

Vermont Exchange Advisory Group Meeting 10
February 27, 2012
MINUTES

Present: Dale Hackett (self), Peter Sterling (VT Campaign for Health Care Security), Trinka Kerr (VT Health Care Ombudsmen), Catherine Hamilton and Ellen Yakubik (Blue Cross and Blue Shield of Vermont), Sonia Tagliento (MAXIMUS), Susan Gretkowski (McLean, Meehan and Rice for MAXIMUS and MVP), Theo Kennedy (Otis and Kennedy), Madeleine Mongan (Vermont Medical Society), George Richardson (Vermont Dental Society) Lucie Garand (Downs, Rachlin and Martin), Jill Sudhoff-Gueria (KSE), April Tuck (CHSI), Craig Fuller (Keller and Fuller), Floyd Nease (VAMH), Jill Olson (VAHHS), Ken Libertoff (Vermont Psychiatric Association), Meg O'Donnell (FAHC), Tom Rugg (HB Benefits), Tom Scull (The Richards Group), Kelly Stoddard (Cancer Society), Mark Hage (VT NEA), Alan Panebaker (VTDigger.org)

Staff and consultants: Lindsey Tucker, Betsy Forrest, & Mark Larson (Department of Vermont Health Access) Robin Lunge and Ena Backus (Agency of Administration), Georgia Maheras, Richard Slusky, Doreen Chambers and Karen Hein (Green Mountain Care Board), Nolan Langweil (Joint Fiscal Office), David Martini, Spenser Weppler, Jessica Mondizabal (BISHCA), Les Birnbaum (Department for Children and Families), Brendan Hogan and Kate Bazinsky (Bailit Health Purchasing), Julie Pepper (Wakely Consulting)

I. **Introduction** – Lindsey invited the people on the phone and in person to introduce themselves.

Robin indicated at the beginning of the meeting that the State would not be asking for decisions on what benchmark plan to select given the fact that the federal government has provided additional guidance that has made the plan selection process more difficult by making some information less clear.

II. Potential Benefits to be offered in the Exchange/Small Group Market

Brendan Hogan from Bailit presented an update to the information that Kate Bazinsky delivered at the previous advisory group meeting. The Department of Health and Human Services (HHS) issued a Questions & Answers document since the last meeting, and some of the information contained differed from Vermont's prior understanding. Please note that this information was communicated through guidance and not regulation. Below are some of the changes and new information contained in the Q&A document from HHS:

- The benchmark plan chosen by states in 2012 will apply to both 2014 and 2015; states will not have an opportunity in 2013 to choose a different plan.
- HHS plans to provide states with a list of the top three small group market products in each state based on data from HealthCare.gov from the first quarter of the 2012 calendar year. If Vermont does not make a decision the default benchmark plan will be the largest of the small group plans according to the list provided by HHS. However, it is important to note that Vermont plans on making a decision by the 3rd quarter of 2012.
- If the benchmark plan selected is missing services in one of the required HHS categories, the category of coverage would need to be supplemented by services offered in that category from the core medical benefits contained in another benchmark option. Further, if the services in one of the required HHS categories are offered only through a rider, the plan will be considered to be "missing" the services in that category and would need to be supplemented. HHS also provided special procedures for filling services in the categories of habilitative services, pediatric vision, and pediatric oral.

- Insurers will have some flexibility to alter the benefits in the benchmark plan, but the resulting plan must be actuarially equivalent to the benchmark plan as defined in the federal regulations for the Children’s Health Insurance Program (CHIP). HHS gave an example of a modification that would fit this description: if the benchmark plan has a limit of 20 physical therapy visits and 10 occupational visits, the insurer could change this to 10 PT visits and 20 OT visits.
- All of the benchmark plan options for Vermont have services “missing” in up to four of the ten categories of coverage required by the ACA. These four areas include: habilitative services, pediatric oral care, pediatric vision care, and prescription drug coverage.
- Vision coverage in a base plan included one exam for BCBSVT and \$100 for either exams or equipment in the state plan. It is unclear whether this is enough coverage to count as services under the required ACA category of pediatric vision.
- HHS is considering proposing that if the benchmark plan is missing services in the category of pediatric vision care, the state would be required to supplement the benchmark plan with the pediatric benefits from the Federal Employees Dental and Vision Insurance Program (FEDVIP) vision plan. If HHS pursues this course of action, then even if the benchmark plan selected were missing pediatric vision services, it would not require any separate decision on the part of the state to supplement services in that category since the state would be required to supplement the services using the FEDVIP vision plan.
- HHS is considering proposing that if the benchmark plan is missing services in the category of pediatric oral care the state would be required to supplement the benchmark plan with either the pediatric benefits from the FEDVIP dental plan or the state’s Children’s Health Insurance Program (CHIP). Therefore, if HHS pursues this course of action, and since all of the Vermont plans are missing pediatric oral care, the state would need to make a decision on which coverage option to adopt.
- HHS is considering proposing that if the benchmark plan is missing services in the category of habilitative services the plans would either be required to cover the same services offered for rehabilitative purpose for habilitative purposes, or HHS would simply allow the plans to define “habilitative services” for themselves and report on the coverage provided. HHS would then review the coverage provided and offer additional guidance at a later date. In order to understand the extent of coverage provided by the plans if HHS adopted the second approach, the Vermont plans were asked to provide their definitions of habilitative services. The definitions provided by MVP and BCBSVT were reviewed. The state plan was not able to provide a definition in time for the meeting. Given this update from HHS, even if habilitative services were deemed to be “missing” from the selected benchmark plan, the state would not be the decision maker in terms of what habilitative services are offered.
- Since HHS has indicated that riders may not be used to cover services in a category required by the ACA, both MVP and BCBSVT would need to have their plans supplemented with prescription drug coverage. The options for supplementing the plans in this area are the prescription coverage offered as a core medical service by the state plan or the Federal Employee Health Benefits Plan. More information is needed from HHS about drug classes and categories in order to conduct a useful formulary comparison of the state plan and the Federal Employee Benefits plan.

HHS has not yet issued proposed rules on essential health benefits; the Q&A document serves as further clarification of the guidance issued earlier. It will be difficult for Vermont to move forward in choosing a

benchmark plan without further clarification from HHS, so the final decision on Vermont's benchmark plan might not be made as soon as we had hoped.

- Question from meeting participant: Will the pediatric vision coverage include the exam/office visit and materials, or just the exam?
Answer: HHS has not yet defined what pediatric vision must include.
- Prior authorization processes were discussed. A handout was distributed that went into greater detail about prior authorization. If people want more information about prior authorization or the restrictions associated with other specific benefits, please contact Lindsey Tucker at the State.
 - a. **Description of Explanation of Benefits requirements** – Federal examples of glossary of benefits and summary of benefits will be sent to the advisory group with the minutes from this meeting.
 - b. **Current Cost of small group policies** – not discussed at this meeting but will be discussed at future meetings
 - c. **Actuarial Analysis (Wakely slides will be distributed with the minutes)**
- Julie Pepper from Wakely Consulting presented information about Essential Health Benefits with high-level cost estimates from preliminary data analysis.
- Julie noted that eventually Wakely will have access to the VHCURES data. She further stated that the information that Bailit, MVP, and BCBSVT were able to provide to her was very helpful.
- Wakely believes they will have state plan data by the beginning of March.
- Slide 4 – the assumption that BCBSVT does not include a Skilled Nursing Facility (SNF) benefit needs to be corrected, since SNF coverage is included in the plan, and differences between MVP and BCBSVT would need to be updated as well.
- Wakely Consulting indicated that they took a very conservative approach to premium impact estimates.
- Preliminary estimates were done independent of downstream effects (SNF impacts on inpatient services, for example).
- Prior authorizations were assumed to have minimal financial effect.
- Initial financial estimates are that the benefits included in the BCBS plan, but not included in the MVP plan, represent around 1.8% of the premium. MVP benefits not included in the BCBS plan represent around 0.8% of the premium.
- Slide 8 is the same as slide 7 but on a PMPM basis.
- Discussion followed about whether \$3 or \$6 a month is significant in terms of an increase in premium. The answer depends on the person (whether they have a subsidy or not) and upon the employer's situation.

Question was raised about how unions fit into this discussion.

Answer – they do not fit into this specific analysis but are connected to multi-state plan offerings and future discussions.

Wakely will need access to VHCURES and at least 2-3 weeks to do a more complete cost analysis.

Robin discussed the tension between doing an analysis with just MVP and BCBSVT (to get the analysis done faster) or to include the State plan/CIGNA in the analysis. If three plans at each actuarial level were reviewed, it is 12 plans for each, and the state employees are not brought in as a group until 2016. What is more important: faster or more complete?

VSEA asked that the state do the analysis of the state plan. After discussion several other meeting participants indicated that they wanted the state plan to be considered.

In other states, Utah for example, they do not impose plan design requirements, but rather allow the plans to develop their own designs. In Massachusetts they provide more specificity in setting options.

The ACA does not call for setting plan design options, but Act 48 in Vermont does ask for more specificity.

Prior authorization discussion followed, during which some people said that PA is a burden. Several people wanted more discussion about PA. Representatives from MVP indicated that not all PAs are equal. For example (for illustrative purposes but not exactly mirroring the process at MVP) a plan may offer 8 Chiropractic visits prior to PA, with a benefit limit is 30 visits. Since most people are receiving 4-5 visits, the PA requirement wouldn't affect them.

Please email Lindsey if you want more information comparing specific services across all three plan options. A big caveat is that the current spreadsheet containing this information is not completely up-to-date because the certificates of coverage provided to Bailit Health Purchasing were out of date. Bailit vetted the presentations with the insurers but has not incorporated all of those updates into the spreadsheet, and has not vetted all of the other benefits contained in that analysis with the insurers.

A comment was made that prior authorization from a consumer perspective must take into account delays in receiving the service and the possible risk of denial.

Wakely Consulting stated that it is hard to put a dollar figure on prior approval. The insurance company representative talked about specific types of PA such as dental and air transport—some have more financial impact than others.

PAs are supposed to be between the insurer and the provider. The goal of payment reform is to reduce PAs in the future.

The definition of “medical necessity” was raised, and the state has a definition that is part of Managed Care requirements in Rule 2009-03.

Much of the remaining discussion was about process. Once people understood that the recommendation to the Green Mountain Care board would be that “a couple of people said that the state should look at all three plans and most of the group was silent,” more people spoke up in favor of looking at all three plans (BCBSVT, MVP, and the state plan).

Several people raised examples of potential positive downstream effects on care, such as for chiropractic services. Robin asked that examples be emailed to Lindsey Tucker at DVHA for more discussion.

- III. Updates (Robin Lunge and Mark Larson) – H-599 was voted out of the house last week and will move to the Senate. The Senate will likely take up testimony after Town Meeting Day.
- IV. Public Comment – no public comment
- V. Next Steps
 - a. Actuarial slides will be emailed out
 - b. More refined cost analyses will occur
 - c. Common conditions- email to Lindsey information (ex. MH/SA)
 - d. What parts of benefits can have downstream effects? - email ideas to Lindsey
 - e. More information – Federal Vision and Dental Plans
 - f. Implementation Plan – To be discussed at a future meeting
 - g. Joint Medicaid & Exchange Advisory Board- To be discussed at a future meeting. These boards will be merged by July 2012. How these two boards will be merged will be part of discussions at future Exchange Advisory board meetings.
 - h. Meeting schedule - **Next meeting is scheduled for March 19, 2012 – location - TBD**