities in health outcomes through benefit design. The SPWG discussions reflected that the group is loath to implement any cost-sharing increases in the bronze plan. The discussion centered around the idea that if the Board chooses to go forward with the equity plan design regarding cardiovascular disease, Option 2 below is the "least bad" of the options. It also leaves the most "wiggle room" when the new AVC comes out and we have to rerun the plans through the new AVC. A carrier member of SPWG was argued that increasing the cost of generic drugs in the bronze plan ran counter to our equity goals in that we are financing our equity objectives by increasing cost-sharing for people with other disorders.

Discussion

Whitman Walker Institute:

To provide some initial direction for this work, HBX staff consulted with experts at the Whitman-Walker Institute (WWI) to undertake the analysis of publicly available information on CVD, a review of clinical guidelines, and to conduct qualitative interviews with mental and medical health providers to produce clinical treatment scenarios conditions to inform the standard plan benefit design. HBX staff also consulted with cardiologist, William B. Borden, M.D., Interim Chair of Medicine and Chief Quality and Population Health Officer, Professor of Medicine and of Health Policy and Management, GW Medical Faculty Associates. Dr. Borden presented to the SPWG on CVD common risk factors, national and local disparities in CVD disparities in treatment and rates of death.

For communities of color, WWI identified structural racism as a fundamental driver of disparities in CVD across the United States and the District. Namely, poverty, housing instability, violence, and other social determinants of health, contribute to chronic stress and CVD among people of color nationally. Specifically, in the District of Columbia, barriers to access of fresh food, community violence, use of tobacco, and high blook pressure play critical roles in the disparate rates of CVD for communities of color.

WWI advised the SPWG that, since cerebrovascular disease and cardiovascular disease share the same risk factors, they focused on CVD for the purposes of their clinical review of publicly available guidelines. Namely, guidelines issued by the American Heart Association (AHA)

recommend the regular CVD evaluation for all adults ages 40-70, and the pursuit of nonpharmacological interventions, such as increased physical activity and a healthy diet prior pharmacological intervention. Namely, WWI identified Medical Nutritional Therapy (MNT), a program that encourages a healthier diet, as a major CVD intervention. However, there would be a significant barrier to cost since health insurance usually covers MNT as treatment for diabetes, but not for CVD. Further, WWI included similar American Heart Association recommendations around CVD which target high cholesterol, post-cardiac events, and smoking cessation.

WWI interviewed both mental and mental health providers on the risk and the barriers for treatment of CVD. Based on their experiences, the providers identified costs as the major barrier to treatment as patients a substantial portion of patients treated for CVD have been unable to seek care or delayed care due to financial reasons. Therefore, WWI recommends that the DCHBX consider, to the degree possible, establishing zero cost-sharing for classes of medications to the classes of medication that treat hypertension, high cholesterol, tobacco use, and CVD post cardiac event.

William B. Borden, M.D.:

Dr. Borden, a renowned cardiologist, gave a presentation to the SPWG titled " Advancing Equity through the DC Health Benefit Exchange." Like WWI, Dr. Borden opined that there is a high financial burden linked to forgoing or delaying CVD care in heart disease patients. He identified smoking, high cholesterol, high blood pressure, obesity, diabetes and nutrition among the most common risk factors and discussed troubling disparities in CVD among district residents based on race and ethnicity.

Dr. Borden recommended the elimination of copays after a heart attack, giving payment vouchers for prescription coverage after a heart attack, and eliminating copays for patients at high risk of CVD as measures that will chip away at the disparities in CVD. Specifically, Dr. Borden opined that the overall impact of combined reduced cost-sharing on medications, visits, procedures, tobacco cessation, home blood pressure monitoring and cardiac rehab will lead to positive CVD in terms of equity. Throughout the course of meetings and discussions, the SPWG requested several analyses of the impact of the benefit designs on the AVC by metal level. These analyses can be found on the SPWG webpage.

AV Analysis

HBX actuarial consultants, Oliver Wyman (OW), advised the SPWG on the actuarial considerations around ensuring standard plan compliance with the US Department of Health and Human Services (HHS) AVC. The AVC is updated yearly. HHS's PY 2024 AVC is the most recent AVC available. Therefore, OW's analysis is based on the PY 2024 calculator. OW amend its analysis after HHS releases the PY 2025 AVC.

First, OW ran a test run of the impact of no copay for standard plans for its impact on the AVC. Those results are below:

We have performed the updated analysis to estimate the impact of including the services previously provided by Whitman Walker for cardiovascular disease. The impact was estimated individually for each row of services from slide 11 of the deck from Whitman Walker and for the combination of all services. The services were only included at $0 member cost sharing if their primary diagnosis code was included in the list provided on slide 8 of the deck from Whitman Walker. Each row of services was added onto the prior 2025 plan analysis we performed and the results are summarized below:

Plan	Current 2024 Plans	Prior 2025 Plan Analysis	Plus 1st Row	Plus 2nd Row	Plus 3rd Row	Plus 4th Row	Plus All Rows
Platinum Plan 2024	91.72%	91.76%	91.77%	91.77%	91.76%	91.76%	91.77%
Gold Plan 2024	81.87%	81.88%	81.88%	81.88%	81.88%	81.88%	81.89%
Silver Plan 2024	70.46%	70.71%	70.72%	70.71%	70.71%	70.71%	70.73%
Bronze Copay Plan 2024	64.95%	65.33%	65.35%	65.34%	65.33%	65.33%	65.35%

The impact, compared to our prior analysis, are summarized below and the impact ranges from 0.00% to 0.02% depending on the plan and scenario:

Plan	Plus 1st Row	Plus 2nd Row	Plus 3rd Row	Plus 4th Row	Plus All Rows
Platinum Plan 2024	0.01%	0.01%	0.00%	0.00%	0.01%
Gold Plan 2024	0.00%	0.00%	0.00%	0.00%	0.01%
Silver Plan 2024	0.01%	0.00%	0.00%	0.00%	0.02%
Bronze Copay Plan 2024	0.02%	0.01%	0.00%	0.00%	0.02%

The tables above show that offering certain CVD Rx drugs and services at $0 copay would push the bronze out of compliance with the AVC. Therefore, the SPWG searched for a solution that would make the bronze plan more equitable, in compliance with the SJHDWG recommendations, while ensuring compliance with the AVC.

To that end, OW initially did a test run of the $25 copay for generic drugs in search for the bronze standard plan tipping point. Assuming all generic drugs would be subject to a $25 copay, OW searched for the impact by introducing increments of $0.50. The results yielded a result of 0.07%. Based on the results, OW opined that there does not seem to be a tipping point for bronze plans.

Consequently, the SPWG inquired what a copay would need to be for a bronze plan that was not in compliance. OW advised that the copay would likely have to be between $22.60 and $25, but, even with those copays, there would not be much movement in terms of impact on the PY 2024 AVC without making any other adjustments. OW further pointed out that the biggest impacts on the AVC include deductible, coinsurance and maximum out of pocket. In search of a tipping point for bronze plan compliance with the AVC, the SPWG requested that OW conduct analysis based on generic drug copay impact only. The basis of the list of generic drugs was identified by WWI and offered by the Massachusetts Connector's standard plans. OW later updated the SPWG that it ran generics at both $5 and $10 copays with little to no impact on the AVC. OW presented the SPWG with three options that would minimally impact the AVC. However, all three options would result in an increase in either maximum out of pocket or copay. Those options are:

Alternatives to bring the Bronze Plan within the de minimis AV range (65%):

OPTION 1:

- **Increase the maximum out-of-pocket from $9,150 to $9,400 (+$250)**
- **Metal AV = 64.93%**

OPTION 2:

- **Increases the generic drug copay from $25 to $30 (+$5)**
- **Metal AV = 64.75%**

OPTION 3:

- **Increase the copay for the following service categories:**
  - **PCP: $45 to $55 (+$10)**
  - **Specialist: $105 to $125 (+$20)**
  - **Office Visit Mental Health/Substance Abuse: $45 to $55 (+$10)**
- **Metal AV = 64.92%**

Considerations related to cost-sharing

Some workgroup members expressed concern about increasing the maximum out of pocket and cost-sharing for CVD. Specifically, one carrier participant of the SPWG stated that the generic forms of the drugs are already low cost. The carrier participant further stated that we should look at the list of services to determine which services have the highest AV impact and leave the copays the same for those services (i.e. drug cost-share) to avoid the need for cost-sharing increases. The carrier participant stated that the wrong decision could undercut plan equity. Some carriers who were concerned about the $0 cost-sharing observed that the proposed benefit design changes are likely to have pricing impacts resulting from the increase to the actuarial value of the plans. The standard plans are more expensive than some other DC Health Link plans, and carriers expressed concern that the PY 2025 changes would add upward pressure on premiums for standard plans and potentially drive the populations we hope to benefit from being able to purchase the plan. Although the group primarily considered the impact of changes on AV limits under federal regulations, which had the strongest effects for silver and bronze plans, it was noted that the changes would increase costs for all plans and likely increase premium cost.

Prescription drug classes and selected drugs covered; attendant services

There was discussion of the appropriateness of the drug classes, drugs within those classes, and other selected drugs proposed for $0 cost-sharing for CVD drugs and attendant services recommended by WWI. In general, carriers preferred a policy that permitted some flexibility in the implementation of the prescription drug $0 cost-sharing. One carrier proposed that $0 cost-sharing be applied only to generic drugs within the identified prescription drug classes.

In its report, WWI recommended that certain services also be provided at $0 cost-sharing. OW determined that adding those services as recommended affected the AV of the plans by only 0.00% - 0.02% depending on the plan.

Originally, WWI had recommended both “Infectious Disease” and “Cardiology” in its list of services in Table 4 below. However, after discussion, the working group members agreed that

the approach should be similar to the one we took when addressing diabetes, and stay with primary care services.

A carrier requested requested removal of the following from Table 2: Medication Classes/Groups

- **PCSK9 inhibitors:** These are not considered first or even second line therapy. Positioning one agent with $0 cost share would drive utilization when many other options exist.
- **(Eliquis) from anticoagulants (i.e., just leave it at anticoagulants)**: There are other preferred Rx in this class.

HBX staff informed the group that it researched PCSK9 is new and expensive. The working group agreed with the recommendation.

A carrier suggested amending the language in the "SP 2025 CVD" grid for clarity and state: *** A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, select drug classes, select agents within the drug class, and a select list of hypertensive medications within the drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary. The working group agreed with the recommendation.

The tables below reflect WWI's recommendation as adjusted by the above discussion.

Appendix: All Medications and Services Related to the Prevention and Treatment of Cardiovascular Disease

Table 1: ICD Codes

Condition	ICD-10 Code	Code Description
Cardiovascular disease	I11	Hypertensive heart disease
	I20-25	Ischemic heart diseases
	I26-27	Pulmonary embolism and other pulmonary heart diseases
	I30-52	Other forms of heart disease
	I70-79	Diseases of arteries, arterioles, and capillaries
Cerebrovascular disease	I60-69	Cerebrovascular disease
Tobacco use	Z72.0	Tobacco use
	F17	Nicotine dependence

Table 2: Medication Classes/Groups

Condition	Medication Classes/Groups at Zero Cost-Sharing
Hypertension	Thiazide diuretics Calcium channel blockers Angiotensin-converting enzyme (ACE) inhibitors Angiotensin receptor blockers Beta blockers
Hypercholesterolemia	Statins Cholesterol absorption inhibitors
Tobacco use	Nicotine replacement therapies Antidepressants (only Bupropion) Nicotine receptor partial agonist (Varenicline)
Post-event care	Aspirin (NSAIDs) Beta blockers Platelet inhibitors (Plavix) Anticoagulants

Table 3: Laboratory Tests

Laboratory Tests at Zero Cost-Sharing	CPT Code
Blood pressure reading (by a physician or self-monitoring)	99211, 99473, 99474
Urinalysis	81000, 81002, 81003
Blood cell count	85025, 85007
Blood chemistry	80053
Lipid panel	80061
Nicotine test	80307, 80323
Troponin testing	84484, 84512
Imaging at Zero Cost-Sharing	**CPT Code**
Electrocardiogram	93000, 93005, 93010
Computerized tomography (CT) scan	70450, 70460, 70470

Table 4: Treatment Scenarios

Table 4: Treatment Scenarios

Unlimited New and Follow Up Visits at Zero Cost-Sharing

Visit Type	CPT Code	Service Type	Specialty	Description
New, follow up	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99441, 99442, 99443, 93798, 93797	Primary Care	Internal Medicine/Family Medicine	New medical visit; New patient, screening/assessment; Evaluation and management; cardiac rehabilitation
New or Follow-up	99211, 99473, 99474, 81000, 81002, 81003, 85025, 85007, 80053, 80061, 80307, 80323, 84484, 84512, 93000, 93005, 93010, 70450, 70460, 70470	Primary Care	Internal Medicine/Family Medicine	Laboratory tests and/or imaging
New, follow up	99406, 99407, 99078	Counseling	Smoking and Tobacco Cessation Counseling Visits	New patient, screening/assessment, follow up
New, follow up	97802, 97803, 97804	Medical Nutrition Therapy	Medical Nutrition Therapy	New visit, follow up and management

AV offsets considered:

Other options were on the table. The group discussed increasing deductibles or MOOP to offset AV increases outside of the permissible actuarial value ranges for metal levels as presented by OW.

Recommendation

The SPWG had discussed that of the three previously listed options Option 2 seemed to have the most impact on the AVC with the least deleterious effect to consumers. On October 24, 2023, the SPWG met to consider Option 2. The discussions centered around the idea that if the Board chooses to go forward with the equity plan design regarding cardiovascular disease, Option 2 below is the "least bad" of the options. It also leaves the most "wiggle room" when the new AVC comes out and we have to rerun the plans through the new AVC. One carrier SPWG member disagreed and did not like any of the options. That member stated that the carrier objects

to Option 2, noting that generic drugs are one of the most important plan benefits for preventing and managing chronic conditions, and the increased cost share for Tier 1 drugs will be the highest among Exchange standardized plans in the Bronze tier in VA, MD and DC. The carrier stated that the vote is a policy choice, not a legal requirement. Therefore, consensus was not reached. The nonconsensus preferences will go to the HBX Insurance Market Committee for deliberation and vote, and then to the HBX Executive Board if approved by the Insurance Market Committee.

Other Discussion Elements

Some other elements of the proposal that were discussed and are important to note.

- **Implementation Flexibility:** HBX made assurances to work collaboratively with carriers as they develop these plans should they encounter additional operational challenges. The flexibility with respect to prescription drugs has been noted.

- **Compliance with Federal and State Laws.** The policy is premised on compliance with applicable federal and state laws. HBX will work with carriers to ensure compliance.

- **Evaluation:** Workgroup members acknowledge the importance of proceeding with this social justice policy goes hand in hand with evaluation on the effects of the lower cost-sharing to determine whether it is reducing barriers to access and narrowing racial, ethnic, and other disparities.

SPWG Members and Staff

LAST NAME	FIRST NAME	Organization
Palankar	Dania	Georgetown University, SPWG Chair
Jensen	Carla	Aetna
Pankow	Jenifer	Aetna
Bailey	LeeAnn	Aetna
Parcham	Cheryl	Families USA
Davis	Janice	Living Capital
Lake	Keith	AHIP
Hathaway	Kris	AHIP
Blake	Nikki	CareFirst
Barlow	Yulondra	CareFirst
Vayda	Kerry	CareFirst
Lucado	Dwayne	CareFirst
Barlow	Yulondra	CareFirst
Bream	Cory	CareFirst
Orlesky	Peter	CareFirst
Sucher	Greg	CareFirst
Ongwen	Sam	KP
Chuang	Stephen	KP
Mangiaracino	Allison	KP
Young	Theresa	KP
Blecher	Keith	UHC
Raymond	Michelle	UHC
Akier	Daniel	UHC
Chandrasekaran	Dave	Voter Empowerment
Beard	Andre	HBX
O'Brien	Ellen	HBX
Senkewicz	MaryBeth	HBX
Liebers	Howard	DISB
Borden	William	GW Faculty Associates
Adomshick	Mary	Oliver Wyman
Scharl	Peter	Oliver Wyman
Feleke-Eshete	Lienna	Whitman-Walker