

Vermont Exchange Advisory Group Meeting 12
May 14, 2012

MINUTES

Present: Randy Cook (FAHC), Mark Hage (VTNEA), Peter Sterling (VT Campaign HC Security), Kelly Stoddard (ACS), William H. Lambrukos (Delta Dental Plan of VT), Tom Rugg (Hickok & Boardman), Donna Sutton Fay (Campaign for HC Security), Trinka Kerr (HCO/VLA), Catherine Hamilton (BCBSVT), Don George (BCBSVT), Paul Harrington (VMS), Theo Kennedy (Otis & Kennedy, LLC), Jim Harrison (VT Grocers), Jennifer Carbee (Leg. Council), Katie McLinn (Leg. Council), Nolan Langweil (JFO), Lucie Garand (DRM), Timothy E. Ford (HVM/VIAA), Jamie Feelnan (Primmer), Heather Caldwell (Xerox), Sonia Tagliento (Maximus), Betty Morse (VFN), Mike Fisher (State Representative), Claire Ayers (State Senate), George Richardson (VT Pediatric Dentistry), Erick Backus (GMCB)

Staff and consultants: Lindsey Tucker and Betsy Forrest (Department of Vermont Health Access, DVHA), Robin Lunge (Agency of Administration), Julie Peper (Wakely Consulting), Melissa Morales (GMMB), Justin Tease (DVHA), Erick Carrera (DVHA), Jessica Mendizabal (Financial Regulation), David Martini (Financial Regulation)

- I. Welcome and Introductions** – Lindsey Tucker opened the meeting and asked the group to introduce themselves.

- II. Legislative Update** – Robin Lunge presented the PowerPoint *Overview – H.559* that detailed components of H.559 pertinent to the Exchange.
 - On the federal regulatory side, Vermont, like other states, has requested and is awaiting further federal regulatory guidance concerning qualified health benefit plans, and multi-State plans, among other policy issues.
 - Robin also related that the federal government is anticipating that state exchanges may all not be 100% operational by October 2013. However, within parameters the federal government will set, a state exchange may still be conditionally approved if it demonstrates that it will become operational.

Paul Harrington commented that small businesses were considering becoming self-funded insurers and asked if thought had been given to this possibility. Robin responded that yes, the administration is looking at this.

Another person asked Robin to forecast related legislative action for 2013. Robin replied that there would be two big financing plans (Exchange in 2014 and Green Mountain Care in 2017), and that perhaps the legislature might need to act as a consequence of the US Supreme Court decision regarding the challenges to the ACA.

III. **Exchange Development Update** – Lindsey Tucker spoke to updates pertaining to the recent CCIIO Vermont Planning Review in Bethesda, Maryland and the Level II Grant Application.

Vermont's planning review last week with the federal government went well, but we have a lot of work still to do. The purpose of the planning review was to allow the federal government to assess Vermont's progress is designing and developing the Exchange.

- Vermont will post CCIIO planning review slides on the website
- Steve Kimbell will send Lindsey the Small Business Majority data.

http://www.smallbusinessmajority.org/small-business-research/downloads/050912_Small_Business_Healthcare_Tax_Credit.pdf

IV. **Qualified Health Plans Design** – Lindsey Tucker, Robin Lunge and Julie Peper of Wakely Consulting presented the PowerPoint *Plan Design: Current Market Overview*. Lindsey noted that, as opposed to the Essential Health Benefits decision discussed as the April 30 advisory board meeting, the State can decide on a plan design at this time. This presentation is an analysis of the market to-date and a mapping of next steps.

Background – Affordable Care Act

- Actuarial Value (AV) is the average expected health care costs a health plan will cover with the essential health benefits as the base benefits. For example, if a plan has an AV of 70%, the plan will pay 70% of the average person's medical costs, with the remaining 30% paid by the person.
- Definitions of different metal (or AV) levels (Ranges = +/- 2% of the middle value)
 - Bronze 58-62% AV
 - Silver 68-72% AV
 - Gold 78-82% AV
 - Platinum 88-92% AV
- Prescription drug co-pays are considered when determining AV.
- Employer contribution to a Health Savings Account (HSA) can be considered when determining actuarial value.
- HHS is expected to release a model to calculate actuarial value. In the meantime, the State will have to make assumptions around HSAs.

State of Vermont

- GMCB has not taken a vote, but they have held two public hearings on Essential Health Benefits, the benchmark plan, and plan design. The board indicated they would like to see some set plan designs. Plan designs will consider:
 - Market disruption: if we change plan designs from those in the market today, what will be the impact on currently insured people?
 - Plan design can cause selection problems, in that certain plan designs could attract either healthier or less healthy populations.

Process for Selecting Plan Designs

- We need to understand the current market. Many of the current plan designs don't comply with ACA regulations, so those will not be allowed to be offered in their current form. The State will also look at which plans are the most popular in today's market.
- GMCB makes the final decision.
- Insurers will be required to offer at least silver- and gold-level plans.

Current Market Enrollment (Based on 2012 enrollment)

- Data includes Catamount, individual market, small group market, and associations.
- Medicaid beneficiaries are not included yet. VHAP beneficiaries are not captured in slide 6 of the presentation.

Current AVs by Market

- Wakely looked at plan designs in each of the markets to determine the current actuarial values, using assumptions on prescription drug cost sharing. HSA/HRA contributions from employers were not considered in the analysis, since the data are not collected in Vermont; assumptions will need to be made based on national data.
- Projected changes to the current market will influence our outreach and education plan and how we communicate the differences between what people have now and how that will change in 2014.

The Catamount Health Plan has an AV of 87% (closest to platinum level of 90%).

Individual market plans have an average AV of 74%. It is likely that there will be disruption to the small group market, and to some extent the association market. Disruption to the individual market will be somewhat mitigated by the availability of federal premium tax credits and cost-sharing subsidies to low-income individuals.

Key takeaways:

- For all markets combined, the distribution of plans across metal levels is fairly consistent.
- The individual market is the most likely to experience changes in premium levels, but some individuals will be eligible for premium tax credits and cost-sharing subsidies.
- In order to receive federal cost-sharing subsidies, individuals must be enrolled in a silver plan.
- Corrections to slide 13:
 - 64% of small group members and 84% of association members are currently in plans that would violate the maximum deductible allowed by the ACA of \$2,000 for an individual.
 - 94% of individual members, 6% of small group members, and 22% of association members are currently in plans that have an out-of-pocket maximum in excess of the ACA-allowed \$5,950 for an individual.

Next Steps:

- Refine analysis (including HSA employer contributions; Wakely might have to test different scenarios).
- Determine which plan designs should be considered
- Develop multiple plan designs
- Provide recommendations to GMCB.

We will continue this discussion at the next advisory board meeting on June 25, 2012.

V. Medicaid and Exchange Advisory Committee – Lindsey Tucker asked EAB and MAB member Trinkia Kerr to walk the Exchange Advisory Board through the key agenda items of the MAB and discuss the makeup of the group. Lindsey shared the *Draft Merging the Exchange Advisory Board and the Medicaid Advisory Board Recommendations*.

The Medicaid Advisory Board is a diverse group that meets monthly for at least 2 hours. The group's makeup is approximately: 1/3 consumers/beneficiaries, 1/3 providers, and 1/3 advocates.

At the meetings there are discussions and presentations on Medicaid policies. The group advises the administration (DVHA; Department of Disabilities, Aging and Independent Living; Department for Children and Families (DCF); Department of Mental Health; Department of Health) and gives advice to policy makers about policies and budgets under consideration by the administration. These topics can include proposed regulations, potential waivers, different policy initiatives, long-term care issues, the dual eligibles pilot project, the Blueprint, chronic care initiatives, utilization management mechanisms, integrated family services, provider rates and taxes, and access issues for consumers.

Lindsey Tucker presented recommendations for the groups' merger as required by Act 48. DVHA is working with GMMB to determine the process for the merger. These recommendations will be presented to the MAB at their next meeting (next week). The recommendations do not address membership by specific groups or individuals; Lindsey will work with Commissioner Larson to decide on membership.

Stakeholders who are not official committee members could participate in subgroups that are addressing issues within their expertise or interest. The stakeholders would be expected to report back to the advisory committee members. This option will be added to the recommendations. Please email Lindsey Tucker by May 25, 2012, with feedback on the recommendations.

VI. Public Comment: No comments were made.

VII. Closing and Next Steps: The next meeting will be on June 25, 2012, in the Pavilion 4th-floor conference room.