

---

Executive Committee  
RI Healthcare Reform Commission  
Wednesday September 19, 2012  
6:00pm – 7:00pm

Attendees: Lt. Governor Elizabeth Roberts, Governor's Policy Director Kelly Mahoney, Director of Administration Richard Licht, Secretary of Health and Human Services Steven Costantino, Health Insurance Commissioner Christopher Koller

- I. Call to Order - Lt. Governor Elizabeth Roberts called the meeting to order at 6:00pm. I want to thank the Executive Committee members, the members of the public joining us this evening, to discuss this topic, which has some time sensitivity. This topic, Essential Health Benefits, has been before us a few times, and has now gone through the Board, so today we hold this meeting to listen to the additional information on this topic, as we look to make a recommendation to the Governor.
- II. Presentation – Essential Health Benefits – Lindsay McAllister, office of the Lt. Governor, presents. Slides available upon request. Ms. McAllister noted that they are pleased to bring forward the actuarial analysis and the stakeholder input, for your consideration this evening.
- III. Memorandum of Decisions:

On September 19, 2012, the Executive Committee of the RI Health Reform Commission met to address the essential health benefits provision of the Affordable Care Act in order to formulate a recommendation to the Governor. This was the third meeting of the Executive Committee at which an update on the EHB stakeholder process was provided and the variables involved in composing an EHB recommendation were discussed. Staff provided the Executive Committee with a summary of the public input on the elements of the recommendation. Public input was gathered from the stakeholder Work Group, a two-week period for written public comment and an R.I. Health Benefits Exchange Advisory Board meeting at which this topic was discussed.

The Committee reviewed an outline of the four decisions required for a comprehensive recommendation. This Executive Committee reviewed an actuarial analyses of the fiscal impact of each option for each of the four components; selection of a benchmark plan, pediatric vision, pediatric dental and habilitative services. The Chair accepted motions on each component of the recommendation separately. Kelly Mahoney announced prior to voting that as the Governor's Policy Director she would abstain from voting, as it would be incumbent on her to carry the Committee's recommendations to the Governor.

A summary of the discussion and recommendations is provided below:

### Benchmark Designation

The Committee was advised that through the stakeholder process, and with significant public input, the array of benchmark options made available to the state had been narrowed to just two. The three federal employee plans were eliminated in light of the proposed federal approach to funding for the subsidies being offered on the Exchange to make insurance more affordable. Based on the federal guidance, state insurance mandates included in the selected benchmark plan will be fully funded for subsidized purchasers of insurance by federal subsidy dollars. On the other hand, if the State were to select a benchmark plan, like the three federal plans, that does not include all state mandates, state general revenue would have to be used to pay that portion of the subsidy associated with the state mandated coverage. This reality made it impractical for the Executive Committee to recommend the adoption of one of the federal plans for the benchmark plan.

The remaining analysis conducted at the stakeholder level focused on selecting a benchmark plan that would drive affordability, and toward that goal, the state's two largest small group plans and the state employees health plan were analyzed for their relative potential impact on premiums. The actuarial analysis showed that the BCBSRI Vantage Blue plan would cost approximately \$1.00 - \$1.25 more (PMPM) than the United Choice Plus plan (a difference of not more than .003 percent on the projected total individual premium of \$360 PMPM). It was also determined that both commercial small group plans would provide slightly more affordable options than the state employee plan.

While affordability was a primary concern of the Executive Committee, in its deliberations the Executive Committee carefully considered comments submitted in writing as well as through the stakeholder meeting process. Medical providers have expressed significant concerns regarding the administrative burden associated with the UHC plan. Administrative burden is not part of the designation of the list of essential health benefits which the EHB determination will require to be covered, medical providers were firm in their view that it would send a negative message to choose a proxy list of services that is perceived to have been linked to more hurdles for administration. The Executive Committee also considered a comparison of the breadth and depth of coverage for behavioral health services between the two small group plans. The UHC plan uses some session limits (consistent with R.I. state law) to manage use of behavioral health services, which were also outlined for the Committee. The BCBSRI plan does not currently use such session limits and the BCBSRI plan is already in compliance with the federal mental health parity law due to be phased in over the next years.

As to the recommendation for the baseline plan, the Chair requested a motion. A motion to recommend the BCBSRI plan, based on the lack of meaningful cost differential, the perception of more streamlined administration with the BCBSRI plan and the more flexible approach to behavioral health coverage was made and seconded. There were four votes in the affirmative and one abstention

#### Pediatric Vision

The Committee considered three issues relating to pediatric vision. The threshold question involved the BCBSRI plan's coverage of an annual vision exam and whether that coverage was sufficient to satisfy this category of EHBs. The Committee was informed that if it intended to recommend supplementing this area to cover vision materials (glasses, lenses, etc.), the only option made available in the federal guidance to supplement our baseline plan would be a federal employee plan. The actuarial analysis indicated that this supplementation plan (providing corrective lenses in addition to an annual vision exam) is estimated to cost an additional \$0.50 -\$0.75 (PMPM). The final matter related to resolving, at the state level, the ambiguity in federal guidance regarding the age cut off for the pediatric population. The Committee was therefore provided two possible options; to cover up to age 19 for the cost cited above, or to cover up to age 21 for an additional roughly \$0.10-\$0.16 (PMPM).

The Committee was advised that the stakeholder feedback and majority of comments from the Exchange Board had been in favor of supplementing vision with the federal employee plan, and that the preponderance of public comment supported providing pediatric coverage through the age of 21 rather than 19.

The Chair entertained a motion to recommend supplementing the pediatric vision category and to cover up to age 21. The Committee voted unanimously in favor of the motion with one abstention.

#### Pediatric Dental

The Committee next considered whether to supplement the baseline plan (which contains no coverage for pediatric dental services) with the RItE Smiles program or a federal employee plan offered by MetLife, the two options available to the state under federal guidance. The plans were estimated to have the same premium impact up to age 19 (\$5.25-\$6.50 PMPM), however the Committee was advised of a potential increase of \$0.25(PMPM) under RItE Smiles if covering pediatric dental up to 21.

The Committee was advised of two considerations relevant to this decision which had been raised during the stakeholder meetings; first, that a commercial plan may be an easier contract to incorporate which might pose an

advantages to providers in terms of ease of transition to the new system, but also that RItE Smiles may address concerns about families transitioning from Medicaid to a commercial plan and minimize the impact on families of so-called “churn”. The Committee discussed this decision at length. During this phase of the deliberations concerns were raised that although each supplemental category, while not expensive in its own right, may add up to a more significant impact on base premiums when taken together. This concern was primarily focused around the lack of clear guidance and cost analysis regarding the potential coverage to be provided in the as yet undefined habilitative category.

The Committee considered the possibility of recommending the MetLife product up to age 19 as a way to drive affordability, but was also sensitive to the concern raised during the stakeholder meetings that consistency in the age of the pediatric population would be important. A motion was made to recommend the MetLife plan and to define pediatric dental coverage as up to age 19 with the condition that the Committee would reopen the age question on pediatric vision and discuss the consistency question. The Committee voted unanimously in favor of the motion with one abstention.

A motion to reopen the matter of pediatric vision followed, and was passed unanimously. Upon reconsideration, the Committee voted unanimously, with one abstention, to recommend supplementing this category with the federal employee plan, but to cover pediatric dental services only up to age 19.

#### Habilitative

The final matter brought to the attention of the Committee was very recent federal guidance that redefined the state’s understanding of how it was being asked to address the issue of whether the habilitative services category is contained in the state’s EHBs. The Committee was advised that the state/federal EHB designation process sought a “yes” or “no” indication from the state as to whether its chosen benchmark plan covers habilitative services. Earlier guidance had suggested that the state would not only make a yes or no determination on whether the baseline plan includes meaningful habilitative services but to delve further into an approach for covering them (i.e. parity with rehabilitative services) if the conclusion was that they are not included in the baseline plan.

The Committee was informed that the BCBSRI plan does not explicitly cover habilitative services, but that some services are covered in practice (e.g., physical therapy, speech therapy) for habilitative purposes, but an episodic basis only.

Furthermore, the strong consensus across the stakeholder process, public comment period and discussion among the Exchange Board members was that existing commercial coverage of habilitative services was insufficient to meet

the legislative intent of the Affordable Care Act in including coverage for habilitative services and should be supplemented.

A motion was made to recommend that habilitative services be considered unfulfilled within the benchmark plan and the Committee voted unanimously in its favor with one abstention.

Summary of Deliberations:

The Executive Committee of the R.I. Healthcare Reform Commissioner recommends to the Governor as follows:

- 1) BCBSRI Vantage Blue Small Group coverage should be designated as Rhode Island's baseline coverage, representing the minimum array of covered services that an individual must purchase in order to fulfill the individual mandate to have insurance coverage.
- 2) BCBSRI Vantage Blue Small Group does not include meaningful pediatric vision services and therefore the annual eye examination should be supplemented by the addition of the Federal pediatric vision coverage (Fedvip BlueVision), which will provide some coverage for corrective lenses. This pediatric vision coverage should be provided for Rhode Islanders up to 19 years old.
- 3) BCBSRI Vantage Blue Small Group does not include pediatric dental coverage and therefore should be supplemented with the services covered by the MetLife dental plan. This pediatric dental coverage should be provided for Rhode Islanders up to 19 years old.
- 4) Rhode Island should indicate in its EHB filing that the baseline plan does *not* include meaningful coverage for habilitative services consistent with the Affordable Care Act requirement and will need to be supplemented by carriers.

IV. Public Comment: No comment put forward at this time.

V. Adjourn