Essential Health Benefits Work Group
Monday April 16, 2012
8:30am - RI-CIE
Meeting Minutes

Attendance: John Fleig, Dawn Wardyga, Kathryn Shanley, Rachelle Dunning, Jill Beckwith, Susan Yolen, Deidre Gifford, Chris Koller, John Cucco, Mark Deion, Melinda Thomas, Holly Garvey, Mark Kerrin, Lizzie Hicks, Craig O'Connor, Chris Kent, Bonnie Larson, Carrie Bridges, Bill Delmage, Tim Bonin, Elaine Jones, Elizabeth Lange, Amy Black, Mike Quirk, Laura Viehmann, Steve Brown, Domenic Delmonico, Dan Meuse, Elaina Goldstein, Bill Hollinshead

I. Call to Order – Lindsay McAllister, Office of the Lt. Governor, welcomed members and thanked them for the time. She asked members to introduce themselves with each comment they make to ensure that this group becomes familiar with one another and allows for a sufficient recording. This is the first meeting of the Essential Health Benefits Work Group, which will serve as an introduction to the topic. This group will then meet about every three weeks.

II. Presentation – Essential Health Benefits under the Affordable Care Act. Ms. McAllister gave the presentation speaking to the introduction of Essential Health Benefits (Hereafter EHB). The slides are available upon request.

Questions/Comments/Clarifications

a. Lindsay McAllister: Initially at the state level we believed that the federal guidance would come out and we would have a specific, well-defined list of benefits. Then the guidance came out and it was clear they were going to be more vague and allow states more leverage. The benchmark determines how our plan will be moving forward. If we chose a benchmark plan that includes statutory mandates, then at least at the state level initially we will not bear the cost that are statutory mandates, which were on the books by the end of 2011.
b. Certain statutory mandates that we have in RI have dollar caps associated. Under the Affordable Care Act, annual as well as lifetime dollar caps are not permitted.
c. Ms. McAllister reminded folks that these groups are not limited to Commission members, and that others in the field who this topic may impact are of course welcome to participate.
d. The decision for choosing a benchmark must be done by October 1, 2012.

III. Questions/ Comments Concerns

a. Kathryn Shanley: So what you are saying then is that it is okay to have some limits on so many procedures, and you can also have prior approval and prior authorizations as requirements?
    i. Lindsay McAllister: Yes that would be a conversation for the qualified health plan process as well. Utilizations that are

considered common practice today will be permitted into the future.

b. Kathryn Shanley: The exception to age is pediatric benefits?
    i. Lindsay McAllister: Yes
c. Mark Deion: If I understand correctly, all our state mandates have to be included?
    i. Lindsay McAllister: They do not have to be included, if we chose one of the federal health benefits plans, that naturally would not include all our state mandates– if we chose a small group plan currently existing today, then yes, the statutory mandates would be included in our benchmark.
    ii. Mark Deion: What is the federal level plan?
    iii. Commissioner Koller: By law state mandates cannot be included by federal employees benefits program.
    iv. Mark Deion: So how does the federal mandate plan compare if we use that as a model can we incorporate state mandates?
    v. Lindsay McAllister: We are working on a report that will give an idea of what is in each plan, and at the next meeting have some sort of discussion of each plan.
    vi. Commissioner Koller: Rule of thumb, state benefit mandates add about 10% to the cost of health insurance, 5% is mental health parity. Another couple percent is infertility, the remaining 35 -70 are worth about 2.5% of your premium. The ability to control the cost of your premium is less in the set of benefits that you cover and more in the design. If you look at how the exchange is going to get to an actuarial value of 60-70% it is going to be more than benefit design and administration.
d. Dawn Wardyga: Being one who has fallen into one of those self-insured groups, we know all too well what is and is not covered by the federal employee plan. Having said that, I would like to know, for context, how many self-insureds and large group plans exist in the state and how many covered lives are impacted? The question has relevance because when we think about the full population of the state of RI, we need to think about what is the percentage?
    i. Commissioner Koller: 30-40% of commercial lives are self-insured. The individual market and small group market will be required to cover the Essential Health Benefits.
    ii. Dan Meuse: Right now in the RI population under 65, commercial large group and self insured make up 518K, commercial small group 87K, individual, 120K uninsured,. Commercial, small group, self-insured makes up about half of that Medicaid population.
    iii. Dawn Wardyga: Thank you.
e. Laura Viehmann: You told us you are going to be working on what the benefits are and what the different options are for benchmarks – is

that possible to have done before the meeting – as I would need to review that before the meeting.

    i. Lindsay McAllister: It is in draft form, and it would not be difficult to send that out before our next session. Will send around.

f. Elaina Goldstein: Two questions, initially, Health and Human Services is going to bear the cost of additional benefits the state decides to include in its package? Are there some things that are in the categories that are not in our mandates?
    i. Lindsay McAllister: What I meant is the benchmark we ultimately choose from among the number of options, may not already cover all the categories of EHB.
    ii. Elaina Goldstein: The Medicaid benefits are different than commercial benefits, but they do not need to be the EHB package. So what happens if someone was on Medicaid, and their coverage changes?
    iii. Lindsay McAllister: That is a decision for Medicaid to make, but it is definitely something that is in our discussion, the issue of churn is very important.
    iv. Elaina Goldstein: Will we be able to see which benefits plan…?
    v. Commissioner Koller: We did not put that up there, in the discussion by HHS, for the new people who are coming on to Medicaid, they can pick the RIte Care benefits, or others – that is not part of our process here, but we should be aware it is coming up.

g. Beth Lange: I understand the charge of this committee is to understand the options and help the state to make decisions about the best fiduciary and comprehensive plan options as well. State advocacy groups are part of this, but we need all stakeholders also.

h. Domenic Delmonico: Can you also put out the state's public health goals, it would be nice to see how those line up? Is it also possible to put some actuarial costs of the mandates with those benefits as that may help with the decision making plan.
    i. Commissioner Koller: Two assumptions in your questions, Domenic, that the state has public health goals and we have these numbers immediately available. That said, we will certainly get all the numbers and information that we can to you in future presentations.

i. Bill Delmage: Is there a target or goal and a percent differential between what the platinum plan is at one rate and EHB will come in at say 60-70% lower than that? Is there a target to define a plan around?
    i. Commissioner Koller: Think of the EHB list of being 100%, the broad list that we are determining as a state that everyone should have access too. How we move off that is a part of this benefit design. Open network, no constraints for accessing those benefits. Then determining what percentage will be

picked up by the consumer - what benefit design will get you 90%, 80% 60% etc. Benefit design gets to that question. EHB is the 100% that we are asking folks to cover- if a plan wants to do more, say cover gym memberships, then so be it, but if we ask them to give a percent it is off the estimated cost of the EHB.

j. Mark Deion: When we figure out what it is that we are trying to do, we need to consider cost control or cost containment. Will that be a consideration here? If we posit that health insurance is not affordable today, then what we design with this ultimately should make health insurance more affordable. Are we using today's rates to help with cost containment?
    i. Lindsay McAllister: That is certainly something that needs to be a part of the conversation.

k. Laura Viehmann: As you move away from daily patient care into policy discussions, I am lost. Can you clarify?
    i. Commissioner Koller: Sure. You take these ten categories, out of these will be a more detailed list that first the Exchange will give to an actuary and say what is the total cost for providing these services. All inpatient hospitalization, prescription drugs are we going to cover all, etc; this is the total cost, come up with a benefit design, the big one being around rehab and habilitative services. Then turn to an actuary and say what is the total cost for paying all around these services. Before cost sharing, before anything else. Then the Exchange says come up with a benefit design that will say we have to pay 90% of that cost sharing. The exchange might say I will ship 10% to the consumer, or they may say we are only going to cover emergency services with a prior authorization, and we estimate that is going to cost a percentage. The Exchange will look at it with an independent actuary, and those will be the products.

l. Domenic Delmonico: At one point we tried to benchmark cost and average salary in RI – is that still a part of this?
    i. Commissioner Koller: The federal government did that for us – they estimated that it is not comparing that cost to an average income, and there assume about 9.5% of income (est.) and they said put in 9.5% of income and the magic of the Exchange will join in on what you can afford to pay and the cost of the essential health benefit. Federal money makes up the difference via subsidies.

m. Elaine Jones: Starting to get nervous with the other two columns, who will be overseeing that to ensure it is not getting shifted to paperwork and red tape?

    i. Lindsay McAllister: Absolutely – there will be a conversation in the exchange stakeholder group around qualified health plans and what they can do in terms of plan and benefit design.
    ii. Commissioner Koller: And the right balance must be struck to ensure we don't dump all on patients or dump all on providers.

n. Steve Brown: what do you see in terms of dental plans and pediatric dentistry – same plan or something else?
    i. Lindsay McAllister: First look at the federal employee plan rider, and for pediatric that needs to be defined separately, it can be provided as both one plan and as a separate plan.
    ii. Dan Meuse: Adult dental is not in the essential health benefits. On the Exchange there are opportunities to purchase dental plans whether they be bundled or stand alone dental, but from a benefits definition perspective, take the federal guidelines on how to integrate pediatric oral health services and consider how to fold those in.
    iii. Steve Brown: I noticed that emergency services are a part of that mandate, and major medical problems, incorporate that into this.

o. Beth Lange: Talking about prior authorizations, as the shift to patient will involve a shift to the provider as well.

p. Domenic Delmonico: In the state employee health plan they can earn back some cost through healthy activities (wellness etc).
    i. Lindsay McAllister: That is something that plans can chose to offer in addition to EHB, but in terms of the practicality of doing so via the Exchange, that needs a closer look.

q. Bill Hollinshead: This state has been fairly enthusiastic about shifting some of it's other costs into what was perceived as a rich cash stream, some environmental health services, some developmental services and the like … unfortunately those long term costs wind up reappearing whether in the school budget or the ACI in future years. I would be interested in your take as to who will try to look at the long term impact in squeezing down on these things.
    i. Lindsay McAllister: That is a great point, and that is why I am pleased we have strong child advocates participating in this discussion. Through some of our existing grant relationships we are trying to look at things like that.
    ii. Commissioner Koller: We cannot neglect the role of the legislature in the process, do not want to usurp that prerogative.

r. Jill Beckwith: Can you talk about this process once October 1st happens?
    i. Lindsay McAllister: This group, under the Healthcare Reform Commission, will be able to share some of the viewpoints and opinions up to the executive branch. CCIIO has indicated they would like to hear from the executive branch on this issue in

quarter three. The process for converting dollars in utilization review is likely where the legislature may play a role.

s. Dawn Wardyga: Will there be some point in time when we get a written copy of the recommendations that you will send forward? We don't always see what is presented to the next level, and I think it would be helpful going forward that whatever set of recommendations that come out of this work group would be wonderful to have a copy of them.
    i. Lindsay McAllister: That is good feedback, it is a little tricky as under the Executive Order this is an advisory group, and there is that affect of tumbling upwards – it is a bit less tangible, and we hear that, but what we can do is work harder on cycling back.

t. Kathryn Shanley: Will an adult buying individual coverage on the exchange, will the pediatric oral and vision coverage be required to be purchased?
    i. Lindsay McAllister: My gut would say since it is an EHB it will naturally be included in any plan.
    ii. Kathryn Shanley: My example would be that say Tufts doesn't want to offer a pediatric dental plan, but Delta dental would be able to offer it. It raises other questions, i.e. if you are a man are you still purchasing maternity benefits?
    iii. Lindsay McAllister: It is a good question; we have not seen anything specifically on it thus far.

u. Laura Viehmann: Glad this is an open session; do you have to pay for services you do not use, but do recall paying for pediatric dental, pay for maternity benefits will all balance out down the road, societal benefits. I read this weekend that the cost of one fatal child abuse case is $1.2million, the cost of one non-fatal child abuse case is $210K, so it is staggering that when you are asking for services that will result in prevention the cost cannot be measured in the way we measure other things.

IV. Public Comment – no additional comment put forward at this time.

V. Adjourn – Next meeting May 11 2012