VERMONTERS
FOR HEALTH CARE FREEDOM

September 11, 2012

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

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

Dear Ms. Maheras:

Vermonters for Health Care Freedom is submitting these extended comments on DVHA's recommendations for EHB benefits and plan designs. These comments are not intended to replace those transmitted on August 31, but rather are to expand upon them. Most of the comments contained here are in response to the additional information DVHA presented to the GMC Board in their meeting of September 6.

As stated in our earlier comments, VHCF maintains that the six prescribed plan designs are much too limited from a perspective of choice available to the individual and small group markets, especially when compared to the range of plan designs currently in use. The insured may invest hope that the 'Choice' plan option will allow insurers the flexibility to diversify the available portfolio, but the planned discussion of the 'guidelines' and restrictions the Board may impose on these plans did not take place in the September 6 meeting. As a result, we are left to speculate on whether the Board's instructions to insurers will encourage or prevent a multiplicity of innovative products. DVHA's recommendations imply that at three of the metal levels each insurer should be allowed a single 'Choice' option. As stated in our previous comments, VHCF strongly believes there should be no limit on the number of 'Choice' plans an insurer may offer at any metal level, including platinum.

VHCF appreciates the supplemental analysis requested by the Board and provided by DVHA. This analysis shows the actual out of pocket cost to enrolled individuals and families under each of the recommended plans, given 5 different health-service needs scenarios. One individual in attendance at the meeting observed that all 5 of these scenarios assume substantial health issues involving significant system costs. Indeed, in the case of the four person family, every family member had either an acute or chronic need. While these examples are very informative, it is much more likely the case that an individual or family will require very little in the way of health care services in a typical year. VHCF supports the request to expand the list of scenarios to include examples that reflect much lower needs to provide guidance on a wider range of scenarios, including those which are more typical.

Speaking for VHCF at the meeting, I asked whether an analysis had been done comparing the projected out of pocket costs for the proposed Exchange plans with those required by Catamount, VHAP, Medicaid and the more popular private insurance plans now in effect. The answer was essentially 'no' but I was offered the opportunity to review the consultant's analysis of the existing insurance plans that

was performed months ago. Deputy Commissioner Lindsey Tucker subsequently provided me with the May, 14, 2012 presentation by Julie Peper titled, "State of Vermont Plan Design Current Market Overview." After reviewing the presentation I emailed Deputy Commissioner Peper indicating that what I was looking for was an analysis of out of pocket costs for the most popular plans in the existing market using the same 5 specific scenarios applied to the 6 proposed Exchange plans and presented to the Board on September 6th. In response Deputy Commissioner Peper wrote, and I quote the email in its entirety, "We are not conducting this analysis."

VHCF does not understand why DVHA is refusing to conduct the analysis, and strongly urges the GMC Board to either request DVHA to complete it or undertake it themselves. The need for this analysis should be self-evident, but given DVHA's reluctance, VHCF offers the following in support of this request.

Comparing the out of pocket costs for 5 'real life' scenarios across 6 proposed plan designs gives the Board a limited picture of the range of burdens the plans and metal levels place on the insured among the options potentially available through the Exchange. But beginning January 1, 2014 Vermont has uniquely decided that for what is now an estimated 118,000 Vermonters the Exchange will be the only place they can purchase health insurance. This means that the vast majority of these individuals and groups (those who currently have coverage) will have to drop their current coverage and select from among the more limited offerings in the Exchange. Every one of these individuals and groups will have an interest in comparing not only the plans in the Exchange with one another, but also with the plan in which they are at that time enrolled. Should not the Board have some idea how the Exchange plans compare to the current plans before deciding what plans will be offered in the Exchange?

It is not necessary to run the analysis for every one of the 3 government programs and 50 private insurance plans available to this market. At a minimum the comparison should look at the out of pocket costs borne by Medicaid, VHAP and Catamount enrollees plus the top several private insurance plans by number of participants. The Chamber of Commerce association plans would be one obvious choice given the number of groups participating. This level of analysis would give the Board

1. a sense of whether the proposed plan designs are comparable with those currently in effect,
2. the ability to anticipate the reaction of enrollees when the Exchange goes into effect, and
3. an estimate of the additional burden Medicaid, VHAP and Catamount enrollees will face, or the size of the required state appropriation necessary to hold them harmless.

This last point was touched upon by DVHA Commissioner Mark Larson in the September 6 meeting, when he indicated that supplemental state funding would be required if the state intended to maintain the out of pocket requirements for Catamount enrollees after transferring to the Exchange.

An incomplete comparison between Exchange plans then under development and market plans was conducted by Ms. Peper and presented to the Board on June 25 of this year. Looking only at the silver level, which is where most enrollees are currently, the analysis on slide 17 indicates some enrollees will see cost share increases of up to 271% for emergency room visits, 255% for 'preferred' drugs and 457% for 'non-preferred' drugs. If the Board is to make a truly informed decision and if the public is to view this process as genuinely open the requested analyses must be completed and released.

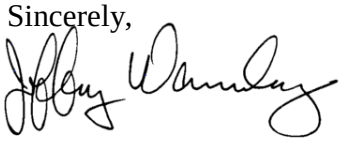
DVHA made a new request to the Board in the September 6 meeting, that is, the authority to 'modify' Board approved plan designs in response to forthcoming federal guidance. VHCF opposes the grant of this authority, even on a limited basis. The Board is more aware than anyone of the magnitude and complexity of the various tasks and responsibilities that have been assigned to it under Acts 48 and 171. Even the federal government with all its resources is finding great difficulty meeting the critical deadlines under the ACA. It is neither prudent nor responsible to delegate critical regulatory authority to the department charged with the administration of the Exchange, especially given that the ranges of 'modification' requested could, in the aggregate, significantly increase the cost to Vermonters under these proposed plans. Also, the Board should seek legal counsel's opinion whether the Board even has the authority to delegate these decisions.

VHCF prefers that the Board defer final action on the recommended Exchange plans until the federal government provides clear and final guidance on the matters still unresolved including guidance on acceptable plan deductibles, copays and coinsurance and the availability of the HHS' actuarial value calculator. VHCF continues to object to the rushed implementation of Green Mountain Care without a budget or financing plan. Likewise, rushing to make Exchange plan design decisions without knowing whether these decisions are consistent with federal requirements is irresponsible.

Finally, it was pointed out in the September 6 meeting that DVHA is now using an assumed 118,000 Exchange enrollees for 2014, instead of 80,000. This is nearly a 50% increase and has huge implications for financing and transition logistics. Where are these new individuals coming from? Is their current coverage consistent with the analysis provided to the Board in May or has it shifted in a meaningful way? A significant shift in the number or status of those who must be transitioned into the Exchange could affect the decisions the Board now faces. VHCF encourages the Board to gain a more detailed understanding from DVHA of the reasons for this change and the implications for the work now before you.

Thank you for the opportunity to offer these supplemental comments on behalf of VHCF.

Sincerely,



Jeffrey Wennberg
Executive Director
Vermonters for Health Care Freedom