The Green Mountain Care Board

Vermont Health Benefit Exchange
Plan Design Recommendations

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September 6, 2012

AGENDA

- Review 8/21 Meeting
- Recommendations
  - Two “choice” plan decisions—process & criteria
  - Mental health/substance abuse treatment codes and co-pays
  - Revisions to approved plan designs
  - Supplementing pediatric vision services
- Requested Information
  - Individual out-of-pocket cost scenarios
  - Estimated costs of adult dental services
  - Stand-alone dental plans
  - Child-only plans
- Updated information
  - Habilitative services
  - Supplementing pediatric dental services

Review of August 21st Meeting

- Provided guiding principles
- Reviewed active purchaser approach
- Recommended:
  - A hybrid approach including both state-specified plan designs and "choice" plans designed by insurance carriers
  - 6 specified design options across four actuarial levels

RECOMMENDATIONS

“Choice” Plan Design Rationale

- DHVA recommended structured standard plan designs
- Intention to also consider other options the issuers may propose as innovative and advance the goals of health reform
- This aligns with state role as active purchaser

“Choice” Plan Design

Recommendation: In addition to approving standard plans presented on August 21, **DVHA recommends that the Board grant DVHA authority to approve “Choice” plans based on proposed criteria.**

Process:

- State would release RFR
- Insurers would submit qualified “choice” plan designs
- DFR would review submissions and certify plans
- DVHA would select plans to offer on the Exchange from certified plans based on specific criteria

“Choice” Plan Design Criteria

Recommendation: DVHA would use following criteria in choosing a “Choice” plan:

- Meaningfully different from standard plans
  - Distinct design structure within same AV level, e.g., difference of $500 in deductible, or an AV that varies by at least 10% for three major service categories
  - Ensures additional plan designs offered will increase the diversity of options for groups/members
  - Both quantitative and non-quantitative differences
- Fosters significant innovations in:
  - Wellness promotion - demonstrated experience and success
  - Promoting individual engagement in prevention
- No additional HDHPs

MH/SA Treatment Co-Pays

Recommendation: Approve revision to bronze plan cost-sharing designs as a result of updated actuarial calculations reflecting MH/SA treatment reclassification of services

- Rationale:
  - Act 171, requires DFR to establish a definition of mental health/ substance abuse PCP and specialist services
  - DFR, in consultation with state experts, is developing a proposal identifying which service codes should be categorized as primary care
  - QHP issuers would update their claims processing to reflect lower co-payments for these codes
  - Reclassification is first tangible step in integrating mental health & substance abuse treatment services

Recommendation: Revised Bronze Plans

Deductible/OOP Max	Plan Design 1: Deductible	Plan Design 3: HDHP
Medical Ded	$1,900	$2,000
Rx Ded	$100	$1,250
Integrated Ded	No	Yes
Medical OOPM	$6,250	$6,250
Rx OOPM	$1,250	$1,250
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive
Drug Deductible waived for:	Applies to all scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient/Outpatient/Radiology	50%	50%
ER [3]	$350	50%
Preventive	$0	0%
PCP Office Visit	$35	50%
Specialist Office Visit	$80	50%
Urgent Care/Ambulance	$100	50%
Rx Generic	$12	$12
Rx Preferred Brand	40%	40%
Rx Non-Preferred Brand	60%	60%

- Specified proposed bronze plans approached the limit of actuarial value level
- Expanding the list of MH/SA treatment codes had modest impact on increasing benefits in the plans
- Prudent to make cost-sharing adjustments for purpose of keeping plans within upper limits of bronze plan actuarial values
- **Difference from previous plan is change in Rx Generic co-pay from $10 to $12**
- Further similar modest revisions may be necessary after HHS releases its actuarial value calculator

Future revisions to approved plan designs

Recommendation: DVHA may make minor modifications to approved plan designs under the following conditions:

1. As needed to meet forthcoming federal guidance
2. Modifications restricted to the following:
   - Co-pay changes of *less than or equal to* $15
   - Co-insurance changes of *less than or equal to* 5 percentage points
   - Deductible changes of *less than or equal to* $200

Supplementing Pediatric Vision

Clarification: Supplement benchmark with FEDVIP plan

- Pediatric vision benefits are mandated as an essential health benefit by the ACA
- When the pediatric vision benefit is not provided by or inadequate under the selected benchmark plan, a state must supplement the benefit by looking to the FEDVIP plan's benefits without any cost to the state
- The BCBS benchmark's pediatric vision benefit is inadequate because it lacks coverage for frames and lenses
- Recommendation is to supplement the BCBS benchmark; the FEDVIP plan is the only option with which to do so

REQUESTED INFORMATION

Requested Information: OOP Cost Examples

Scenario 1:

27 year old female on single insurance. Pregnant.

ER visit/delivery/surgery due to Ectopic pregnancy.

Out-Of-Pocket Cost Scenarios									
				Deductible plans				HDHP Plans	
				OOP Expenses to Patient				OOP Expenses to Patient	
Services Used	**# Units**	**Avg Cost**	**Allowed costs**	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver-HD**	**Bronze-HD**
OB/GYN exams X 8	8	$81	$650	$80	$120	$160	$650	$650	$650
Ambulance	1	$900	$900	$50	$50	$100	$900	$780	$900
Rx drugs (3x pref. brand)	3	$117	$350	$120	$170	$217	$200	$350	$350
ER services	1	$4,345	$4,345	$0	$0	$0	$0	$869	$2,223
Surgery (co-ins. + ded.)	1	$14,000	$14,000	$1,625	$3,400	$6,740	$7,950	$2,800	$7,000
Actual OOP Paid by Patient				$1,370	$4,420	$5,217	$6,250	$6,250	$6,250

*A correction is reflected on the ER services row.

Requested Information: OOP Cost Examples

Scenario 2:

Family of four. One child with diabetes.

Dad with cholesterol and high blood pressure meds.

Mother to receive colonoscopy. Other child breaks arm in ski accident.

Out-Of-Pocket Cost Scenarios									
				Deductible plans				HDHP Plans	
				OOP Expenses to Family				OOP Expenses to Family	
Services Used	**# Units**	**Avg Cost**	**Allowed costs**	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver-HD**	**Bronze-HD**
Total PCP visits (8)	8	$100	$800	$80	$120	$160	$800	$800	$800
Diabetes meds (generic)	12	$144	$1,725	$60	$60	$120	$244	$120	$144
Cholesterol, BP generic meds	12	$79	$950	$120	$120	$240	$288	$240	$288
ER services	1	$1,100	$1,100	$100	$150	$250	$1,100	$1,100	$1,100
Colonoscopy (preventive)	1	$4,300	$4,300	$0	$0	$0	$0	$0	$0
Actual OOP Paid by Patient				$360	$450	$770	$2,432	$2,260	$2,332

Requested Information: OOP Cost Examples

Scenario 3:

35 year old male, bipolar, stable on lithium meds.

PCP every 6 months for check-up and labs.

Psychiatrist visits 12 times per year, Counselor 6 times.

Out-Of-Pocket Cost Scenarios									
				Deductible plans				HDHP Plans	
				OOP Expenses to Patient				OOP Expenses to Patient	
Services Used	**# Units**	**Avg Cost**	**Allowed costs**	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
PCP visit - 2 per yr.	2	$85	$170	$20	$30	$40	$120	$102	$128
Rx maint. drugs (generic)	12	$40	$480	$60	$60	$120	$220	$150	$172
lab tests	1	$750	$750	$300	$750	$750	$750	$750	$750
Psychiatrist visits - 18	18	$200	$3,600	$180	$270	$360	$1,520	$1,404	$2,351
Actual OOP Paid by Patient				$560	$1,110	$1,270	$2,610	$2,406	$3,400

Requested Information: OOP Cost Examples

Scenario 4:

58 year old male with COPD, vascular disease and back pain.

PCP every 6 mos. Hospitalized twice for pneumonia.

Requires home oxygen and chronic steroid therapy.

Out-Of-Pocket Cost Scenarios									
				Deductible plans				HDHP Plans	
				OOP Expenses to Patient				OOP Expenses to Patient	
Services Used	**# Units**	**Avg Cost**	**Allowed costs**	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
PCP twice per year	2	$90	$180	$20	$30	$40	$70	$36	$90
Hospitalized - twice	2	$6,000	$12,000	$1,425	$3,000	$5,940	$6,950	$3,752	$6,970
Rx drugs -- 12X generic	12	$20	$240	$60	$60	$120	$152	$120	$144
Rx drugs - 12X pref. brand	12	$60	$720	$480	$500	$620	$324	$610	$324
Home Oxygen and equipment	1	$2,800	$2,800	$280	$560	$1,120	$1,400	$560	$1,400
Actual OOP Paid by Patient				$1,790	$4,150	$5,740	$6,250	$5,078	$6,250

Requested Information: OOP Cost Examples

Scenario 5:

30 year old previously healthy female newly diagnosed with MS.

Serious impairment requires motorized chair, in-home hospital bed, etc.

Out-Of-Pocket Cost Scenarios									
				Deductible plans				HDHP Plans	
				OOP Expenses to Patient				OOP Expenses to Patient	
Services Used	**# Units**	**Avg Cost**	**Allowed costs**	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
PCP 6 visits/yr.	6	$80	$480	$60	$90	$120	$300	$160	$280
Neurologist 3 visits/yr.	3	$300	$900	$60	$75	$90	$460	$420	$600
Rehab 24 visits per yr.	24	$50	$1,200	$480	$600	$720	$1,200	$360	$675
Durable medical equip.	1	$5,000	$5,000	$725	$1,600	$3,140	$3,020	$1,000	$2,500
Specialty Drugs - 12X/yr.	12	$1,000	$12,000	$6,000	$6,025	$6,050	$7,240	$6,410	$7,528
Actual OOP Paid by Patient				$2,500	$3,615	$5,320	$6,230	$3,190	$5,305

Adult Dental Options

- The Board requested cost estimates for offering adult dental services
- We analyzed four different options (see appendix)
- The options estimated cost ranges in **millions**
  - Two exams / cleaning per year: **$17 - $21m**
  - Preventive services: **$25 - $32m**
  - Preventive and restorative services: **$40 - $63m**
  - Preventive, restorative and major services: **$47 - $87m**
- Any additional adult dental cost borne solely by state
- It is uncertain whether any cost-sharing could be applied to the service costs

ADDITIONAL INFORMATION NOT REQUIRING BOARD ACTION

Stand-Alone Dental Plans

- Questions have been raised about the relationship of stand-alone dental to the Board's authority on plan design
- **Under Vermont law, stand alone dental plans are not health benefit plans and therefore do not require Board's approval**

Child-Only Plans

- ACA requires issuer offering a QHP on the Exchange to offer an identical child-only plan
  - Federal regulations provide that carriers could offer a single QHP as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules
- Individuals under age 21, aligned with Medicaid program
- These plans will increase the total number of plans offered on the Exchange

Habilitative Services

- **HHS has clarified that carriers will decide the approach for providing these services; therefore, there is no state decision at this time**
- DVHA will alert the Board if a carrier chooses the approach to provide habilitative services on par with rehabilitative services
- DVHA would then recommend a definition and return to the Board for approval

Supplementing Pediatric Oral

- It has been suggested that the state consider the next largest plan in the small group market for supplementing pediatric dental benefits
- The approach by HHS for supplementing the pediatric vision benefit is to look to either the state's CHIP plan or the FEHBP plan, not the next largest plan in the category
- The BCBS benchmark offers no pediatric dental benefit
- Our recommendation remains to supplement the BCBS benchmark with pediatric dental benefits offered in the state's CHIP plan

APPENDIX

Appendix: Adult Dental Options

		2 Exams/ Cleanings per year	Preventive Services	Preventive and Restorative Services	Preventive, Restorative, and Major Services
Preventive Services					
	Clinical oral examinations	C limit 2 / yr	C limit 2 / yr	C limit 2 / yr	C limit 2 / yr
	Radiographs	NC	C limit 1 / year for bitewings limit 1 / 5 years for panoramic	C limit 1 / year for bitewings limit 1 / 5 years for panoramic	C limit 1 / year for bitewings limit 1 / 5 years for panoramic
	Dental prophylaxis	C limit 2 / yr	C limit 2 / yr	C limit 2 / yr	C limit 2 / yr
	Fluoride treatments	NC	NC	NC	NC
Restorative Services					
	Amalgam, silicate, acrylic or plastic restorations	NC	NC	C	C
	Endodontics - pulp capping, pulpotomy and root canal therapy	NC	NC	C	C
	Periodontics	NC	NC	C limit 1 / 2 yrs	C limit 1 / 2 yrs
	Maintenance prosthodontics	NC	NC	C	C
	Simple extractions	NC	NC	C	C
	Oral Surgery	NC	NC	C	C
	General/Local anesthesia	NC	NC	C	C
Major Services					
	Inlays / Onlays	NC	NC	NC	C
	Crowns - Full and temporary	NC	NC	NC	C limit 1 / 5 years excludes use of High Noble Metal
	Installation of prosthodontics - complete or partial dentures, pontics and abutment	NC	NC	NC	C limit 1 / 5 years
Orthodontics					
	Medically necessary	NC	NC	NC	NC

Appendix: Adult Dental Options, cont.

Cost-Sharing:

	Member Cost Sharing (Preventive / Restorative / Major)		
Benefits Covered	**Option 1**	**Option 2**	**Option 3**
Two exams / cleaning per year	0% / na / na		
Preventive Services (exams, cleanings and x-rays)	0% / na / na		
Preventive and Restorative Services (filling and extractions)	0% / 0% / na	0% / 20% / na	0% / 40% / na
Preventive, Restorative and Major Services (crowns and dentures)	0% / 0% / 0%	0% / 20% / 50%	0% / 40% / 60%

Appendix: Adult Dental Options, cont.

- Cost: Costs based on an estimated 118,000 Exchange enrollees in 2014

	Premium		
Benefits Covered	**Cost-Sharing Option 1**	**Cost-Sharing Option 2**	**Cost-Sharing Option 3**
Two exams / cleaning per year	$16,638,000 – $21,240,000		
Preventive Services (exams, cleanings and x-rays)	$25,134,000 – $31,506,000		
Preventive and Restorative Services (filling and extractions)	$49,914,000 – $63,012,000	$44,958,000 - $56,640,000	$40,020,000 - $50,268,000
Preventive, Restorative and Major Services (crowns and dentures)	$69,030,000 – $87,438,000	$54,516,000 – $68,676,000	$47,436,000 - $60,180,000

Appendix: Adult Dental Assumptions

- Would be a mandatory benefit and thus no adverse selection was included.
- Pent up demand was not included in the premium impacts because it would likely only be a first year impact. While some pent up demand would be expected as uninsured become newly insured, it may be partially offset by a lag in services as newly insured persons learn to use their benefits.
- The PMPMs spread the cost of the adult benefits over the entire population (pediatric benefits were also spread across the population).
- Some high level pricing assumptions exist such as the percent of the population that will be eligible and will use adult dental services.
- The adult benefits are assumed to be starting with age 19.
- The premium dollar impacts reflect 2014 PMPM estimates.
- An estimated administrative load of twenty percent (20%) was included in the premium estimates.
- Costs for services were adjusted for Vermont specific estimated costs.

Appendix: Optional Catastrophic Plans

- At the option of carriers catastrophic plans may be offered on the Exchange
  - ACA requirements: Catastrophic plans may be offered
    - Limited to the non-group market
    - Must provide the Essential Health Benefits
    - Have a minimum deductible which equals amount of HDHP OOPM in the individual market, i.e., approx., $6250 in 2014, except for preventive health services and three primary care visits
    - Under the age of 30, if exempt from the individual mandate because no access to affordable coverage or has an economic hardship