

Vermont Exchange Advisory Group Meeting 11
April 30, 2012

MINUTES

Present: Bea Grause (Vermont Association of Hospitals and Health Systems), Randy Cook (Fletcher Allen Health Care), Susan Barrett and Danielle Hibbard (Bi-State Primary Care), Mark Hage (VT NEA), Dr. Julia McDaniel (McDaniel Chiropractic), Trinka Kerr (VT Health Care Ombudsman), Peter Sterling and Donna Sutton Faye (VT Campaign for Health Care Security), Don George and Catherine Hamilton (Blue Cross Blue Shield of Vermont), Betsy Bishop (VT Chamber of Commerce), Trey Martin (Downs, Rachlin and Martin), Mary Eversde (VIAA), Cheri L'Esperance (William Souldice and Associates), Karena Shipee (VOA), George Richardson (Pediatric Dentistry), Heather Caldwell (Xerox), Jamie Feehan (Primmer), Liz Cote (Dental Society), Betty Morse (Vermont Family Network), Floyd Nease and Path McCord Metcalf (VAMHAR), Heidi Tringe (MMR), Bill Little (MVP), Kelly Stoddard (American Cancer Society), Theo Kennedy (Otis & Kennedy, LLC), Jill Guerin (KSE Partners), Julie Tessler (VT Council of Development and Mental Health Services), Lynn Raymond-Empey (VCCU), Barry McPhee, Tom Scull (The Richards Group, Insurance & Financial Services), Tim Ford (Hackett Valine & MacDonald), Craig Fuller (Keller & Fuller), April Tuck (Copely Hospital), Scott DeLuca (Oracle), Abe Berman (Vermont Managed Care)

Staff and consultants: Lindsey Tucker and Betsy Forrest (Department of Vermont Health Access, DVHA), Robin Lunge (Agency of Administration), Eric Carrera (Vermont Health Benefit Exchange), Les Birnbaum (Department for Children and Families), David Martini (BISHCA), Dr. Karen Hein (Green Mountain Care Board), Julie Peper (Wakely Consulting), Alison Betty (GMMB), Melissa Morales (GMMB)

I. Welcome and Introductions – Lindsey Tucker opened the meeting and asked the group to introduce themselves. Lindsey introduced Erick Carrera, a lawyer for the Exchange and the Exchange's first new employee, and consultants GMMB and Wakely Consulting.

II. Benchmark Survey – Alison Betty and Melissa Morales of GMMB presented the PowerPoint *Benchmark Survey Findings*.

The benchmark survey was designed to inform future planning of the Exchange outreach and education plan and Navigator program. The survey was fielded statewide in March 2012 with a sample size of 1,004 Vermont residents, age 18 and older.

The benchmark survey found that nearly 30% of Vermonters are uninsured or worried about losing health coverage. In all, Vermonters have largely not yet heard anything about the Exchange. But 3 out of 4 respondents indicated that they would be interested in using a website to compare and buy health insurance. Vermonters identified the

following aspects of the Exchange as the most motivating reasons to use the Exchange:

- All plans on the website will cover basic services (83% were motivated by this statement)
- The website will have side-by-side comparisons of health plan benefits and prices (81%)
- Insurance plans cannot deny coverage to people with pre-existing conditions (80%)

Vermonters who would like assistance comparing plans or enrolling would prefer help in-person (59%), by telephone (47%), or online (30%). They are interested in getting help from: doctor's offices, clinics, community organizations, and health insurance companies. Vermonters are interested in hearing about the Exchange from someone who has used the Exchange, a doctor or nurse, and a hospital or clinic.

After learning more about the Exchange, 86 percent say they would be interested in using the website if they were uninsured in 2014.

Next Steps:

- Draft an outreach and engagement plan
- Begin to develop the bones of the Navigator program

III. Stakeholder Outreach Update: Alison Betty and Melissa Morales of GMMB presented the *Stakeholder Outreach Findings* memo. Lindsey Tucker noted that the stakeholder outreach conducted by GMMB pertains to the development of the outreach and education plan and Navigator program. Wakely Consulting is in the process of conducting stakeholder outreach to small businesses, and UMass is in the process of conducting stakeholder outreach pertaining to the quality rating system for plans and wellness program.

GMMB conducted stakeholder interviews with 15 stakeholders representing community organizations, businesses, brokers, insurance carriers, providers, and consumer advocacy organizations in March 2012. The interviews covered several topics, including:

- Important qualities of the Exchange
- Challenges and opportunities to development and implementation
- Lessons learned from existing enrollment practices
- Key audiences and how to reach them
- Characteristics and roles of Navigators

Some highlights shared during the presentation include the following insights from stakeholders:

- The Exchange must balance choice and simplicity – giving Vermonters a simple shopping experience while allowing them to make informed choices.

- Limiting paperwork and streamlining the registration process would be important to enrollment.
- Some challenges facing the Exchange include:
 - Addressing the needs of current Medicaid beneficiaries
 - Affordability
 - Outreach assistance, particularly to those without internet
 - Previous experience with other state programs
- Stakeholders identified the general population, the uninsured, small businesses, and the self-employed as priority audiences. Other audiences identified include current VHAP and Catamount beneficiaries, employees currently covered by their small employers, and young adults.
- To reach small businesses, stakeholders suggested providing information that goes beyond health care but also pertains to business operations. To reach individuals, stakeholders suggested building upon existing outreach infrastructure.
- Stakeholders identified the following criteria for Navigators: certification and training, experience with target populations and the health system, and people skills.

IV. Legislative Update – Robin Lunge

- H.559 passed out of the Senate last week
- Conference committee had been appointed but had only met once. The conference committee was meeting 3pm that afternoon.
- Outstanding issues – the House had suggested changes to the broker language that came out of the Senate version in their conference proposal.
- Duals section update is currently out for comments
- Both the Senate and the House are struggling with what legislative oversight will look like over the summer. The House had one version; the Senate had combined committees into a super committee.

V. Essential Health Benefits – Julie Peper of Wakely Consulting presented a PowerPoint *Vermont Essential Health Benefits: Premium Impact of Benchmark Options*. Lindsey Tucker and Robin Lunge led a discussion following the presentation.

The goal of the analysis was to assist in the selection of the Essential Health Benefit (EHB) benchmark plan by quantifying the premium impact of the different benchmark options. Vermont has four options; however, the State is ignoring the federal one because it does not include the State mandates.

Previously, Wakely Consulting had done a high-level comparison of Blue Cross Blue Shield of Vermont HMO and MVP RMO. This deeper dive now includes the Cigna state employee plan and compares the three plans. The analysis also fills gaps from the original comparison. For the comparison, all three plans were assumed to contain state mandates. The focus of the analysis was the relative richness of each plan. The identification of detailed benefit differences used information provided by Bailit Health

Purchasing of over 500 benefits. Wakely went back to the health insurers to supplement that data. Exclusions from the comparison include: any remaining differences expected to be insignificant from a cost perspective, benefits under optional riders, and non-benefit differences.

Comparison of Benefit Differences:

- A benefit is considered to be a difference if it is a benefit that is not covered by, or is a richer benefit than is provided by, either of the other two benchmark options
- Cigna has the highest number of benefits not provided by the other two plans. The Cigna benefit with the highest cost impact is infertility treatment.

Premium Impact of Benefit Differences:

- Downstream effects were not considered
- 22 differences are negligible in terms of cost
- Appendix lists all differences that were analyzed
- BCBS HMO benefit differences account for about ¼ of a percent increase in premium cost
- Cigna's differences would increase premiums by 1.12% and infertility treatment is a significant part of that
- Based on VHCURES, PMPM differences were adjusted down to \$290 from \$350. We've done another data call and think that \$350 might be more appropriate, probably the safer number to think about since the premiums are based so much on plan design.

If Cigna is chosen as the benchmark plan, we would expect that the MVP health plan would need to add \$3 to the premium to cover the additional benefits. BCBS would only need to add \$2.

The 4 high-cost benefits are chiropractic services, infertility treatments, pediatric vision care, and routine vision care and lenses. Pediatric vision care will need to be covered regardless of cost. For chiropractic services the difference is in preauthorization requirements. Infertility treatment accounts for around 1/3 of Cigna's difference. If Cigna covers infertility drugs, that would be a large difference, but drugs were not included in the analysis.

Summary of Analysis:

- We thought the differences among the three plans were going to be much more significant. Through refinement, we realized that there were not that many differences.
- There is only a 1% benefits richness difference.

Next steps:

- Selection of a benchmark plan
- Determination of which benefit gaps need to be supplemented

Discussion:

- \$350-400 would be more of an appropriate PMPM. We just did a data call with the plans and we're seeing closer to the \$350-400 range.
- This analysis does not include the cost of prescriptions, but rather looks only at medical premiums.
 - HHS is going to issue a standardized list of classes for prescription drugs.
- Downstream effects were not analyzed. There is not enough credible data to analyze these effects or determine which year the effects would take place. Additionally, health plans may price the overall health impact differently than we would.
- The PMPM is per individual; that is, the average member whether a child or adult.
- The Green Mountain Care Board will make the final EHB decision. Pending federal guidance, the State would like to finalize benefit design in early summer.
- Although the data show a 1% estimated difference, the plans may price premiums differently.
- The analysis does not include cost-sharing or subsidies/tax credits that individuals might receive.
- Is there flexibility in designing the plan in terms of vision care? The federal government has given states a finite set of existing plans to choose from. The state does not have the authority to change the plans.
- Feedback to the analysis included:
 - \$3 (out of \$290) is not significant for me, so why not use Cigna as the baseline?
 - I find it hard to figure out which plan to use without the drug benefit information.
 - Most state employees consider their plans more than 1% richer than others.
 - Difficult to look at straight up costs of providing certain services when downstream effects haven't been taken into account. They need to be somehow factored in.
 - Having the plan on the Exchange be the same plan that the State employees receive would be a good sales point.
 - There is the perception that 1% isn't a lot. It could become a big number for the base plan.
 - The major difference between an MVP plan and a BCBS plan will be the cost-sharing. What a small group will pay in cost-sharing will be quite different from cost-sharing in the state employee plan. There is a perception that the state employee plan is richer than small group plans, so we need to manage expectations around this.
 - Teachers' benefits are very similar to the state employee benefits, and at some point they will be in the Exchange. It would be very important to teachers to have the benchmark plan be modeled on the state employee plan.
 - It is clear that smoking cessation will not be a covered benefit if the State plan is selected; however smoking cessation services are offered by the Health Department.

- We're building the Exchange for small groups, which will include employers with up to 100 employees in 2016. I'm not sure why we would choose a large group plan as the base plan. We should look at plans that have the largest number of people in the. There are 80,000 lives in the BCBS small group plan. It would make more sense to have the BCBS plan as the base plan.
- The teachers' plan benefits are negotiated.

VI. Exchange Planning Timeline and Process - Lindsey Tucker told the committee that the State is moving forward with hiring staff for the Exchange, and consultants continue to move forward with their work. UMass is reaching out to stakeholders regarding quality issues and the wellness program. Let Lindsey know if you want to be contacted and haven't been, or if you are receiving too many requests for input and don't want to be interviewed. We do appreciate your input but realize it can be time-consuming to provide it.

VII. Medicaid and Exchange Advisory Committee – Lindsey Tucker shared a *Draft 2012 Agenda Items for Medicaid and Exchange Advisory Committee*. The agenda currently contains only issues pertaining to the Exchange; Medicaid issues will be added later.

The Medicaid Advisory Board suggested having sub-groups in addition to the broader committee. GMMB will help design a process to align and merge the two groups, from logistics to representation.

VIII. Public Comment: No comments were made.

IX. Closing and Next Steps: Next meeting was originally scheduled for May 21st, which conflicts with a national exchange grantee meeting in Washington D.C. Lindsey proposed moving this meeting forward by a week to May 14th.