VERMONTERS
FOR HEALTH CARE FREEDOM

August 31, 2012

Georgia Maheras, Esq.
Executive Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

RE: Comments on benchmark Essential Health Benefits plan selection and plan design recommendations

Dear Ms. Maheras:

Vermonters for Health Care Freedom offers the following comments in response to the recommendation of the Department of Vermont Health Access for the benchmark Essential Health Benefits Plan for the Vermont Health Benefits Exchange under the Affordable Care Act and relevant Vermont statues.

VHCF supports the selection of Blue Cross Blue Shield as the benchmark plan for the Exchange. As demonstrated by DVHA's research, the differences in benefits among the BCBS, MVP, CIGNA and other insurers in the small group and individual markets are minimal, so the impact of choosing anything other than BCBS would not materially affect the EHB benchmark benefits within the Exchange. The selection of BCBS ensures the least disruption in the market as small groups and individuals make the required transition into the Exchange, and VHCF appreciates DVHA's recognition of the need to be sensitive to this. We encourage the Green Mountain Care Board to also respect this concern in your decision.

Likewise, VHCF supports DVHA's recommendation for using the SCHIP Pediatric Dental benefit package and the recommendation to require Habilitative benefits at parity with rehabilitative services for these required ACA benchmark plan benefits.

VHCF recommends that either the GMC Board conduct or requests DHVA to conduct an actuarial analysis of the cost of the required 10 categories of services under the ACA, not including Vermont mandated benefits. It is not the purpose of the request to seek reconsideration of the mandated benefits Vermont has adopted over the years, but to provide the Board and the Legislature with an estimate of the size of the contingent liability facing Vermont starting in 2016.

Director Lunge and Commissioner Larson have pointed out in presentations to the Board (08-09-12) and the Legislative Health Care Oversight Committee (08-14-12) that the Essential Health Benefits approach to be used by the federal government in 2014 and 2015 is likely to be revised starting in 2016. The revision "leaves open the possibility of an exponential increase in state costs in 2016" (slide 15). According to CMS guidance (Essential Health Benefits Bulletin, December 16, 2011), "HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the state EHB package" (page 10).

HHS makes it clear in both the Bulletin and the FAQs' that the federal government will subsidize the premiums for EHB plans purchased through the exchange by low and moderate income households, including benefits historically required by states but not by the federal government for 2014 and 2015. However, the question of whether this practice will continue past 2015 is left wide open, which is apparently the basis for DVHA's cautionary note on slide 15.

When asked by a legislator whether the Administration had conducted an analysis of the cost in Vermont of the federal-only mandated benefits Director Lunge said this had not been done due to 'resource constraints.' VHCF respectfully points out that in the same meeting (08-14-12) Commissioner Larson presented information regarding the cost of planned information technology and related efforts to establish the comprehensive management systems required by the federal and state laws. The total is $278 million, of which the state is expected to fund only $21 million. Given that the requested analysis is clearly a priority for budgeting and policy planning purposes VHCF believes the required resources should be found among the vast sums available.

Once the analysis is completed, Vermont will know the difference between the best case (HHS continues to fund both federally and state mandated benefits) and the worst case (HHS ceases to fund state-mandated benefits). And because the state plans to transition the federal subsidies from insurance premium support to direct GMC funding in 2017, the impact on Vermont's finances are doubled – every dollar the feds withdraw is a dollar Vermont must supply, since the Bulletin requires the state to provide the subsidy for state mandated benefits and disallows the state from passing the cost on to the insured.

As an illustration, let us assume total federal support of individual purchases through the Exchange is $300 million in 2014 and 2015. Assuming for illustration purposes that the actuarial value of Vermont-only benefits is 10% of the total, starting in 2016 the federal support could drop to $270 million and Vermont will be obligated to provide $30 million. But if Vermont budgeted $300 million as revenue for GMC starting in 2017, that estimate would be $60 million short from the perspective of required state resources.

While Vermont cannot know the actual requirement to provide premium support under the ACA until HHS completes its evaluation, the requested analysis would give policy makers guidance on the upper limit of this contingent liability, and allow the state to prepare budgets and financing plans with a clear understanding of the range of potential revenues and associated risks.

Vermonters for Health Care Freedom offers the following comments in response to the recommendation of the Department of Vermont Health Access for the Essential Health Benefits Plan designs for the Vermont Health Benefits Exchange under the Affordable Care Act and relevant Vermont statues.

VHCF believes the recommendation of six specific plan designs and three "choice" plans is too restrictive to satisfy the diversity of needs in the Vermont market. This would not be as critical a concern had participation in the Exchange not been made mandatory, but given that as of 2014 the only plans available to more than 80,000 Vermonters will be those offered through the Exchange, the limited choices thus far recommended will certainly fail to meet the needs of a great many.

The consultant who prepared the analysis examined and presented 13 different plan designs and there are currently 50 plans available to the small group market in Vermont, according to the 2011 BISHCA

"Vermont Consumer Handbook." The studied plans that were dropped from the recommendations tend to be those designed to work with HSA and similar accounts. These feature higher deductibles and require lower premiums, and have been extremely popular among employers and subscribers in the individual and small group markets. VHCF believes that the thoughtful use of HSA-type plans returns health insurance to something closer to true insurance, rather than prepaid health care which invariably increases cost and utilization. VHCF recommends that for the gold, silver and bronze levels the studied HSA Q/HDHP plan designs be recommended for the Exchange. Furthermore VHCF agrees with the comments offered by BCBS to include a $5,000 deductible HSA plan for the individual market. There are many individuals for whom this has proven to be an excellent option and the affordable premiums they currently enjoy will no longer be available if this option is not included.

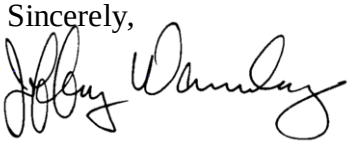
According to written summaries of stakeholder comments during the deliberative process leading up to these recommendations, Blue Cross Blue Shield of Vermont stated several times that the most popular plan in the small group market offers a $2,500 deductible and that there are a very large number of employers and individuals who use HSAs as a means of mitigating the exposure to the deductibles and giving subscribers more control over their health care dollars. In fact, Vermont leads the nation in participation in HSA based plans at nearly 20% of all insured. If the GMC Board is seeking minimal disruption in the transition from the current market to the Exchange, elimination of the single most popular plan design would not be advised.

VHCF believes there are a wide variety of options for subscribers within the platinum, or 'richest' category of plans and therefore disagrees with the recommendation to offer only one plan in this category.

VHCF supports the recommendation of "Choice" plan options for insurers for gold, silver and bronze levels but believes that the option should also be offered at the platinum level, especially given that only on plan design has been offered for recommendation. VHCF is still unclear exactly what is meant by "Choice," and encourages the Board to provide insurers with the broadest possible flexibility to innovate and design offerings. Given that the Exchange is mandatory, VHCF also recommends that insurers be allowed to offer more than a single "Choice" design at each level. VHCF would prefer there be no limit on the number of Choice plans an insurer may offer at each level.

Thank you for the opportunity to offer these comments.

Sincerely,



Jeffrey Wennberg
Executive Director
Vermonters for Health Care Freedom