

Vermont Health Benefit Exchange

Advisory Group Meeting 2
Monday, April 4, 2011



Today's Meeting

- ❖ **Overview of Interactions between the Exchange, Medicaid and Insurance**
- ❖ **Overview of the Innovator Grant and potential for Vermont – Michael Tutty – University of Massachusetts (by phone)**
- ❖ **Discussion of findings to date: Current Insurance Market**
- ❖ **Discussion of the Integration Work plan**
- ❖ **Basic Health Plan**
- ❖ **Essential Health Benefits**

Overview of Interactions between the Exchange, Medicaid and Insurance

- ❖ PPACA creates significant overlap between the Exchange and Medicaid, and the Exchange and Insurance
- ❖ In Vermont, plan to site Exchange within DVHA lessens difficulties of coordination across the Exchange and Medicaid
 - ❖ Still requires significant systems and business operation changes
- ❖ PPACA requires implementation of several “floor” insurance requirements that impact plans covered in and out of the Exchange
 - ❖ By creating the potential for a market in and outside of the Exchange opens up possibility of overlap and conflict between Exchange and Insurance Department
- ❖ Our work explores the integration of the Exchange with both Medicaid and Insurance and anticipates the need for ongoing efforts by state staff to develop a functioning Exchange that does not conflict with, and to the extent appropriate, collaborates with Medicaid and Insurance policies and procedures.

Overview of Innovator Grant – Presented by – Michael Tutty, UMASS (by phone)



New England States

Collaborative Insurance Exchange Systems

Overview of Innovator Grant: CCIIO's Role

- ❖ Center for Consumer Information & Insurance Oversight (CCIIO) has a phased approach to provide States with resources for implementing Exchanges
- ❖ Second phase funded seven “innovator” states to develop Exchange IT systems that will serve as models for other States (*NESCIES Funding*)
 - Others funded: Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin
 - NESCIES the only innovator award that is offering a formal collaboration between states
 - Innovator award recipients are seen by CCIIO as “pacer states” and will be on an accelerated schedule to develop technology by 2013

Overview of Innovator Grant: NESCIES

Goal

- ❖ The overall goal of the ***New England States Collaborative Insurance Exchange Systems (NESCIES)*** project is to create **Health Insurance Exchange (HIX) Information Technology** components that are consumer-focused, cost-effective, reusable, and sustainable that can be leveraged by the **New England states to operate Health Insurance Exchanges (HIX)**.
- ❖ The **NESCIES** project approach will be to create a flexible **HIX Information Technology framework in Massachusetts** designed to connect consumers, small businesses, and health plans that can be tailored to the needs of the New England states and beyond. Achieving this goal will require the creation of solution that is service-oriented, adaptable, and based on the Exchange Reference Architecture.

Overview of Innovator Grant – NESCIES Organization

University of Massachusetts Medical School (UMMS) serves as the recipient and manager for the lead state of Massachusetts

- Manu Tandon, Chief Information Officer for the Executive Office of Health and Human Services (EOHHS) serves as Principal Technology Lead
- Robert Nevins, Chief Operating Officer of the Massachusetts Connector Authority serves as Principal Functional Lead
- Jay Himmelstein (UMMS) serves as Principle Investigator
- Michael Tutty (UMMS) serves as Project Director

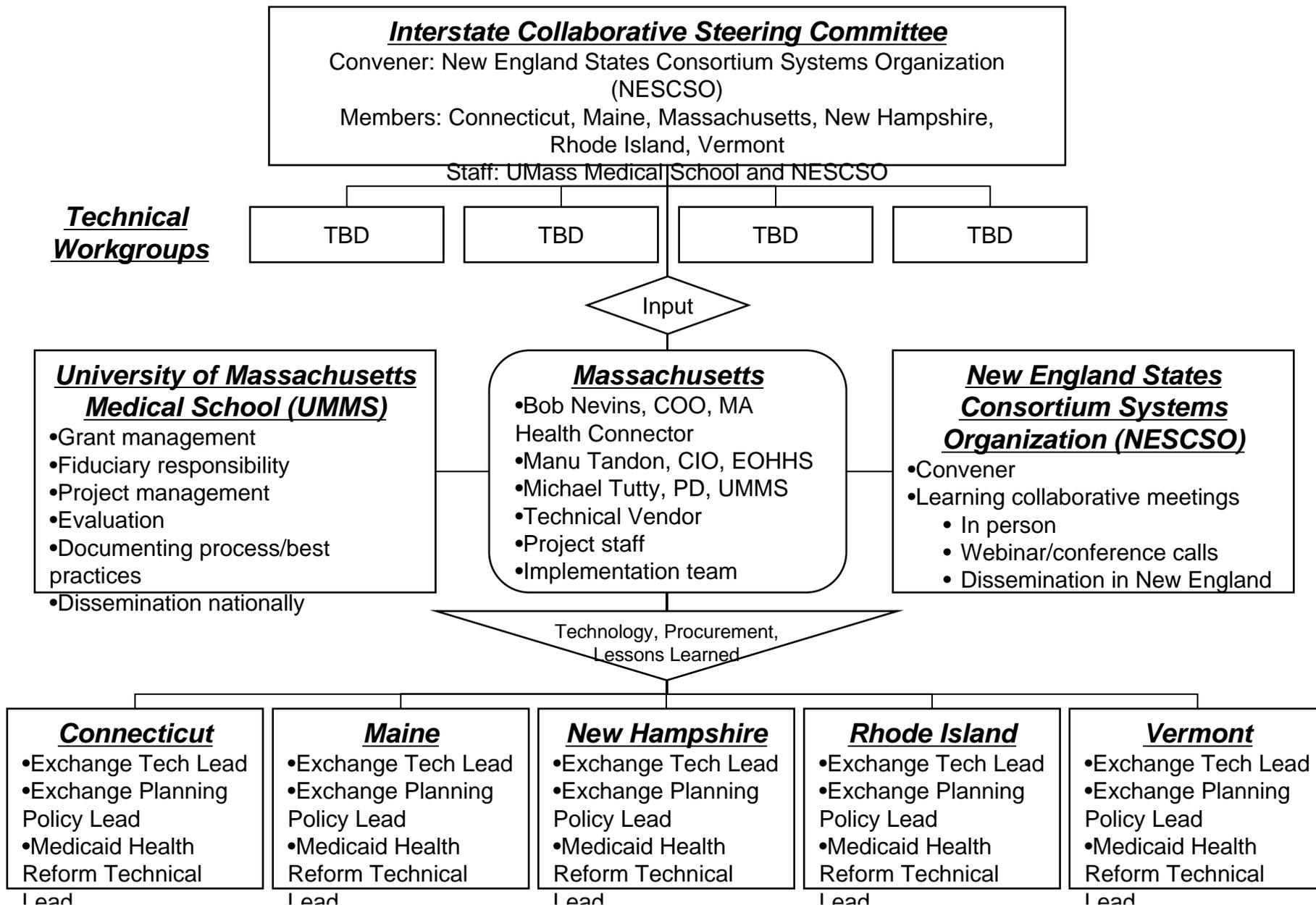
New England States Consortium Systems Organization (NESCSO)

- Nancy Peterson, Deputy Director of NESCSO serves as Interstate Project Lead
- Brenda Harvey, NESCSO Executive Director, chairs the Interstate Steering Committee

Interstate Steering Committee (representation from the New England states)

- Exchange Development Technical Lead
- Exchange Planning Policy Lead
- Medicaid Health Reform Technical Lead

NESCIES Organization Structure



Overview of Innovator Grant – Interstate Collaborative Steering Committee

- ❖ Inform
 - Massachusetts HIX development team on the ability for HIX components to be built as easily adaptable and usable in other states
 - Design and implementation for the component capabilities to be implemented by Massachusetts
- ❖ Learn
 - From CCIIO’s guidance to and learning from the “Innovator States”
 - From the Massachusetts HIX implementation
 - From each participating states’ Exchange development efforts
- ❖ Share
 - Knowledge base
 - Development documents, protocols, and guidelines
 - *Appropriate technical component residuals from Massachusetts*
 - Group purchasing agreements

Overview of Innovator Grant – Interstate Collaborative Steering Committee

- ❖ Representation from the New England states
 - Exchange Development Technical Lead
 - Exchange Planning Policy Lead
 - Medicaid Health Reform Technical Lead

- ❖ Vermont Members
 - Hunt Blair
 - Terry Bequette
 - Joseph Liscinsky

- ❖ UMMS can contract with each state for staff participation on the Interstate Steering Committee and Technical Workgroups
 - Staff time
 - Travel costs
 - Lodging

Overview of Innovator Grant – Massachusetts Efforts To Date

- ❖ Created a MA specific Exchange development working group
- ❖ Completed Architecture Review
 - Presented to CCIIO on April 1st
- ❖ Procuring a Business Process Redesign Contractor
 - Inventory current systems / IT components
 - Assess current systems / IT components
 - Update Architecture Review and Project Baseline Review (PBR) documents
 - Complete Detailed Design Review process documents that map the ideal business and consumer flow processes as required by ACA and CCIIO
 - *Create a scorecard and rate the reusability of each HIX component, both current and to be developed, that could be reused in other New England states*
 - Create a Project Plan, a component-based project plan for updating the Massachusetts Health Connector, including technology updates and timelines

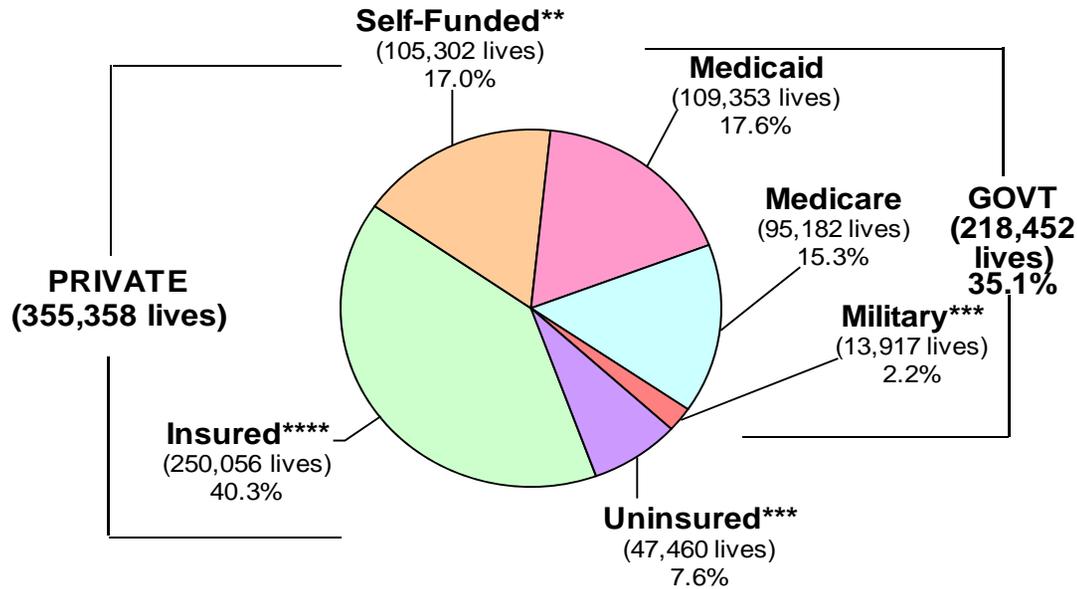
Insurance Market Study

- ❖ Bailit conducted two pieces of work:
 - ❖ Interview with BISHCA Staff
 - ❖ Interview with Insurers

- ❖ Focus of study was to understand the current insurance market and obtain any early understanding of potential approaches to implementing an Exchange in VT.

VT: Primary Source of Health Insurance

**PRIMARY SOURCE OF HEALTH INSURANCE
ALL VERMONT RESIDENTS, 2009**
N=621,270 VT Residents*



* 2009 Vermont Household Insurance Survey that used the U.S. Census Bureau state-level annual population estimate to weight the files.

** BISHCA does not regulate or collect data on Self-Funded. This is an estimate of the total Vermont lives covered by Self-Funded plans which includes Federal Employees Health Benefit Plan

***2009 Vermont Household Insurance Survey

****This number includes 62,061 Vermonters covered by health plans licensed in other states.

Private Insurance Market by Groups

Private Insurance Market, Vermont Residents 2009		
Health Insurance Market Insurance	Covered Lives	Earned Premium
Insured Non-Group ¹	16,521	\$65,872,129
Insured Group ²	233,535	\$703,649,104
Self-insured Employer Plans ³	105,302	Not fully reported
Privately Insured Total	355,358	
¹ Includes Catamount Health plans offered by BCBS VT and MVP Health Plan.		
² Includes Large Employer, Small Employer, Associations, and Vermonters covered by health plans licensed in other states. BISHCA does not have premium information from insurers that are not licensed in Vermont.		
³ BISHCA does not regulate self-insured plans and this estimate is based on the BISHCA Annual Statement Supplement Report and the Vermont Healthcare Claims Uniform & Evaluation System.		

Limited Benefits Coverage – Top Six Carriers

Carrier	Lives	Earned Premium
Vision Services Plan	31,060	\$1,685,203
National Union Fire Insurance Company of Pittsburgh, PA	9,312	\$46,558
American Family Life Assurance Company of Columbus	2,915	\$494,614
Markel Insurance Company	1,039	\$5,211
Connecticut General Life Insurance Company	885	\$17,460
Fidelity Security Life Insurance	613	\$36,657

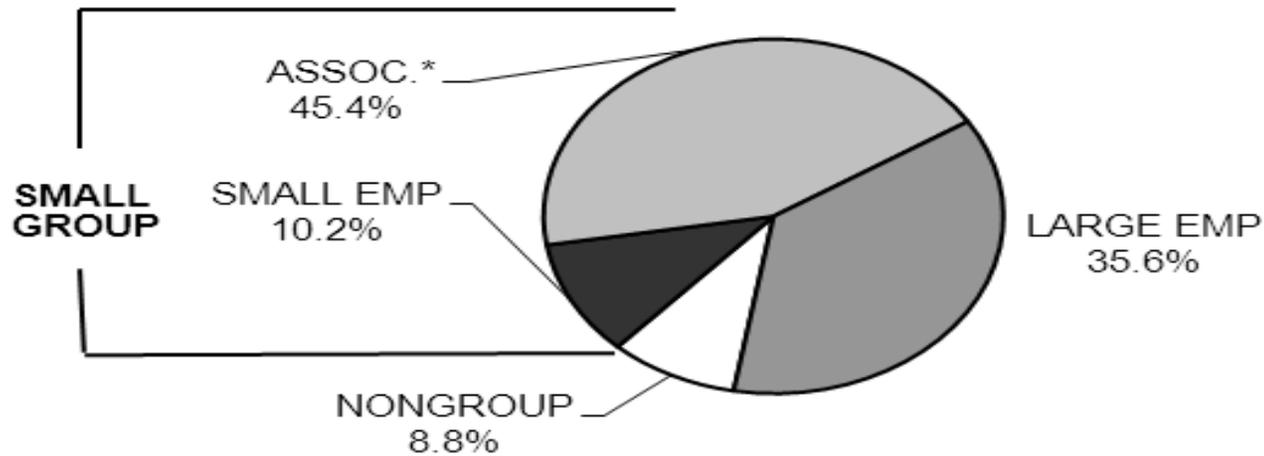
Medicare and Medicare Supplemental Coverage: Top Five Carriers

❖ Medicare and Medicare supplemental – top 5 carriers

Carrier	Earned Premium	Vermont Lives
United Health Care Insurance Company	\$33,170,737	18,447
Blue Cross and Blue Shield of Vermont	\$13,898,731	6,123
Bankers Life and Casualty Company	\$7,434,162	4,144
Mutual of Omaha	\$3,432,830	2,093
American Progressive Life and Health Insurance Co. of NY	\$2,292,696	1,347

VT Insurance Enrollment by Market Segment

ENROLLMENT IN INSURED PLANS BY MARKET SEGMENT: VERMONT, 2009
N=187,995



Data Source: 2009 Annual Statement Supplement

*Association includes Trusts and Discretionary Categories

Data Request

- ❖ The 4 Large Commercial managed care plans in Vermont; CIGNA, MVP, BCBSVT and TVHP are working with the state and Bailit Health Purchasing on clarifying a data submission request made by Bailit.
- ❖ This data submission by the carriers will allow our subcontracted actuary firm Oliver Wyman to do analyses in the future such as the impact of merging the individual and small group markets.

Summary of Interviews with Insurers

- ❖ Interviewed: BCBSVT, CIGNA and MVP
- ❖ Impact of state mandates in total ranges from 1% to over 5% of premium costs
- ❖ Community rating is seen as both beneficial in terms of stabilizing rates across a population and a challenge in terms of increasing premiums 5-10% nationally

Summary of Interviews (cont'd)

- ❖ **Impact of benefit changes already implemented within the ACA on premiums**
 - Dependent coverage to age 26 = 1 – 2 or 3% of premiums
 - No lifetime limits allowed on policy coverage = 0-.25% impact
 - No pre-existing conditions exclusions for children = 0 - .25% impact
 - No discrimination in insurance offerings based on salary and changes in appeals and reviews – no impact on premiums
 - Coverage of preventative care without cost sharing = 0-3% depending upon the plan

Summary of Interviews (cont'd)

- ❖ **No pre-existing condition exclusions for adults & No annual limits on policy coverage**
Insurer's estimate no impact on premiums.
- ❖ **No deductibles beyond ACA limit (noted above)**
Insurers indicated that this will be determined when the caps are known.
- ❖ **No out of pocket costs above ACA standards**
Insurers indicated that this will be determined when standards are known.
- ❖ **No employee waiting period of longer than 90 days**
Insurers indicated that there is no impact (waiting period is usually driven by the employer).

Summary of Interview's (cont'd)

❖ Cost impact on premiums of the following PPACA requirements:

Administrative simplification rules & development of uniform explanation of coverage documents and standardized definitions and having to produce annual reports of quality improvement benefits and reimbursement structures =

The impact is likely to be insignificant may increase administrative costs
IT development and implementation costs and a one-time cost.

Coverage for routine costs associated with clinical trials =

Based on experience with Vermont's current mandate, this is not a significant cost. If participation in clinical trials increases the impact could be greater.

Summary of Interviews (Cont'd)

- ❖ The insurers anticipate few grandfathered plans
- ❖ BCBS and MVP are willing to offer coverage through the Exchange. CIGNA will not make the decision until the final rules have been issued.
- ❖ All three insurers offer small group plans with deductibles above \$2000 for individuals and \$4000 per family. They noted that customers want these plans and hope that the final PPACA rules will allow them in the future

Summary of Interviews (Cont'd)

- ❖ Provider payment arrangements for physicians and hospitals.

By far most payments are made on a fee for service basis and very little is currently done with pay for performance or provider incentive payments

All three of the insurers are waiting to find out more information about Accountable Care Organizations (ACOs) before they make contracting decisions

Distribution of Lives Across Carriers

Insured and Self-Insured Enrollment, Vermont Residents*						
Incurred Claims Period: Jan- Dec 2009						
Insurer Name	Self-Insured	Insured	Total	Percent of Self-Insured	Percent of Insured	Percent of Total
Connecticut General Life Insurance Company	49,759	32,925	82,684	60.9%	17.9%	31.1%
Blue Cross Blue Shield of Vermont	4,368	78,199	82,566	5.3%	42.5%	31.1%
The Vermont Health Plan	0	28,685	28,685	0.0%	15.8%	10.9%
MVF Health Insurance Company	0	19,480	19,480	0.0%	10.8%	7.3%
MVF Health Plan, Inc.	0	14,334	14,334	0.0%	7.8%	5.4%
Complanets Ins Benefits- Administrator (CBA Blue)	10,885	0	10,885	13.1%	0.0%	4.0%
Aetna Life Insurance Co-VT Members	7,498	2,537	10,035	9.2%	1.4%	3.8%
United Healthcare Insurance Company	0	5,297	5,297	0.0%	2.9%	2.0%
MVF Select Care, Inc.	5,233	0	5,233	6.4%	0.0%	2.0%
Other Insurers Combined	4,184	2,468	6,652	5.1%	1.3%	2.5%
	81,705	183,925	265,630	100.0%	100.0%	100.0%

*VHOURS covers over 70 percent of the commercial insurance market

Source: Vermont Healthcare Claims Uniform Reporting & Evaluation System

Current Vermont Mandated Benefits

- ❖ **Guaranteed Issue**
- ❖ **Community Rating**
- ❖ **Chiropractic services**
- ❖ **Clinical trials for cancer patients**
- ❖ **Chemotherapy treatment**
- ❖ **Naturopathic physicians**
- ❖ **Prosthetic parity**
- ❖ **Coverage for covered services provided by athletic trainers**

Current Vermont Mandated Benefits (Cont'd)

- ❖ **Contraceptive mandate**
- ❖ **Health insurance coverage, mental health and substance abuse**
- ❖ **Diabetes treatment**
- ❖ **Treatment of inherited metabolic diseases**
- ❖ **Craniofacial disorders**
- ❖ **Retail pharmacies filling of prescriptions**
- ❖ **Autism mandate**

Integration: Strategy

- Bailit charged with developing an integration strategy to assist Exchange, Medicaid and BISHCA to work together in a coordinated and collaborative way
- Key focus is to ensure all integration activities are in place that are needed to request second phase of Implementation Grant Funds (rolling availability, VT plans to apply no later than 9/30/11)
- Will include detailed business process documentation to reflect current state business processes, and include future State process changes to support proposed Exchange operational requirements
- Will require ongoing communication with the State HIT Coordinators, BISHCA, DVHA, and DCF and AHS

Integration: Determine Roles of Exchange, BISCHA and DVHA

- ❖ Determination of the roles and responsibilities of the Exchange and BISCHA as they relate to qualified health plans offered inside and outside of the exchange.
- ❖ Devise a strategy for limiting adverse selection between the exchange and the outside market, possibly including legislative changes to level the playing field
- ❖ Execute an agreement with DVHA as appropriate for eligibility determination, verification and enrollment

Integration Work: Access, Operations & Funding

- ❖ Strategies for compliance with the “no wrong door” policy
- ❖ Decide what will be the primary access point for coverage
- ❖ Standard operating procedures for interactions between the Exchange and other state health subsidy programs
- ❖ Cost Allocation between the Exchange grants, Medicaid Federal Financial Participation (FFP) and other fund streams as appropriate

Integration: Single Payer

Include in the implementation grant planning an approach that moves towards the state's goal of integration of all insurance into a single payer system in Vermont

- ❖ Integrating or interfacing with DVHA to support enrollment transactions and eligibility referrals
- ❖ Coordinating Appeals
- ❖ Coordinating applications and notices
- ❖ Managing transitions
- ❖ Communicating the enrollment status of individuals

Integration: Enrollment Process

- ❖ Begin developing requirements for systems and program operations, including:
 - Providing customized plan information to individuals based on eligibility and Qualified Health Plan (QHP) data
 - Submitting enrollment transactions to QHP issuers
 - Receiving acknowledgements of enrollment transactions from QHP issuers
 - Submitting relevant data to HHS

ACA Basic Health Program

Who can receive coverage through the Exchange in 2014?

- ❖ Individuals with income < 400% FPL who can receive a federal subsidy if:
 - ❖ ineligible for Medicaid and do not have access to ESI
- ❖ Individuals with access to ESI but who qualify for a voucher based on cost of coverage
- ❖ Individuals who purchase in the non-group market, without access to a subsidy
- ❖ Small employers (to 50, unless state chooses to expand to 100)

ACA Basic Health Program

What is the Basic Health Program?

- ❖ Option for states to implement a program for people 134-200% FPL (outside the Exchange)
- ❖ Must include essential health benefits and consumers may not be charged more than what they would have been charged in the Exchange
- ❖ State receives 95% of the second lowest cost silver plan in the Exchange for each person covered under the Basic Health program
- ❖ Must establish a managed care system with care coordination, incentives for preventive services, etc.

Eligibility for Basic Health Program

- ❖ Option for states to implement a program for people 134-200% FPL
- ❖ People eligible for Basic Health do not receive subsidies through the Exchange
- ❖ Also available to legally resident immigrants with incomes below 133% FPL

Advantages and Disadvantages of Basic Health Program

Advantages

- ❖ Potentially, additional revenue for Vermont
- ❖ Better continuity of care
- ❖ Greater safety net viability
- ❖ Greater financial protection for consumers

Disadvantages

- ❖ Less access to providers
- ❖ Fewer people in the Exchange
- ❖ Risk selection

Options for Vermont regarding Basic Health Program

- ❖ Do not establish a Basic health program and moves all adults above 133% FPL from VHAP to Health Benefit Exchange
- ❖ Transition VHAP and Dr Dynasaur adults between 133-200%FPL to new Basic Health program
- ❖ Do not establish a Basic Health program but maintain coverage under VHAP and Dr. Dynasaur for eligible adults.

Essential Health Benefits

What are Essential Health Benefits?

- ❖ Section 1302 of the PPACA requires health plans offered through an Exchange and state Medicaid plans to meet a minimum set of benefits.
- ❖ Much to be defined, but PPACA includes categories of benefits as essential health benefits (see next slide)
- ❖ HHS must further define and consult with Department of Labor
- ❖ ACA also places some parameters around criteria to be used in finalizing the definition, including balancing among benefits; not discriminating based on disability

Categories of Essential Health Benefits

- ❖ Ambulatory patient services
- ❖ Emergency services
- ❖ Hospitalization
- ❖ Maternity and newborn care
- ❖ Mental health and substance use disorders, including behavioral health treatment
- ❖ Prescription drugs

- ❖ Rehabilitative and habilitative services and devices
- ❖ Laboratory services
- ❖ Prevention & wellness services
- ❖ Chronic disease management
- ❖ Pediatric services, including oral and vision care

Timing for Final Definition of Essential Health Benefits

- ❖ HHS designated IOM to make recommendations on criteria (expected Fall 2011)
- ❖ HHS develop final definitions through rulemaking process (calendar year 2012)
- ❖ State cannot wait until final rules before it begins to analyze the potential impact of Essential Health Benefits on Vermont.

Potential Impact

- ❖ Federal subsidies for coverage within the Exchange will be developed based on projected cost of services that fall within the Essential Health Benefits
- ❖ If any of Vermont's state mandated benefits are not included within an Essential Health Benefits category, then state must bare the cost to continue to require that mandate.
- ❖ Insurers estimate a range of impact of the current mandates (from 1-5% of the total premium amount)

Recommended Analysis

- ❖ There are two choices once we know what is included in Essential Health Benefits:
 - ❖ Amend state law to remove mandates that are not included, or
 - ❖ Appropriate state funds or allocate other resources to pay for additional benefits
- ❖ Analysis should include weighing and prioritization of the following factors:
 - ❖ Cost to the state of including each mandate
 - ❖ Approximate number of VT residents utilizing mandate on an annual basis
 - ❖ Impact of each mandate on individual utilizers

Exchange Advisory Group Meetings

