

## Vermont Exchange Advisory Group Meeting 7

November 18, 2011

### MINUTES

**Present:** Peter Sterling and Donna Sutton Fay (VT Campaign for Health Care Security), Trinka Kerr (VT Health Care Ombudsmen), Leigh Tofferi, Don George, Kevin Goddard and Catherine Hamilton (Blue Cross and Blue Shield of Vermont), Floyd Nease (Vermont Association for Mental Health), Danielle Hibbard (Bi-State Primary Care Association), Senator Sally Fox, Representative Michael Fisher, Sonia Tagliento (MAXIMUS), Susan Gretkowski (McLean, Meehan and Rice for MAXIMUS and MVP), Bill Little (MVP), Theo Kennedy and Anthony Otis (Otis and Brooks), Dr. Julia McDaniel (Chiropractor), Cory Gustafson (Vermont Association of Hospitals and Health Systems), Betsy Bishop (Vermont Chamber of Commerce), Dr. Tim Tanner, Paul Harrington (Vermont Medical Society), Bill Lambrukos (Delta Dental Plan of Vermont/Northeast Delta Dental), George Richardson (Vermont Dental Society) Lucie Garand (Downs, Rachlin and Martin), Timothy Ford (VIAA and Hackett & Valine), , Nancy Metz (self), Susan Barrett (Bi-Stae Primary Care Association), Craig Fuller and Jeanne Keller (Employers Health Alliance/Keller and Fuller), Joshua Slen (Mollina Healthcare), Lawrence Miller, (VT Agency of Commerce), Meg O'Donnell (Fletcher Allen Health Care), Russell Green (Connecture), Dr. Tim Tanner, Jill Sudiff-Gueria (KSE); Julie Tessler (Vermont Council for Developmental and Mental Health Services), Tom Rugg (HB Benefits), Abe Berman (Vermont Managed Care)

**Staff and consultants:** Betsy Forrest & Mark Larson (Department of Vermont Health Access, DVHA) Robin Lunge and Ena Backus (Agency of Administration), Jennifer Carbee & Katie McLinn (Legislative Council), Nolan Langweil (Joint Fiscal Office), Brendan Hogan, (Bailit Health Purchasing)

#### I. Welcome

Robin Lunge opened the meeting and talked about future meeting topics for 2012. She asked the group if they would be interested in having external speakers come in and present to this group about exchange-related topics. If people are interested in having external speakers present about exchange-related topics, please let Robin Lunge or Brendan Hogan know your opinion on this topic. Robin and Brendan can be reached at [robin.lunge@state.vt.us](mailto:robin.lunge@state.vt.us) or Brendan Hogan at [bhogan@bailit-health.com](mailto:bhogan@bailit-health.com)

#### II. Exchange Benefits – review and discussion of revised mandate lists

Robin reviewed the updated mandate list. This list of mandates was divided into 3 groups:

- State Mandates that would likely be covered as essential health benefits
- State Mandates that would likely not be covered as essential health benefits
- State Mandates the state is unsure will be included in essential health benefits

These lists were created as a way to begin actuarial analyses of the benefits the state is relatively certain the federal government will not include as essential health benefits. The actuarial analysis will help the state determine how much it would likely cost if the state decided to retain the mandate and therefore had to pay for the specific benefit in the future.

Any feedback from the group is welcome – please email Robin or Brendan (see above emails addresses) .

Comments were made about the Anesthesia for Certain Dental Procedures mandate. The cost of not covering this mandate (i.e. other costs as a result of not covering this service) should be considered as well as the cost of covering the service.

Robin further explained that these lists are works in progress and are not policy decisions by the state of Vermont; rather, they are a starting point for actuarial analysis. The state is likely not going to do actuarial analysis of mandates that are on the likely-to-be-covered list.

### III. Updates from listening sessions

Robin spoke about a listening session that Region 1 Department of Health and Human Services held in Boston, Massachusetts. Robin Lunge, Nolan Langweil, and Rep. Mike Fisher all attended the listening session. The purpose of the listening session was to get input on how HHS should determine what should and should not be included in the essential benefits for exchanges around the country. The discussion involved the following:

- Definitions of what is in the 10 categories within the exchange
- How the federal government will determine the cost of mandated benefits, and if the states have to pay, what the cost offsets might be
- Additional clarity on how payments would work (federal requirement vs. a state-by-state approach)
- Robin may also make a legal argument about how the federal government should pay for mandates.

### IV. Medicaid Changes Overview pro/con chart

Robin reviewed a PowerPoint that discusses the integration of Medicaid and the Exchange.

The PowerPoint had a list of goals that are directly from Act 48.

The federal government wants state Medicaid programs to integrate with the exchange, and one indication of this wish is that the federal government only approved a renewal of the Global Commitment to Health 1115 Medicaid waiver through 12/31/13. The state will likely pursue another 1115 waiver and will be reviewing what will be included in that waiver application during this exchange implementation phase.

Robin went into detail about the Medicaid income eligibility changes that are occurring in 2014. Right now, Medicaid eligibility stops at 100 % of FPL, but with health care reform Medicaid eligibility will increase to 133 % of FPL. VHAP currently goes up to 150% of FPL. The income determination process is changing for Medicaid to MAGI – Modified Adjusted Gross Income. More guidance on how this change will occur is due from the federal government in additional regulations and guidance.

Discussion followed about how the application process would work if someone applies for insurance on 1/1/14. They would apply on a website, their income information would be verified by the IRS, and the system would determine which MAGI group they would fall into. The federal government's goal is that this would be done all electronically and in real time. The Health Benefit Exchange would serve:

- Individuals without employer-sponsored insurance
- Small Businesses and their employees

Federal tax subsidies will be available for people with incomes under 400% of FPL = \$3684/Month.

One of the challenges in this shifting insurance market is that 70-80% of VHAP will be moved to Medicaid. Individuals who are disabled and elderly would likely stay on Medicaid. The Federal government also has maintenance-of-effort requirements that keep SCHIP (state child health insurance program) children eligible through 2019.

In the PowerPoint chart the 133 % of FPL was represented as 138% of FPL because of a 5% income disregard.

Most of the discussion at the meeting focused on the 4 options that are outlined on the 9<sup>th</sup> slide in the PowerPoint presentation (copied below)

### Medicaid & the Exchange: 2014 Health Coverage Options

| FPL (max) | Today (oversimplified!!) | 2014 Option 1   | 2014 Option 2                         | 2104 Option 3                         | 2014 Option 4                        |
|-----------|--------------------------|---|---------------------------------------|---------------------------------------|--------------------------------------|
| <100%     | Medicaid                 | Medicaid  | Medicaid                              | Medicaid                              | Medicaid                             |
| 138%      | VHAP                     | Medicaid  | Medicaid                              | Medicaid                              | Medicaid                             |
| 150%      | VHAP                     | Basic Health Plan<br>• Via Private MCOs<br>• Via GC MCE | Exchange w/ fed subsidy               | Exchange w/ fed and state subsidy     | State Medicaid Option for Above 138% |
| 185%      | VHAP                     | Basic Health Plan<br>• Via Private MCOs<br>• Via GC MCE | Exchange w/ fed subsidy               | Exchange w/ fed and state subsidy     | State Medicaid Option for Above 138% |
| 200%      | CHAP                     | Basic Health Plan<br>• Via Private MCOs<br>• Via GC MCE | Exchange w/ fed subsidy               | Exchange w/ fed and state subsidy     | State Medicaid Option for Above 138% |
| 300%      | CHAP                     | Exchange w/ federal subsidy                             | Exchange w/ fed subsidy               | Exchange w/ fed and state subsidy     | State Medicaid Option for Above 138% |
| 300%      | VHAP / CHAP ESI subsidy  | ESI (if affordable and comprehensive)                   | ESI (if affordable and comprehensive) | ESI (if affordable and comprehensive) | State Medicaid Option for Above 138% |
| 400%      | Private Insurance        | Exchange w/ fed subsidy                                 | Exchange w/ fed subsidy               | Exchange w/ fed and state subsidy     | State Medicaid Option for Above 138% |
| >400%     | Private Insurance        | Exchange  | Exchange                              | Exchange                              | Exchange                             |

Discussion followed about the four different options.

Current ESI – some people will transition to Medicaid (if income < 133%). Some small employers may receive a subsidy if they buy insurance through the exchange.

The federal subsidy to individuals buying insurance through the exchange is 100% federal funds. Transitioning people into the exchange would be better financially than expanding Medicaid above 133%, since the current Medicaid Federal Financial Participation (FFP) match rate is approximately 60/40.

The federal premium subsidy levels are tied directly to income levels.

The federal system is set up to allow people to remain on a subsidy if their income drops to avoid and/or prevent excessive churning of eligibility on and off of programs. The federal government has not yet explained exactly how this will work.

It is difficult to compare Catamount with the exchange, since the out-of-pocket amounts are higher in federal law than in the Catamount/state law. However, some people currently enrolled in Catamount could actually have lower cost sharing under exchange rules than they currently have in Catamount.

Provider rates are an issue (paying at commercial rates vs. paying at Medicaid rates).

A state subsidy wrap could be set up. This wrap would subsidize someone on a federal subsidy to make the out-of-pocket and premium expenses more affordable.

The basic health plan option is allowed and would be paid for at 95% federal funds. The ACA makes an assumption that states could bargain with insurance companies to make up the other 5%.

The state is building a cost model for each of the options.

Question was asked about "GC MCE" and what that stands for. Global Commitment - Managed Care Entity - this refers to the state being the Managed Care Entity for Medicaid in Vermont under the Global Commitment to Health 1115 Medicaid waiver.

### **Comments from meeting participants about options**

#### **Option # 1**

There is a disadvantage to the state in having a Basic Health Plan. It is one more option for consumers (too many options make things confusing for people), it would allow for more people to go on and off of programs, and Vermont is so small that it would cut into the population on the exchange (and the actuarial makeup of the group on the exchange).

#### **Option # 2**

The disadvantage with this option is that having just federal subsidies alone will not allow some individuals who are currently served by VHAP or Catamount Health to afford health insurance coverage.

#### **Option # 3**

This option appears to be the best option as state subsidies would be added to the federal subsidies to allow for the coverage to be more affordable for consumers.

#### Option # 4

The scope of practice issues should be considered before the state considers using option # 4. For example under this option, chiropractors would be able to bill for 10 visits only.

Further discussion continued:

The state will need to do financial analysis of what they are paying for now vs. what they might pay for in the future with these various options.

The state subsidy would follow the federal subsidy process, since it covers both premiums and cost sharing.

An actuarial analysis will occur to determine the cost of covering a benefit wrap or services that are not covered under the federal mandates – how much would it cost to have the state government cover those services?

The federal cost-sharing subsidy is up to 250 % of FPL, and state-level wrap might be above that level.

ESI wrap is also being considered.

Questions were raised about the Federal Financial Participation matching rates.

Vermont's federal match rate (the amount of federal funding the federal government will match state general fund dollars to pay for Medicaid services) is roughly 60 % federal to 40% state.

The amount of federal match is tied to the per capita income levels in the state and when income goes down, the federal rate goes up and vice versa.

18 different legislative reports are due on 1/15/11.

The reports will be put on the DVHA website once they are complete and links can be shared with this advisory group.

#### Public Comment

A question was raised about the medically needy and Medicaid working people with Disabilities eligibility groups. Comments about eligibility changes for these groups can be found within eligibility comments that the state made to the federal government. The federal government has not yet clarified how these groups will be treated in 2014.

A question was raised about setting the cost share at the state level. This is primarily done at the federal level.

#### **VI. Next steps (Robin Lunge)**

**The next** Monthly Advisory Group meeting will be in the House Chamber of the Statehouse in Montpelier from 10-12 on Friday, December 16th.