

Essential Health Benefits
Monday August 6, 2012
Brown Continuing Education Building
8:00am – Meeting Minutes

Attendees: Gary Witman, Betsy Loucks, Paul Block, Julie Meyer, Bill Hollinshead, Elaine Jones, Mark Deion, Jason Brown, Owen Heleen, Pat Blankiron, Megan Tucker, Tim Bonin, Susan Yolen, Kathryn Shanley, Judy Bentkover, Chris Koller, Lindsay McAllister, John Cucco, Sandi Ferretti, Elaina Goldstein, Dawn Wardyga, Tara Townsend, Stacy Paterno, Holly Garvey, Linda Katz, Rich Leclerc

- I. Call to order: Lindsay McAllister called the meeting to order at 8:00am. She advised this would be one of the last meetings on the Essential Health Benefits as we draw closer to an autumn deadline. Today we will look at Habilitative Services as relevant to the Essential Health Benefits.
- II. Presentation – Habilitative Services – Presentation available on website and upon request.
Questions/Comments/Clarifications
 - a. Dawn Wardyga: I know there were three terms, “keep, learn or improve” your emphasis as you spoke was on learn, and as we think about habilitative services there is a certain plateau that some patients may reach, so there is a term used in Medicaid documents in the state – ameliorate. I think it helps to aid the “keep” word in that realm, I think we need to be sure we do not lose that in the context. I think the word keep is very key.
 - i. Lindsay McAllister: I think that is a good point and if we talking about the congressional intent here, they included rehabilitative as well as habilitative and other included the term keep.
 - b. Elaina Goldstein: In a side meeting some of us held, Dr. Jones noted that the distinction in rehabilitative is post acute maintenance and required skills and functions; the second is a primary delayed function, acquire skills function that are not readily available. The rationale for the length of time needed is also really important.
 - c. Elaina Goldstein: I would also like to emphasize that the Medicaid definition says about home and community based settings they include prevocational similar community based settings.
- III. Discussion – Opening the floor up for detailed discussion about the choice we may make in RI about covering habilitative services.
 - a. Kathryn Shanley: Has there been any discussion of what this new benefit may cost?
 - i. Lindsay McAllister: We are working to have an actuarial analysis done, but you will remember that in our discussions we have been keen to keep affordability as one of our main ideals, we are aware of this. It is hard to say.

- b. Elaine Jones: You have hit on the big issues here, this is totally new ground, it is exciting but has the potential to be extremely expensive. With the habilitative side you also have the opportunity to reduce costs in other arenas. It is potentially very exciting, but how do we keep those costs under control. We do see this over and over in neurology particularly with stroke patients. When we had a side meeting, we discussed a lot of how we define the services, but I think the key part of it is the “keep” in the services. My personal opinion is that we shouldn’t just punt it to insurers to decide how they will do it – they will have great resources on how to consider it, but they have a different world view. I am not enamored with the parity idea, but I do see its value.
 - i. Lindsay McAllister: That raises a good question though, under parity or the second approach does that leave room for controls in the state field.
- c. Unidentified participant: In CT, there was a group in charge of trying to come up with the benefits for the plan, we looked at several points of research. We looked at the Oregon plan, federal guidelines, and some plans in the UK, as well as the Kaiser Family Foundation. In this case I don’t know if the sources have any insights. In the UK for example, they have to make decisions based on a budget, and how to make the benefits work with said budget, there are reduced numbers of MRIs, etc.
- d. Mark Deion: It is interesting that they use parity for two things that are not the same. How can you take something that is a potential life long problem and say you can only link a benefit to it that is not life long. Providing a service that prevents someone from being hospitalized, coming up with that kind of analysis of cost makes a great deal of sense. The word parity is concerning as rehabilitative and habilitative are two distinctly different things, and do it while saying it is a cost effective use of health insurance.
- e. Elaina Goldstein: I agree with the point about parity not being directly relevant as the two things are expressly different. One of the things we did talk about and are trying to learn lessons from is RITE Care. The way in which RITE Care does things is there are criteria they must meet. Perhaps in this case it would be up to the insurers to work with the exchange board to try to determine how to work this all out. Maybe that walks us away from parity; perhaps this issue will be one of the issues that classify a plan as a QHP.
- f. Bill Hollinshead: How does this play with the mandated benefit issues that you have outlined in previous discussions?
 - i. Lindsay McAllister: I haven’t taken a look yet to see how our state mandates would overlap with these particular benefits, but I do know in other states there are mandates that would cover many of these benefits. Nothing comes to mind off the top of my head.

- g. Lindsay McAllister: I think the conversation has hit, do we chose parity and at least know there is a minimum level, the alternative being allowing plans to issue their own benefit design and allowing uncertainty there. Are there other comments about pros or cons on either of the approaches?
- h. Paul Block: This change pushes the boundary between public good and insurance coverage into play – has there been a discussion about how to define that difference?
 - i. Lindsay McAllister: No, but there is an awareness that there is a potential for cost shifting with this decision.
 - ii. Paul Block: My comment would then be trying to determine what we want that definition to be. It's not just cost shifting, but people are going to begin to think about these as challenges as unrelated efforts for employers to be able to offer health insurance.
- i. Bill Hollinshead: How would HHS likely respond? We say we are going to just follow the IOM and do what Medicaid does?
 - i. Lindsay McAllister: That is a fair question, one to which I do not know the answer. It is hard to know how far we can push back with the feds before they will react. HHS is in some ways on the same level of this as the states are, but it is indeed hard to know their reaction points. I would imagine that with respect to the EHB categories they do want to see their guidance pretty well adhered to, at least for the first two years.
- j. Elaina Goldstein: I do want to point out one other inconsistency with this whole thing. This flies in the face of preventing dollar caps. Ask how does this tie in...?
 - i. Lindsay McAllister: Elaina is alluding to any specific dollar caps to any of the EHB categories, and while this doesn't have a dollar sign it does have an allusion of a max out of benefits.
- k. Dawn Wardyga: The length, duration and scope of the benefits needed for someone with lifelong needs. Having said that, what Elaina says is right, this suggested max out does fly in the face of what the original intent have been. I would be really uncomfortable if RI begins to move in a direction in which we move in a way that eliminates or limits some of the benefits. Applying for Medicaid is one thing; eligibility is a whole other story. You can have two people with the exact condition, with the exact needs and whatever, and one of those people will clearly get in the Medicaid door, and the other will not.
- l. Unidentified participant: To the extent that it matters, I would support those coming up with a decision rather than punting it to those at the health plans. I think we can do as good of a job, whether we pick the IOM report or head in a direction of parity.
 - i. Lindsay McAllister: It sounds like you are suggesting parity, but continuing to work perhaps at a stakeholder level to continue the conversation.

- m. Kim Holloway: Outside the exchange you have the complication that you will be impacting large groups, and if it starts to increase the cost to an extent it is unaffordable, essentially someone will stop covering them. It gets confusing.
- n. Elaina Goldstein: The big thing when we went through the global waiver process we realized that many states have top notch benefits programs, I think the other thing we need to include here is an assessment tool. It is not constraining costs – when you spread the risk over a large population it will not hit any one plan to that extent. Yet when it hits you and your family it is devastating which is where we want to get away from on ACA.
- o. Mark Deion: I listen to the word parity, parity with rehabilitative to habilitative, in one instance you have a car that needs 2 quarts of oil to run in another you have a car with 5 quarts of oil to run, but you're saying we need to treat them the same. I don't understand how we say that. Also, Elaina you said at some point there will be a dollar assessment for these issues – but I don't see the numbers. My one criticism with all of these processes is that I don't see the numbers to back these words and statements up. I worry that at the last minute someone will add this all up, and someone will say “oops” this is more money than we expected. I am ill equipped to make a decision on many of these questions, and I understand theoretically that would be a good thing, but unless I see numbers I can't qualify my decision.
 - i. Lindsay McAllister: We are hoping to bring an actuarial assessment back to this group at our next session. It is difficult to get numbers on a national scale or on take up.
 - ii. Elaina Goldstein: Can we ask Medicaid for numbers?
- p. Kathryn Shanley: Does habilitative include nursing care?
 - i. Lindsay McAllister: No - not an institutional benefit.
- q. Unidentified Participant: Given this conversation, part of what is doable in terms of all the comments and suggestions before the time that the Governor needs to bring this to EOHHS and what will be done in RI, I think it is key to know what the definition is, what the numbers are etc. We as a state need to have the time to do the habilitation definition for RI. This is a very short period of time to be taking this one – I think some of the other states like Maryland are thinking ahead. Thinking of using these two years as a baseline, and then build off of it. How do we come forward with a greater definition for our state I think is a key thing to think about.
 - i. Lindsay McAllister: There will absolutely still be time at our next meeting to be formulating our opinions and recommendations.
- r. Lindsay McAllister: We are getting to a point where we are looking to bring all the discussions and the points made at this group up to the Executive Committee. As you are thinking through the work we have done the last several months, I would encourage you to take a review

of those meetings. We will be holding a public comment period for this work group, so you may submit your opinions in writing.

- IV. Public Comment: No additional comment put forward at this time.
- V. Adjourn.