A HIGH LEVEL OVERVIEW
Part 1

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This Presentation will cover:

- Insurance Coverage
  - High level market overview
  - Self-insured
  - HRAs, HSAs, FSAs
- Insurance Basics
  - Actuarial value
  - Cost-sharing
  - Risk pooling
  - Premiums
- Rate Review

INSURANCE COVERAGE

Health Insurance Coverage Vermont Residents**

	2013	2014	2015	2016*	2017	2018	2019	2020	Change, 2013-2020
Total Insured Market	**151,752**	**156,430**	**145,803**	**95,131**	**92,920**	**94,415**	**92,321**	**84,830**	▼*44.1%*
Individual & Small Group*	*35,509*	*69,272*	*66,203*	*75,659*	*74,680*	*73,064*	*68,390*	*67,337*	▲*89.6%*
Large Group	*116,243*	*87,158*	*79,600*	*19,472*	*17,610*	*21,351*	*23,931*	*17,493*	▼*85.0%*
Total Self-Insured Market	**157,047**	**170,440**	**159,812**	**202,101**	**214,476**	**208,439**	**209,347**	**200,766**	▲*27.8%*
Total Other	**41,191**	**25,143**	**20,077**	**18,276**	**15,540**	**12,135**	**11,937**	**11,812**	**▼ 71.3%**
TOTAL COMMERCIAL MARKET	**349,990**	**352,013**	**325,692**	**315,508**	**322,306**	**314,989**	**313,605**	**297,408**	**▼ 15.0%**
Medicaid	**127,342**	**146,273**	**161,097**	**157,112**	**150,375**	**154,943**	**148,689**	**148,686**	**▲ 16.8%**
Medicare	**111,954**	**115,649**	**119,477**	**131,344**	**133,915**	**136,567**	**141,895**	**145,956**	**▲30.4%**
TOTAL GOVERNMENT COVERAGE	**239,296**	**261,922**	**280,574**	**288,456**	**284,290**	**291,510**	**290,584**	**294,642**	**▲ 23.1%**

* **Note**: As of 2016 the Definition of Small Employer Group Changed from 50 to 100 lives

Resources:

Annual Statement Supplement Report (ASSR)

Vermont Household Health Insurance Survey (VHHIS)

Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

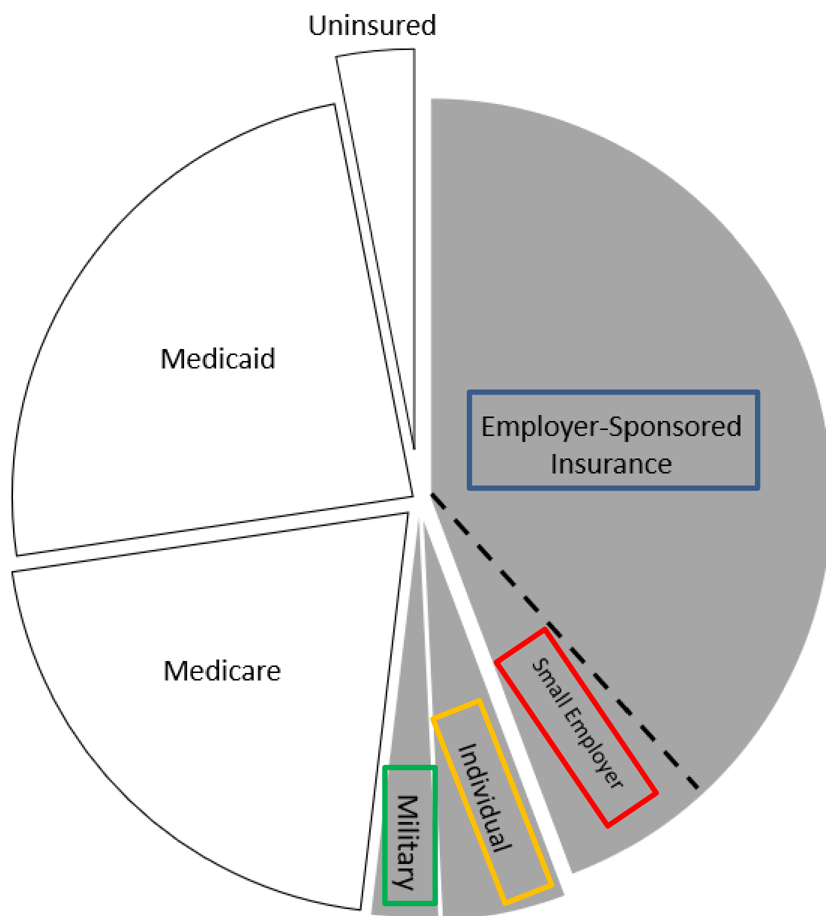
Department of Vermont Health Access (DVHA)

The Dartmouth Institute for Health Policy and Clinical Practice (TDI)

Note: At this time we little data on how many Vermonters have HSAs, HRAs, or FSAs.

Source: 2020 Vermont Health Care Expenditure Analysis (released May 2022), Green Mountain Care Board

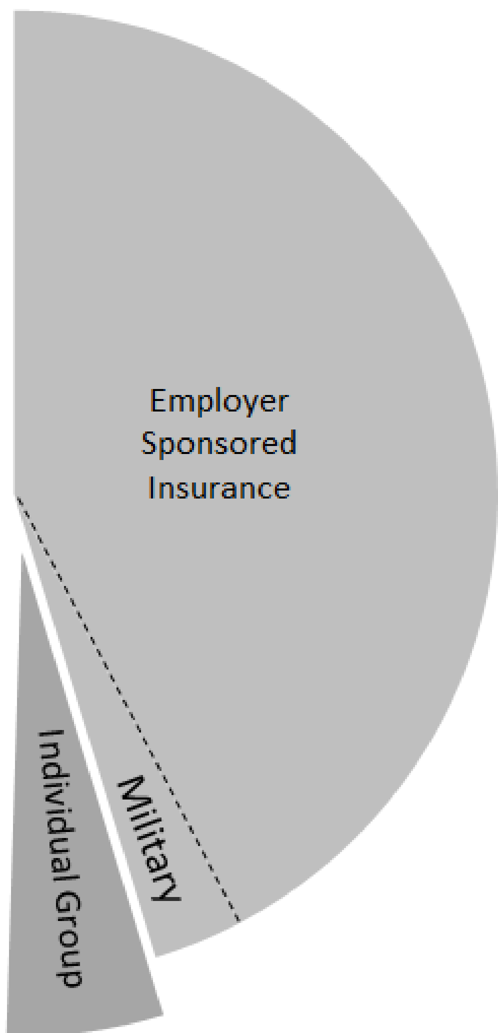
PRIVATE / COMMERCIAL INSURANCE



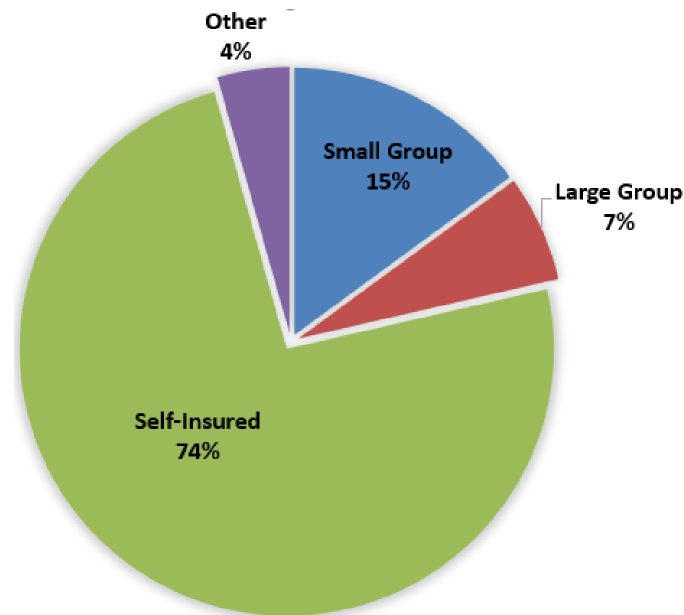
- **Employer-based**
  - Self-insured
    - Self-insured employer plans
    - Federal Employee Plan
  - Insured
    - Large Group ★
    - Small Group ★
- **Individual Market** ★
  - Qualified Health Plans
  - Reflective Plans
- **Military**

★ = Regulated by the State

PRIVATE / COMMERCIAL INSURANCE



- Approximately half (49%) of Vermonters have private insurance*
  - Most private insurance plans are through an employer-related source.
    - Employer-sponsored insurance (ESI), COBRA, or retirement plan.
  - Approx. 3/4 of ESI plans are self-insured plans.



* *2021 Vermont Household Health Insurance Survey (VHHIS)*

** *Health Insurance Map, Dept. of Vermont Health Access*

PRIVATE / COMMERCIAL INSURANCE
Employer-based

INSURED vs. ***SELF-INSURED***

INSURED

- INSURER bears ALL (or most) of the financial risk
- Employer purchases coverage from a regulated health insurance company
- Insurer is subject to state regulations

SELF-INSURED

- EMPLOYER assumes ALL (or most) of the financial risk
  - may utilize stoploss insurance
- Employer purchases administration services
  - Third Party Administrator (TPA)
- Not subject to state regulation

A Quick Note about HRAs & HSAs

Health Reimbursement Arrangement (HRA) – An employer funded account that helps employees pay for qualified health expenses.

- HRAs are entirely funded and owned by an employer.
- Are often unfunded notional accounts. Employers pay only after employees incur expenses.

Health Savings Accounts (HSA) – A tax-advantaged account for individuals who are covered under high-deductible health plans (HDHPs) to save for medical expenses not covered by their plan.

- Can be funded by both employer and employee
- Can only be used with a qualifying high-deductible health plan (HDHP)
- Contributions are made whether or not expenses are incurred.
- Employees keep all unused HSA employer contributions.

… & FSAs

<u>Flexible Spending Account</u> (FSA) – an account that allows employees to set aside pre-tax income for routine medical expenses.

- Set up by employers for employees
- Allows employees to contribute a portion of their earnings to pay for qualified health expenses.
  - Deducted from employees earnings before they are made subject to payroll taxes.
- Can be used to pay deductibles and co-pays but not premiums
- Generally must use the money in an FSA within the plan year.
- Limited to $2,650 per employee per year.
  - At the end of the year employers have the option to either allow a 2.5 month grace period to use the funding or carry over $500 of unused funds (but not both).

Feature	HRA	HSA	FSA
Funds	Employer owns account and makes contributions	Employees own account Employer has option to contribute	Employer owns account
Plan design	Employer has flexibility in plan design	Requires High Deductible Health Plan (HDHP) as defined by IRS	Employer has flexibility in plan design
Contribution limits	Employer can set limits	Controlled by IRS $3,500 single; $7,000 family (2019)	Employer can set limits subject to IRS/health care reform requirements ($2,650 per employee/yr)
Qualified expenses	Employer has option to cover all IRS qualified medical expenses or limit those for reimbursement	IRS qualified medical expenses	Employer has option to limit reimbursable expenses

Source: https://medium.com/@livelyme/employers-a-quick-guide-to-health-savings-options-531de366e441

INSURANCE BASICS

ACTUARIAL VALUE

<u>Actuarial Value</u> (AV) – The average share of medical spending paid by a plan for a defined set of covered services across a population.

- For example, if a plan has a 70% AV, on average the plan would pay for 70% of medical spending for covered services and the beneficiary would pay the remaining 30% out-of-pocket in the form of deductibles, co-pays, and coinsurance.

Metal Levels under the Affordable Care Act (ACA)

- The ACA established 'Metal Levels' for plans in the health benefit exchange.
- Each metal level represents an AV value / range.

Costs Covered by the plan ↓

Metal Level (Plans)	Expected Insurer Cost
Platinum	90% AV (88-92%)
Gold	80% AV (78-82%)
Silver	70% (68-72%)
Bronze	60% (58-62%)

↑ Premiums paid by the consumer

COST SHARING

<u>Cost Sharing</u> – When users of a health care plan share in the cost of medical care. ***Deductibles***, ***coinsurance***, and ***copayments*** are examples of cost sharing.

<u>Deductible</u> – the amount an individual must pay for health care expenses before insurance (or a self-insured company) covers the cost.

<u>Coinsurance</u> – Refers to money that an individual is required to pay for services after a deductible has been paid. Coinsurance is often specified as a percentage. For example, an employee might pay 20% towards the charge for a service and the plan pays 80%.

<u>Copayment</u> – A predetermined, flat fee that an individual pays for health care services, in addition to what the insurance covers. For example, an insurer might require a $20 copayment for each office visit.

Examples: Standard Plans 2023 - Vermont Health Connect

	Bronze (Approx. 60% AV)		**Silver** (Approx. 70% AV)		**Gold** (Approx. 80% AV)		**Platinum** (Approx. 90% AV)	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
Medical Deductible	$6,450	$12,900	$4,000	$8,000	$1,400	$2,800	$425	$850
Rx Deductible	$1,100	$2,200	$500	$1,000	$200	$400	$0	$0
Med. OOP[1] Max.	$9,100	$18,200	$9,100	$18,200	$5,600	$11,200	$1,500	$3,000
Rx OOP Max.	$1,400	$2,800	$1,400	$2,800	$1,400	$2,800	$1,400	$2,800
Integrated OOP	Yes		Yes		No		No	
Office Visit (PCP/MH)[2]	Ded., then $35		$40		$20		$15	
Office Visit Specialist	Ded., then $90		$90		$50		$40	
Emergency Room[3]	Ded., then 50%		Ded., then $500		Ded., then $150		Ded., then $100	
Rx Generic	$15		$20		$12		$10	
Rx Preferred Brand	Ded., then $85		Ded., then $70		Ded., then $55		$50	
Non-Preferred Brand	Ded., then 60%		Ded., then 50%		Ded., then 50%		50%	
Monthly Premium (before Subsidy)								
BCBSVT	$640.78	$1,800.59	$848.31	$2,383.75	$941.63	$2,645.98	$1,134.56	$3,188.11
MVP	$674.76	$1,896.08	$854.37	$2,400.78	$939.60	$2,640.28	$1,138.38	$3,198.85

1) OOP = Out-of-Pocket

2) PCP = Primary Care Physician. MH = Mental Health.

3) ER co-pay is waived if admitted.

Note: Preventative services are covered without a co-pay or deductible under the ACA.

RISK POOLING

- *Pooling risk is fundamental to the concept of insurance.*
- A risk pool is a group of individuals whose medical costs are combined to calculate premiums.
- Allows higher costs of the less healthy to be offset by the relatively lower cost of healthy, either in a plan overall or within a premium rating category.
  - <u>Community Rating</u> – when health insurance providers are required to offer health policies within a given territory at the same price to all persons regardless of their health status.
    - VT has pure community rating in the merged market that includes health status, gender, age, risk factors (such as smoking, etc.)
  - <u>Guaranteed Issue</u> – when a policy is offered to any eligible applicant without regard to health status.
- In general the larger the risk pool, the more predictable and stable the premiums can be.
  - However, larger risk pools do not necessarily mean lower premiums.
  - The key factor is the average health care costs of the enrollees included in the pool.

RISK POOLING

- Vermont was one of only two states that had merged its individual and small group markets. Currently, these are temporarily unmerged. Remerge 1/1/2024.
  - Individual Group = 24,189
  - Small Group = 45,769

69,958 lives when combined

https://dvha.vermont.gov/sites/dvha/files/doc_library/Health_Coverage_Map%20As%20of%20September%202022_0.pdf

- **Adverse selection** – when an insurer (or a market as a whole) contains a disproportionate share of unhealthy individuals.
  - A common example of this occurs when people are allowed to wait until they know they are sick and in need of health care before purchasing a health insurance policy.

- The ACA instituted an individual mandate with a tax penalty as one measure to reduce adverse selection
  - The tax penalty was eliminated in the 2017 Tax bill (starting in 2019).

RISK POOLING

- **Risk Adjustment** – Under the ACA, CMS collects funds from insurers who enroll more low-cost health people and distributes them to insurers who enroll more high cost people.

HEALTH INSURANCE PREMIUMS

Factors that affect proposed premiums include:

- Projected medical and pharmaceutical costs
- People expected to be insured in this risk pool
- Administrative costs
  - Including product development, sales and enrollment, claims processing, costumer service, contribution to reserves and regulatory compliance
- Also includes taxes, assessment, and fees.
- Laws and regulations
  - Not just existing laws and regulations but uncertainty as well (such as proposed federal changes to parts of the ACA).
- Plan design
- Market competition

A quick not about Medical Loss Ratio

- MLR is the percentage of premium an insurer spends on claims and expenses.

- The ACA requires most insurers that cover individual and small businesses to spend at least 80% of their premium income on health care claims and quality improvement.
  - The remaining may be spent on administration, marketing, profit, etc.

Where Do Health Care Dollars Go?

NOTE: This graphic from AHIP is demonstrative and may not exactly represent the Vermont experience.

This data represents how your commercial health plan premiums pay for medical care, as well as related services and essential operations. This data includes employer-provided coverage as well as coverage you purchase on your own in the individual market. Data reflects averages for the 2018-20 benefit years. Percentages do not add up to 100% due to rounding.

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https://www.ahip.org/documents/202208-AHIP_HealthCareDollar-v02.pdf

AHIP
Guiding Greater Health

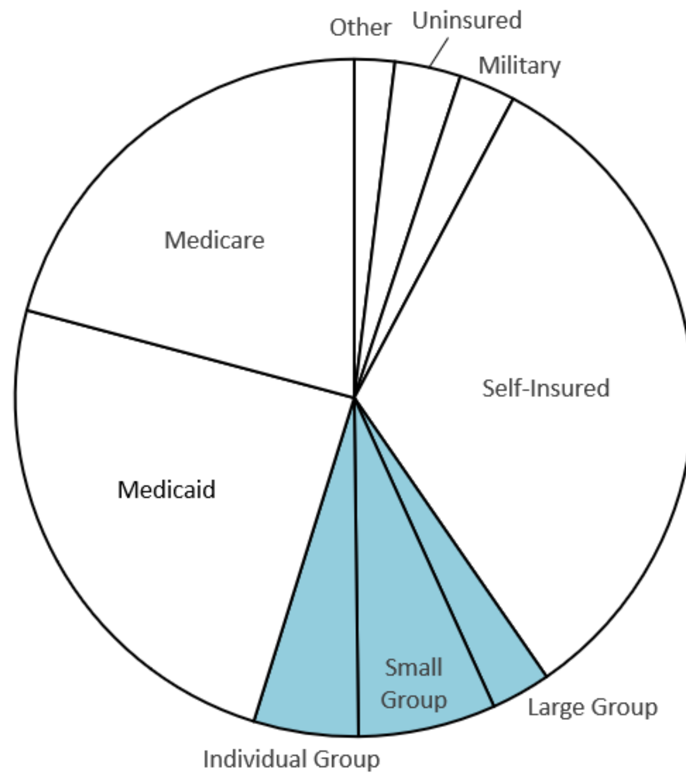
ACA Insurance Protections by Market Segment

(applies to fully insured)[1]

ACA Market Reform	Individual Market	Small-group Market (<100)	Large-group Market (>100)
Guaranteed issue	Yes	Yes	Yes
Pre-existing condition exclusions prohibited	Yes	Yes	Yes
Out-of-pocket maximums	Yes	Yes	Yes
Annual and lifetime limits prohibited	Yes	Yes	Yes
Preventive services covered without cost-sharing	Yes	Yes	Yes
Essential health benefits	Yes	Yes	No
Rating rules	Yes	Yes	No
Single risk pool	Yes	Yes	No
Risk adjustment program	Yes	Yes	No
Medical loss ratio	80%	80%	85%

[1] Source: The Actuary Magazine, May 2018 (https://theactuarymagazine.org/new-rules-to-expand-association-health-plans/)

RATE REVIEW



HEALTH INSURANCE RATE REVIEW

Process

Filing: Insurance carriers submit filings to the Green Mountain Care Board (GMCB). The filing often requests a change in the rate charged for a particular health insurance plan.

Public Comment period: Lasts for 15 days after the GMCB makes all required postings on its website.

Opinions: Within 60 days, the *GMCB* must post the opinion of an actuary discussing the reasonableness of the rate change and the opinion of the *VT Dept of Financial Regulations (DFR)* regarding the impact of the requested rate change on the solvency of the health insurer.

Public Hearing: The GMCB holds public hearing within 30 days of posting the GMCB and DFR opinions. Hearings can be waived.

Decision: The GMCB decides to approve, modify, or disapprove a rate request within 90 days of the filing date. Decisions may be appeaked to the Vermont Supreme Court within 30 days of the decision.

HEALTH INSURANCE RATE REVIEW

Standards for Review

- **The board is tasked with determining if rates:**
  - Are excessive, inadequate, or unfairly discriminatory
    - Through an actuarial review
  - Are affordable, promote quality care, promote access to health care
  - Protects insurer solvency and is not unjust, unfair, unequitable, misleading, or contrary state laws.
    - This standard is interpreted by looking at the individual components and breakdown of requested rate to see whether they are reasonable and appropriately applied, both across the marketplace and within the specific rate filing under review.
    - Examples include looking at changes in unit cost, utilization, risk pool, plan membership, reserve needs, and administrative expenses.
  - Board must also consider changes in health delivery, payment methods and amounts, contribution to reserves and "other issues at its discretion."
- The Office of the Health Care Advocate has "party status" during the rate review proceedings.

THE END
(for now)