SPWG Notes, Meeting 1, September 12, 2023

Attendance:

LAST NAME	FIRST NAME	Organization
Palanker	Dania	Georgetown University, SPWG Chair
Jensen	Carla	Aetna
Pankow	Jennifer	Aetna
Vayda	Kerry	Aetna
Weber	Joni	Aetna
Speidell	Paul	Aetna
Hathaway	Kris	AHIP
Barlow	Yuolondra	CareFirst
Lucado	Dwayne	CareFirst
Neimiller	Jason	CareFirst
Orlaskey	Peter	CareFirst
Sucher	Greg	CareFirst
Parcham	Cheryl	Families USA
Chuang	Stephen	KP
Le	Ky	KP
Young	Theresa	KP
Mangiaracino	Allison	KP
Davis	Janice	Living Capital
Blecher	Keith	UHC
Chandrasekaran	Dave	Voter Empowerment
Liebers	Howard	DISB
Beard	Andre	HBX
O'Brien	Ellen	HBX
Senkewicz	MaryBeth	HBX
Adomshick	Mary	Oliver Wyman
Scharl	Peter	Oliver Wyman
Feleke-Eshete	Lienna	Whitman-Walker

Discussion:

Standard Plans Working Group (SPWG) Chair, Dania Palankar introduced herself to the meeting participants, discussing her prior experience with the DC HBX, specifically the SPWG.

Dania then opened the floor for introductions of all meeting participants which included the DC HBX staff: Ellen O’Brien, MaryBeth Senkewicz and Andre Beard. DISB was represented by Howard Liebers, Policy Advisor and Supervisory Insurance Examiner. The call also included actuaries, consumer advocates (Whitman Walker and Families USA) and representatives from all

carriers including carrier actuaries, compliance, state and local government, and products professionals. Oliver Wyman (OW) was represented by Peter Scharl and Mary Adomshick.

Dania discussed this season's SPWG working group priorities, including goals and timelines in implementing the next recommendation of the Social Justice & Health Disparities Working Group (SJDWG). Specifically, the SPWG will work to implement the SJDWG working group's recommendation around cardiovascular disease (CVD) in implementing cost-sharing reforms to address disparities by race and ethnicity in CVD incidence, prevalence and outcomes. Dania asked the participants if they thought there were other areas of focus the SPWG should put on its radar for the future.

Keith Blecher (UHC) asked whether HBX has information to share about how the standard plan design we have approved in the past is working, and what kind of data HBX has collected.

Ellen O'Brien indicated that we do not have a data collection, but that HBX can come back to the group at a future meeting about how we are thinking about evaluation of the equity-based benefit design going forward. She also noted that carriers are encouraged to weigh in, at any time, about their perceptions about any implementation or operational challenges since it will take some time to understand the effect of the equity-based design on access to care, utilization, and outcomes.

Ellen provided a brief overview of the equity-based benefit design for PY 2024.

DC Health Benefit Exchange 2024 Standard Plans

Equity-focused benefit design

People with a diagnosis of Type 2 Diabetes

$0 copays for:

Primary care visits
- Dilated retinal exam (1x per year)
- Diabetic foot exam (1x per year)
- Nutritional counseling visits (unlimited)

Lab tests
- Lipid panel test (1x per year)
- Hemoglobin A1C (2x per year)
- Microalbumin urine test or nephrology visit (1x per year)
- Basic metabolic panel (1x per year)
- Liver function test (1x per year)

Prescription drugs
- Preferred brand insulin (one or more, as defined by the carrier)
- Diabetic agents (defined by the carrier)

Diabetic supplies
- A select list of diabetes supplies (defined by the carrier)

Children and adolescents with a mental health condition (aged 18 and younger)

$5 copays for:

Primary care, specialist, and mental health counseling (no cap on $5 copay visits, but subject to medical necessity)
- New medical visit;, screening/assessment; Evaluation and management; Psychotherapy crisis; Individual therapy; Family/Group therapy.

Prescription drugs
- SSRIs, SNRIs, Atypical antidepressants, Atypical anxiolytics, Anti-manic agents, Stimulants, GnRH analogs, Sex hormones, Non-steroidal anti-androgens, 5-alpha reductase inhibitors (drugs in each of these classes, as defined by carrier)
- Other medications: Prazosin, Clonidine, Guanfacine, Quetiapine, Aripiprazole, Brexpiprazole, Lurasidone, etc.

Lab tests and related services (for children and adolescents with gender dysphoria taking selected medications)
- Testosterone, estradiol, blood panel, comprehensive metabolic panel, Lipid panel, DEXA scan, bone age x-ray, etc.

Keith Blecher also asked whether HBX has received any feedback on the equity-based benefits from people enrolled in standard plans. Are they satisfied with what they are getting? Are the benefits being administered to them as expected? Are there complaints coming in, in terms of operations, with regard to these plans?

Ellen agreed that it is a great question and that HBX staff would follow up with their colleagues in operations to ask about the consumer-facing information on the equity-based design, and to learn about what they have heard from applicants and enrollees about the standard plan

designs, including reduced cost sharing for drugs, items, and services used by people with type 2 diabetes.

<u>Presentation: Dr. William Borden, MD (Cardiologist and CVD Policy Expert)</u>

Dania introduced Dr. William Borden, Professor of Medicine and Policy and Chair of Medicine at George Washington University. A renowned cardiologist, Dr. Borden's presentation centered around the importance of CVD treatment, prevention, and risk factors.

Dr. Borden explained that there is a tremendous burden of cardiovascular disease. When we talk about cardiovascular disease, we're talking about heart attack, stroke, and peripheral artery disease. We put these together under this rubric of cardiovascular disease, because the risk factors are similar. We think of these together, because if we can address the underlying causes, then we can hopefully address cardiovascular disease as a whole.

It's the number one cause of death in the United States. And that doesn't even account for the disablement, the discomfort, the other complications that can come even when people survive their cardiovascular disease events. It's a tremendous part of US healthcare costs about 12%.

It's also a burden on people individually. A study from 2019 published the American Heart Association Journal showed that individuals with a high financial burden they're linked to either foregoing not getting it all or delaying care.

Risk factors for CVD include smoking, high cholesterol, high blood pressure, overweight, obesity, diabetes, but then also physical inactivity and nutrition, and sleep and poor sleep has become increasingly recognized as a risk factor for cardiovascular disease.

We also see tremendous inequities around the country and in DC. So, when we look nationally, at death rates from heart disease, by race and Hispanic origin, you can see that individuals who are black non-Hispanic have the highest rates than people who are white, non-Hispanic, and then people who identify as Hispanic and then people identify as Asian Pacific Islander or non-Hispanic.

Even with the decline in mortality, we still see this disparity nationwide.

Here in DC, there also are wide disparities by race and ethnicity. Adults who experience coronary heart disease, and you can see it the darker blue, the highest rates, you know, in Ward seven, and eight, and some other pockets throughout the city, but also correlating with where we demographically see more of our fellow DC residents who are people of color

We know we can reduce disease and morbidity from heart disease. Over a 20-year period, the US saw a 50% reduction in deaths from heart attack. 50% of this came from treatment. So, things like, you know, stenting, when someone has an acute heart attack, or treatment for a heart failure. But 50% of this was from prevention. We can prevent this from happening.

When you look at that 50% prevention, and you see the different components, the biggest component was around reducing cholesterol levels on a population scale, then reducing blood pressure levels, then reducing smoking, then reducing sedentary lifestyles

What can we do, as we think about this from the perspective of the Health Benefits Exchange? There have been a couple which have looked around co pays for medications. The MI-three study from 2011, looked at eliminating co pays for patients after a heart attack. So, patients had a heart attack, they were prescribed heart medications, and they were randomized to either for prescription coverage, they had nothing to pay out of pocket for their heart medicines, or whatever their usual prescription coverage wise. And what this study found was that the individuals had better medication adherence, they took more of their medications. They saw a lot of difference in the secondary endpoints -- the group with full prescription coverage (no cost sharing) had fewer major vascular events or revascularization.

An even more recent study was one that came out this year, which looked at not just patients who had had a heart attack in the past, but patients who are at high risk for heart attack and eliminated their copays. Again, there was better medication adherence.

To summarize: We have very effective interventions, both to prevent and treat cardiovascular diseases. The randomized control trials that have kind of limited medication cost reduction showed a modest improvement adherence, and on some secondary endpoints have improved outcomes, and we know improved adherence with medications reduced the risk of heart disease.

I think if you looked at an overall program where you combined reduced cost sharing for a combination of medications, visit, procedures, tobacco cessation and blood pressure monitoring, cardiac rehab--which is highly underutilized of nationwide—we may see an impact that's beneficial on overall health outcomes and costs as well. I'm happy to take any questions.

Dr. Borden opined that the lack of cardiac rehabilitation centers should be explored as cardiac rehabilitation is a major factor in CVD equity in the District. He further stated that GW is building a new hospital with a cardiac rehab center in the District that would increase access to care for vulnerable District residents.

Kerry Vayda (CareFirst) asked Dr. Borden whether prevention-- rather than a reduction of co-pays for treatment for people with CVD-- should be the focus of the group's equity work. Dr. Borden stressed that the focus should be on both; he said CVD needs to be attacked on all sides because the most impact is made when the approach is comprehensive.

Dr. Borden also stressed that low re-imbursement rates for providers are a major issue, which is why there aren't many cardiac rehab facilities in the District. He reiterated that, even with the addition of GW's new cardiac rehab, the lack of rehab centers is a major issue and that the issue should be explored.

Dania Palanker noted that one issue people face with cardiac rehab is visit limits that apply across all rehab. She noted that insurers often will expand the limits if requested in a situation where it's medically necessary. She wanted to know whether the SPWG would get into the question of whether the plan limits, or how a plan limits, the number of visits.

MaryBeth Senkewicz stated that we will research the question as there may be EHB and AV implications on the imposition of limits.

MaryBeth asked Dr. Borden to discuss the tiering of CVD drugs and its impact on the CVD co-pay implementation. Dr. Borden said some tier 2 and 3 drugs are very expensive with higher co-pays. For example, some medications, like Jardiance, are the pillars of CVD treatment right now. The drugs are covered but, due to their tier, are attached to very high co-pays. In other words, out of pocket costs can be very high for evidenced and branded meds.

In closing, Dania reminded the participants that their input is necessary and highly encouraged as we implement the CVD reduction in co-pay.