

## Vermont Exchange Advisory Group Meeting 4

June 27, 2011

### MINUTES

**Present:** Peter Sterling and Donna Sutton Fay (VT Campaign for HCS), Trinka Kerr (VT Health Care Ombudsmen), Catherine Hamilton (Blue Cross and Blue Shield of Vermont), Floyd Nease (Vermont Association for Mental Health), Denis Barton (Bi-State Primary Care Association), Andrea Cohen (Vermont Businesses for Social Responsibility), Senator Claire Ayer, Senator Jane Kitchel, Senator Sally Fox, Sonia Tagliento (MAXIMUS), Bill Little (MVP), Susan Gretkowski (McLean, Meehan and Rice for MAXIMUS and MVP), Russell Greene (Connecture) Heather Shouldice (William Shouldice and Associates LLC), Anthony Otis and Theo Kennedy (Otis and Brooks for PhRMA). Bea Grause (Vermont Association of Hospitals and Health Systems), Dr. Tim Tanner, Representative Michael Fisher, Paul Harrington (Vermont Medical Society), Michael Del Trecco (Vermont Assembly of Hospitals and Health Systems) Mark Hage (Vermont NEA), Peter Cobb (Vermont Assembly of Home Health Agencies), Cathy Davis, Lake Champlain Chamber of Commerce, Andy Neary (Connecture) George Richardson (Vermont Dental Society)

**Staff and consultants:** David Mannis (Banking, Insurance, Securities and Health Care Administration, BISHCA), Kevin Veller (Department of Vermont Health Access, DVHA) Betsy Forrest (DVHA), Robin Lunge (Agency of Administration), Jennifer Carbee (Legislative Council), Beth Waldman (Bailit), Joshua Slen (Bailit), Brendan Hogan (Bailit), Amy Lishko (Bailit) and Erica Garfin (Bailit)

#### **Updates on Implementation of H.202/Act 48 (Robin Lunge, VT Agency of Administration)**

A series of internal cross-agency workgroups have been created for the purpose of organizing a preliminary work plan for each of the studies within Act 48, the legislation that authorized both the health care Exchange as well as a framework for universal health care coverage in Vermont. (<http://www.leg.state.vt.us/docs/2012/ACTS/ACT048.pdf>)

Some workgroups are further along than others. Each team lead will come up with a public participation strategy and plan so interested stakeholders can be involved. This Health Care Exchange Advisory Group will continue to be a key public way to remain involved.

Robin will also be updating the Medicaid Advisory Group, which is an additional venue to obtain advice and guidance for the planning and implementation of the health care Exchange.

The goal is to try to use existing advisory group structures to get input. Existing health care workforce groups will be included in the Act 48 planning.

#### **Review of Basic Health Program Analysis (Amy Lischko)**

Amy Lischko an associate professor from Tufts University School of Medicine and a subcontractor working for Bailit Health Purchasing, reviewed analysis to date of the Basic Health Program option. Please see the Basic Health memo which walks through the analysis and/or the meeting slides for a summary of analysis.

Following her presentation, a series of questions were asked.

*Question 1: Are there requirements from the federal government that the Basic Health Program follow managed care requirements?*

*Answer: Yes, and those managed care requirements will be further explained in regulations due out this summer.*

*Question 2: Is the Basic Health Program for adults only?*

*Answer: Yes, it is expected that most children at these income levels will continue to receive coverage through CHIP or the Exchange if over the state CHIP cap.*

*Question 3: Are the assumptions in take up rate based on existing Medicaid/Catamount enrollees and current uninsured information*

*Answer: The assumptions used here were not based on previous take-up. It is assumed that 90% of people currently enrolled in coverage programs will enroll in new coverage and that fewer (here we assume 50%) of the currently uninsured will enroll. These assumptions can be adjusted up or down and depend on many different factors.*

*Question 4: The Silver Plan level of benefits and premiums is used to calculate "money in" and the VHAP level of benefits is used to calculate "money out" under the Basic Health option?*

*Answer: Yes, that is correct.*

*Question 5: Who is responsible for the 5% difference between the 100% costs and funding at 95%?*

*Answer: It is assumed that the state will be able to negotiate for lower premiums than commercial plans operating in the Exchange and therefore realize at least 5% savings. The analysis was undertaken to determine if the state could run the program with that 5% reduction or not. According to the preliminary analyses, Vermont would need to identify additional funds if it ran a Basic Health Program with benefits and premiums equivalent to VHAP*

*Question 6: Does the Basic Health Program need to cover people all the way to 200% FPL or can it cover people to an income below that level? For example, if it looks like VT will lose money on the higher-income eligibles, can it cap the program at 150% FPL?*

*Answer: More federal guidance is needed, but current assumption is that you have to include everyone up to 200% of federal poverty level.*

*Comment: The provider reimbursement figures are off and the administrative figures are off. The Administrative figures for Catamount are currently capped at 6% not 20%.*

*Response to comment: Is 6% reasonable for Basic Health Program or the Exchange, or should a higher level be assumed for analysis? Actually, are 2 administrative fees are needed, one for running Basic Health, and the other for what should be assumed for silver-level plan in Exchange?*

*Answer: Assume half of 20%. Administrative expenses would be lower with a program laid out like the Basic Health Plan, maybe 8-10%.*

*Question 7 – What is the impact on the risk pool of pulling out individuals up to 200% FPL from Exchange, since this group would probably include younger, healthier people, and so would it skew the population that is left in the Exchange?*

*Answer: This was discussed in policy options but not analyzed numerically. We don't have a lot of information on the population above 200% FPL.*

*Question 8 – What is the financial impact of the Basic Health Program or the Exchange relative to the cost of doing it through Medicaid; would both other options still be advantageous (capturing savings from what was paid for the 40% state match for Medicaid)?*

*Answer: Yes, that's correct; either option is less expensive than covering these individuals under Medicaid. The current estimate regarding net savings to Vermont is approximately \$5 million in 2014.*

*Comment: The assumed take-up rate may be double relative to Catamount's experience. Is this accurate and how does this work with the insurance mandate aspect of Act 48?*

*Answer: The state may need to look at the mandate provisions within Act 48.*

*Comment: Businesses will drop insurance and allow employees to go to the Exchange, since lower-wage workers will fare better with a subsidy. So maybe 40% of individuals in the employer groups for employers with 50 or fewer employees will move to the Exchange. This is a whole new population that will be purchasing insurance directly; therefore, it is very important to have the Exchange function well for these people. The current take-up rate estimates may in fact be too low.*

*Answer: The state will need to look at additional factors as the analysis is refined over time.*

*Question 9: The Exchange out-of-pocket costs, OOP, for low-income people are scary high; is this accurate?*

*Answer: These are set by the federal government. These are maximum out-of-pocket costs, and they are correct.*

*Additional response: one option not talked about yet is doing a state subsidy in an Exchange. If the Exchange is too small, in terms of enrollment, one potential way of keeping the pool of people within the Exchange at a sufficient size is to keep premiums at reasonable level by not doing a Basic Health Program but doing a state subsidy for folks in an Exchange on top of a federal subsidy.*

*Comment: We do not want more uninsured as a result of whatever decision we make.*

*Question 10: Would the Basic Health Program have the essential benefits that are offered in an Exchange?*

*Answer: Yes.*

*Question 11: Are state mandates an additional cost in both the Basic Health Program and in an Exchange?*

*Answer: Yes, if the state chooses to fund these. Once the federal rules come out about the essential benefit coverage and the state cross walks that rule with its current list of mandates, there may be services that are not covered by the federal government, and those services would require state-only funding.*

*Question 12: When do we need to pin down analysis regarding whether or not to establish a Basic Health Program in Vermont?*

*Answer: We need to have a recommendation by next legislative session in order to build IT systems in 2012 to test in 2013 for operation in 2014.*

*Question 13: Which rate is assumed for reimbursement from the federal government?*

*Answer: We need to revise the model and potentially look at commercial premium rates.*

*Comment: We need to be realistic about what it is going to cost in the future, not just at start-up, and also think ahead to the single-payer plan.*

*Question 14: If the 50% take-up rate turns out to be only 30%, does state eat the difference?*

*Answer: If the take-up rate is lower than expected, there would be a higher than anticipated per-person cost in order to cover the cost to build the Exchange infrastructure. We are predicting that the Basic Health Program will cost the state some money, so if there is additional take-up, it will cost the state more. If there is less take-up, it will cost the state less.*

*Question 15: Would churning increase as more options are available? Would we be creating more opportunities for churning if we created more options?*

*Answer: Yes and no. If you establish a Basic Health Program to look like Medicaid, you may have less churn between these programs. The key here is to minimize the number of transitions people make as their income fluctuates. If everyone stays in the Exchange, but with different levels of coverage, it may be a better option, though people will still have different coverage than their kids. As Vermont moves towards single-payer this will be a very important consideration.*

Next, Amy reviewed with the group some of the policy considerations related to the decision of whether or not to establish the Basic Health Program. The considerations do not necessarily provide a yes/no answer on whether to establish a Basic Health Program, but are things to think about regardless of the path the state chooses.

#### Comments, Questions and Discussion

*Comment: Lower rates are more an issue of viability of providers to stay in business.*

*Comment: The state needs to adhere to the Act 48 principles when making policy considerations.*

*Comment: If we pull people out of a Basic Health Program, there could be a possibility of increased stigma.*

*Question 16: What is the impact on the Exchange if a large number of people go to a Basic Health Program? Is it significant and can an Exchange be viable with a Basic Health Program?*

*Answer: Nationally, the recommended minimum in an Exchange is 100,000. However, estimating the current number of people in small group market vs. individual market right now in Vermont is tricky to calculate because of associations. The state is working on better analysis of this information.*

*Question 17: What does the Basic Health Program give us – pros and cons?*

*Answer: Pros and cons are in the eye of the beholder, so this analysis is not laid out like that. The state will develop a pros and cons list.*

*Question 18: What was the federal motivation for putting a Basic Health Program in the bill?*

*Answer: Washington State has had a successful Basic Health Program in place for a few decades. Senator Cantwell from WA spearheaded the inclusion of this language in the PPACA.*

*Comment: One aspect that should be considered a con is to have the state expand coverage by under-reimbursing medical professionals. This is fundamentally incompatible with the principles in Act 48 regarding insuring financial solvency. Vermont Medical Society would be in opposition to this.*

*Question 19: What benefits are there in VHAP benefit package that would or wouldn't be in other packages?*

*Answer: Some limited dental coverage, and an annual eye exam. Most of what VHAP covers is likely to be in an essential benefits package with the exception of dental.*

*Question 20: Whatever rate basis is assumed going forward with the Exchange would be a matter of accepting assumptions already existing, which locks in inequities. Is there an attempt to look at those assumptions, and would there be an opportunity to look at a cost-plus reimbursement system?*

*Answer: This is the intersection of Green Mountain Care Board and the Exchange Advisory Board. The Green Mountain Care Board will be looking at inequities. This may evolve to an all-payer basis. For the Exchange feasibility analysis we need to make our best guess at what these rates will be.*

*Question 21: What happens to folks who go off Medicaid?*

*Answer: The ACA requires streamlined eligibility. There is potential for one eligibility system for Medicaid and the Exchange. As part of their work, the Bailit team is conducting a churn analysis that will include recommendations on how to reduce churn going forward. It is helpful that the Exchange will be within DVHA.*

*Question 22: Is there a difference in what people pay in premiums in a Basic Health Program or in the Exchange?*

*Answer: The analysis assumes VHAP level for premiums, which is lower than what would be paid through the Exchange as described in the ACA.*

*Comment: The individuals who fall in the 200-400% FPL also have a big affordability issue, especially if the Exchange is small.*

*Response: This is another argument for thinking about a state subsidy to keep Exchange enrollment numbers up.*

*Question 23: What are the ramifications of having reduced Exchange enrollment?*

*Answer: A key issue may be whether the enrollment produces enough money to build/maintain infrastructure. In addition, a goal of Act 48 is to reduce fragmentation of lots of little groups, and fewer numbers would affect that. There is no federal funding for operation of Exchange infrastructure, so the state has to be able to afford to run it.*

*Question 24: People on VHAP won't be able to afford Exchange premiums, so don't assume that people in VHAP as included in the Exchange.*

*Answer: We now pay 40% of Medicaid costs for people on state programs. That is a potential source of funding to add a state subsidy so that the premiums could be more affordable.*

*Comment: After this conversation, we would need a real reason why we'd want to have a Basic Health Program, assuming state subsidy can address out-of-pocket costs for low-income individuals.*

### **Advisory Group process – next steps – how can further comments or questions be addressed?**

Email Robin Lunge ([Robin.Lunge@state.vt.us](mailto:Robin.Lunge@state.vt.us)) or Beth Waldman ([bwaldman@bailit-health.com](mailto:bwaldman@bailit-health.com))  
This is the beginning of a long, iterative conversation.

### **Proposed approach to marketing/outreach/navigators (Beth Waldman)**

Beth provided an overview of the proposed approach to both marketing and outreach and the Navigators. The findings from Bailit research and recommendations are included in the Marketing/Outreach and Navigator Proposal Memo as well as in the meeting slides.

### **Discussion of Marketing and Outreach**

#### **The group provided the following comments:**

Instead of marketing as something happening in future, think about it as transition from where we are now to where we're going. Lots of opportunities now with touch points to consumers through letters and notices during a pre-launch period.

Be careful that we don't scare people and generate calls unnecessarily if we use existing letters and notices.

There should be some continuity to an outreach program. People pay attention to outreach at different times, their circumstances change, and there should be a high-level continuity of the message over time.

Businesses know nothing about ACA. Start education next year so they can be prepared to start informing employees in 2012.

Start sooner rather than later so can dovetail/capitalize on current marketing efforts.

State should carefully monitor the information being provided and make a concerted effort to correct any misinformation provided to the public.

The Act 60 marketing campaign was a disaster. Go back and learn from it. Use a local marketing firm. Don't call it a marketing campaign--that would turn off voters; people ask how much it costs. Paul Cillo and Sean Campbell would know about the Act 60 Marketing campaign.

When hiring a marketing firm, consider that the state's experience is in talking with consumers, not with businesses. Get input from businesses in developing a marketing plan and messages. We will also get input from consumers.

When the state puts out information, the state should look at its capacity to respond to questions. People want to know--who do I call? What to do when we have a public inquiry? How to respond, who does it? Navigator, customer service and state staff—how do they work together?

**Discussion of the Navigator Proposal:**

Question: Is there a liability issue for navigators? There's some risk; however, this risk can be mitigated by defining the role of navigators. Providing information and reviewing options is different than telling someone what option to select.

Comment: Still work to do to figure out limits of navigation. Can you sue your navigator? It shouldn't be informal.

Question: With lots of entities doing navigating, how would people get to a navigator?

Comment: SHIP program advises people on choosing Medicare Part D programs, somewhat analogous (hopefully easier).

Comment: Need hours beyond standard business/working hours when navigators are available.

Response: This may be a call center function, or that could be required as part of the Navigator role through an RFP.

Comment: Navigators are a function of the Exchange, so the state will be responsible to pay for them, not the federal government. When thinking about how many there will be and what they'll do, cost will be a factor.

**Next steps**— Next meeting is Sept 12, 2011, at 1:30, 4<sup>th</sup> Floor, Pavilion office building.

Agenda will include:

- Talking through full Exchange design process with some level of funding listed.
- Draft implementation grant plan that is due at the end of September
- Design draft will go out in advance of meeting