

Vermont Exchange Advisory Group Meeting 9

February 13, 2012

MINUTES

Present: Peter Sterling (VT Campaign for Health Care Security), Trinka Kerr (VT Health Care Ombudsmen), Catherine Hamilton (Blue Cross and Blue Shield of Vermont), Sonia Tagliento and Susan Bauer (MAXIMUS), Susan Gretkowski (McLean, Meehan and Rice for MAXIMUS and MVP), Theo Kennedy and Anthony Otis (Otis and Kennedy), Jill Olson (Vermont Association of Hospitals and Health Systems), Betsy Bishop (Vermont Chamber of Commerce), George Richardson and Elizabeth Cote (Vermont Dental Society) Lucie Garand (Downs, Rachlin and Martin), Timothy Ford (VIAA and Hackett & Valine), Jill Sudhoff-Gueria (KSE); Abe Berman (Vermont Managed Care), Barbara Beaty (Hewlett Packard), Casandra Gekas (Vermont Public Interest Group), April Tuck (CHSI), Craig Fuller (Keller and Fuller), Floyd Nease (VAMH), Jill Olson (VAHHS), Justin Pentenrieder (Cancer Society), Ken Liebertoff (self), Meg O'Donnell (FAHC), Molly Turco (Dartmouth), Peter Cobb (VAHHA) Rep Sarah Copeland Hanzas, Tom Rugg (HB Benefits), Tom Scull (Richardson Group)

Staff and consultants: Lindsey Tucker, Betsy Forrest, Kevin Veller & Mark Larson (Department of Vermont Health Access) Robin Lunge and Ena Backus (Agency of Administration), Nolan Langweil (Joint Fiscal Office), Steve Kimbell, David Martini, Spenser Weppler, Jessica Mondizabal (BISHCA), Lawrence Miller (Agency of Commerce), Les Birnbaum (Department for Children and Families), Beth Waldman, Brendan Hogan and Kate Bazinsky (Bailit Health Purchasing)

I. Welcome and Introductions - Lindsey Tucker, DVHA Deputy Commissioner for the Exchange and Mark Larson opened up the meeting and asked that the group introduce themselves.

II. Updates

Connections to Green Mountain Care Board

Robin indicated that one of the goals from the meeting was to have a plan design recommendation presented to the Green Mountain Care Board on Thursday February 16, 2012. This benefit design discussion would also be further discussed at the February 27, 2012, Exchange Advisory Board meeting and the March 1, 2012, Green Mountain Care Board meeting.

The goal would be to have the Green Mountain Care Board vote on a benefit design by March 1, 2012. Lindsey Tucker will be sending out 2 RFIs this week. One RFI will be sent out to the insurance community and one RFI will be sent to the broker community asking both groups for information that can assist the state with planning for the Exchange.

Contract assistance with exchange implementation planning

Lindsey indicated that 5 contracts have been signed to have vendors assist the state with additional planning work for the exchange. A request was made to post contracts from vendors on the state website.

State staff will be hired to assist with the following areas: policy development, legal, project management, information technology, education and outreach. If any of the steering committee members have people in their professional network that they want to recommend, or have questions about these job openings, please contact Lindsey at Lindsey.tucker@state.vt.us.

H-559 update

H-559 is in the house health care committee and is expected to be voted out of committee this week. The recommended change to small employer definition from 50 to 100 or less will not be implemented until 2016 when the ACA requires this change. H.559 requires all individual and small group products to be sold in the exchange to make for a more vibrant exchange. A bronze plan will be added as a choice on the exchange. Employers have wanted bronze plans to be available, and since it is likely to be a federal requirement, the administration is recommending that the legislature allow for a bronze option.

A question was raised about federal multi-state plans. The current understanding is that the type of federal multi-state plans that will be offered and jurisdiction over these plans is still being debated by the National Association of Insurance Commissioners (NAIC) and the federal Office of Personnel Management (OPM). It appears that OPM may prevail on the issue of federal pre-emption issues related to exchange implementation. It is also understood that the federal government is looking at having a non-profit and a for-profit plan, and several plans are interested including Blue Cross Blue Shield, United Health Care, and CIGNA.

Federal RFP requirements from the Office of Personnel Management will be distributed to the advisory board as they are made available.

A question was raised about whether additional guidance has come out from the federal government about the Navigator program, and the answer is none thus far.

III. Comparison of Vermont Plans to Select an Essential Health Benefits Benchmark Plan (Katharine Reinhalter Bazinsky, Bailit Health Purchasing)

Kate reviewed the PowerPoint slides with the group and began the presentation.

State needs to select from four Benchmark Plan options:

1. Any of the 3 largest products in the small group market – MVP EPO and BCBSVT- Bluecare
2. The largest HMO operating in the state - BCBSVT
3. The state employee health benefits plan – CIGNA (TPA)
4. The federal employee health benefits plan – Bailit analysis did not include the federal employee health benefits plan, since the federal plan would not include state mandates.

Other factors to take into consideration include network issues and costs for employers and individuals.

A comment was made that a cost analysis should include costs for consumers and what is most beneficial for consumers. An additional comment was made that the platform for coverage should consider both PPO and HMO options since employers and consumers want choice of options.

It was noted that the benefits for small group and individual plans inside and outside of the exchange would have to be substantially equal to the benchmark plan; choice of a benchmark plan does not affect cost sharing, which determines metal levels.

Insurers are able to change quantitative limits and some of the specific services as long as the benefits are “substantially equal,” which is yet to be defined by the federal government.

A question was raised about whether Rule 10/Rule 2009-03 network adequacy requirements would continue, and the answer is yes, that a contractor will be looking at these connections.

A comment was made that the state could change its benchmark plan in 2015. The state must choose a benchmark plan for 2014 in the third quarter of 2012, or the largest small group plan (per enrollment in the 1st quarter of 2012) will be used as the benchmark plan by default.

A question was raised about where the decisions on plan design are made. The answer is the Green Mountain Care Board will make these decisions.

A comment was made that 60% of children are covered by Medicaid: how will that change in 2014? The number of individuals eligible for Medicaid will increase in 2014 with the individual mandate; enrolling more parents will also help to enroll children who are eligible but unenrolled today. Kate Bazinsky will come back on Thursday to present similar information to the Green Mountain Care Board.

Comments/Questions were raised about dental. The Vermont Dental Society indicated that people who have dental insurance coverage see a dentist twice a year about 80% of the time. Individuals who do not have dental insurance coverage see a dentist twice a year about 30% of the time.

Question: since pediatric dental policy is required to be included in any small group or individual plan sold after 2012 (either as part of the core medical benefits or as a mandatory rider), can there be adult-only dental packages offered on the exchange so that a family that already receives the pediatric dental through any plan could purchase an adult-only dental package for the parents as an add-on to the basic coverage? Dental must be included as an Essential Health Benefit for children (per the ACA), and we should continue to talk about the coverage available for adults and the impact that offering coverage to children only could have on consumer purchasing patterns.

A question was raised about whether the Essential Health Benefits constitutes a minimum level of coverage. The benchmark plan that is used to define the Essential Health Benefits package for the state is minimum coverage, but rather the required level of coverage. While the plans offered in the

small group and individual market may have some small differences around the specific services included and the specific restrictions included, the plans must be “substantially equal” to the benchmark plan. In other words, the plans cannot be significantly more or less generous than the benchmark plan.

A question was raised about the actuarial values of coverage.

1. Bronze coverage is at 60% actuarial value.
2. Silver coverage is at 70% actuarial value.
3. Gold coverage is at 80% actuarial value.
4. Platinum coverage is at 90% actuarial value.

The assessment as to whether offering a more generous benefits package is better for consumers is complicated by the question of the level of subsidies that the consumers receive. Individuals who are below 400% of FPL might want a very generous benefits package (because they get a federal subsidy and their premiums are capped; they therefore receive more benefits for their money). Those above 400% of FPL may want less generous benefits included since they won't receive a federal subsidy and will therefore have to pay higher premiums in to order to purchase the plan.

Comments were made that there are affordability issues for employers and trade-off costs for employees.

A suggestion was made to move the financial data and actuarial cost analysis forward as quickly as possible, since making a recommendation on quality and access issues alone is difficult.

The state indicated that it is hard to do actuarial analyses on open questions (such as the demographics of the pool that would be covered), but that they understand that cost is a significant issue and must be considered.

Other issues discussed:

- Selecting a plan by September 2012
- Providing the most generous plan that the state and federal government can afford
- Having an adequate network of providers.

Question was raised about whether all state mandates would be included in the plan requirements. Answer is yes, any mandate in existence now would be included in the plan requirements (since all of the options being considered include the state mandates), and any changes to add mandates at this point would increase the state's costs.

Discussion followed about having more details about the differences among the benchmark plan options at a future meeting.

Discussion and information should include more information about costs and coverage.

IV. Public Comment

No public comments were made.

V. Next Steps

- a. More information that was requested today and report to Green Mountain Care Board 3/1/12. More information needed from insurers at MVP and BCBS on customer issues, visit limit issues, prior approval issues, administrative costs to people and providers, and insurance costs.
- b. Implementation Plan--to be discussed at a future meeting
- c. Joint Medicaid & Exchange Advisory Board--to be discussed at a future meeting

The Medicaid Advisory board and the Exchange Advisory Board will be merged by July 2012. How these two boards will be merged will be part of discussions at future Exchange Advisory board meetings.

- d. Meeting schedule

Next meeting is scheduled for February 27, 2012.