



A HIGH LEVEL OVERVIEW

Part 1

Nolan Langweil, Joint Fiscal Office
Amerin Aborjaily, Legislative Counsel

January 17, 2023



This presentation will cover:

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



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:**

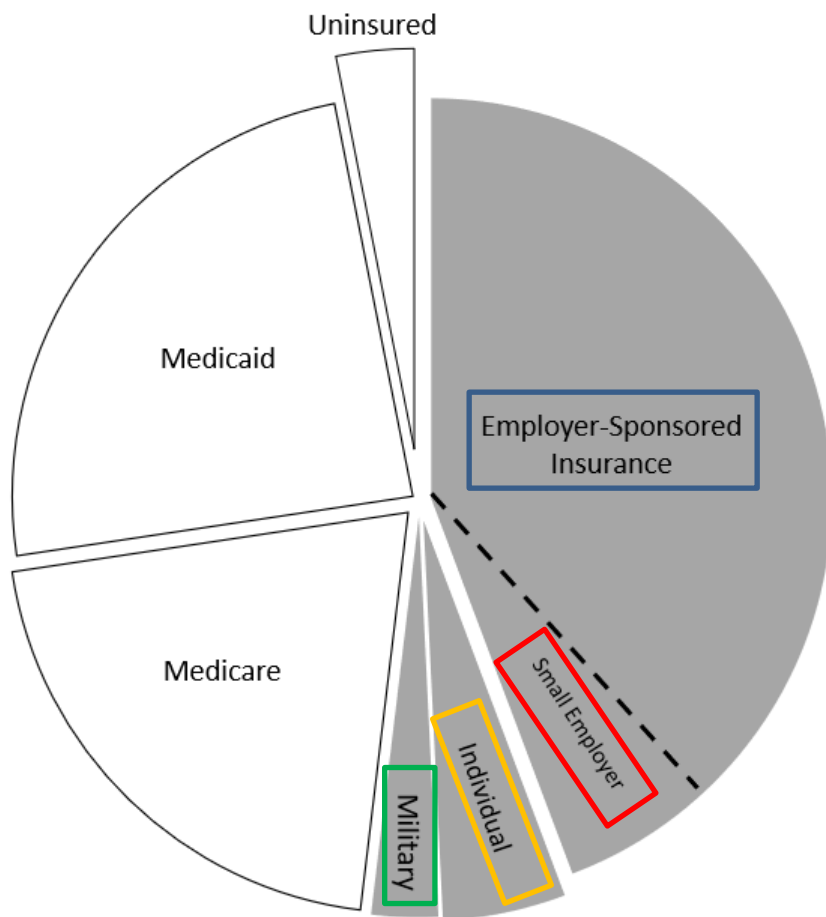
- Annual Statement Supplement Report (ASSR)
- Vermont Household Health Insurance Survey (VHHIS)
- Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)
- Department of Vermont Health Access (DVHA)
- The Dartmouth Institute for Health Policy and Clinical Practice (TDI)

Note: At this time we have 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

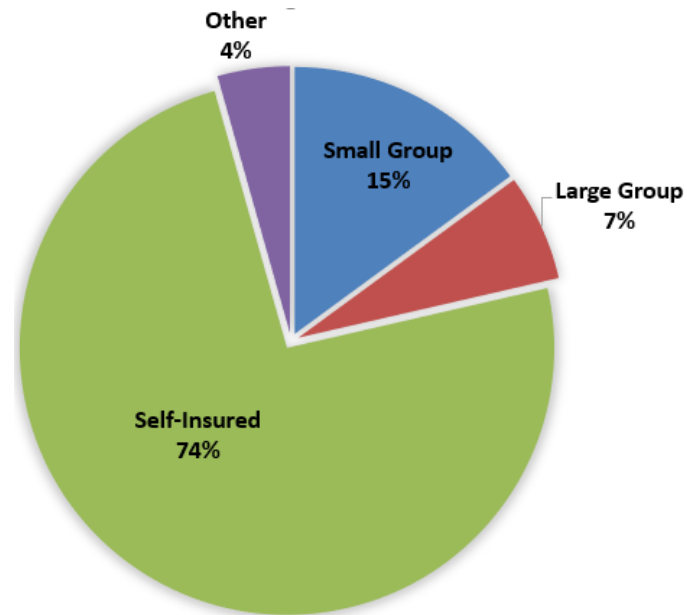
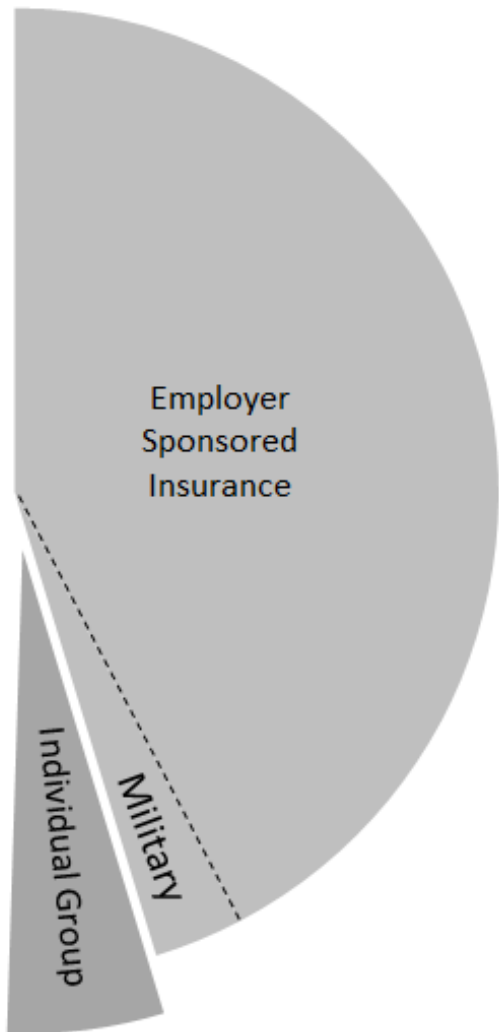
➤ Military

★ = 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

- 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 stop loss insurance
- Employer purchases administration services
 - Third Party Administrator (TPA)
- Not subject to state regulations



INSURANCE BASICS

Actuarial Value

Actuarial Value (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

The diagram consists of a central table with two large arrows. On the left, a downward-pointing arrow is labeled 'Costs Covered by the plan'. On the right, an upward-pointing arrow is labeled 'Premiums paid by the consumer'. The table has two columns: 'Metal Level (Plans)' and 'Expected Insurer Cost'. The rows are Platinum, Gold, Silver, and Bronze. The Gold row is highlighted in yellow.

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

Cost Sharing

Cost Sharing – When users of a health care plan share in the cost of medical care.

- **Deductible** – The amount an individual must pay for health care expenses before insurance (or a self-insured company) begins to cover costs
- **Coinsurance** – 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%
- **Copayment** – 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 copay or deductible under the ACA

Risk Pooling

Risk pool – Group of individuals whose medical costs are combined to calculate premiums

- Risk pooling is fundamental to the concept of insurance
- 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
 - Community Rating – 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.)
 - Guaranteed Issue – 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 (continued)

- Vermont was one of only two states that had merged its individual and small group markets
 - These are temporarily unmerged but will re-merge 1/1/2024
 - Individual Group = 24,189
 - Small Group = 45,769

69,958 lives combined
- **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 by the federal Tax Cuts and Jobs Act (2017) starting in 2019

Risk Pooling (continued)

- **Risk Adjustment** – Under the ACA, the Centers for Medicare & Medicaid Services (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 the risk pool
- Administrative costs
 - Including product development, sales and enrollment, claims processing, customer 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 Note about Medical Loss Ratio

- **Medical Loss Ratio** – The percentage of premium an insurer spends on claims and expenses
- The ACA requires most insurers that cover individuals 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 reflect the Vermont experience exactly



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.

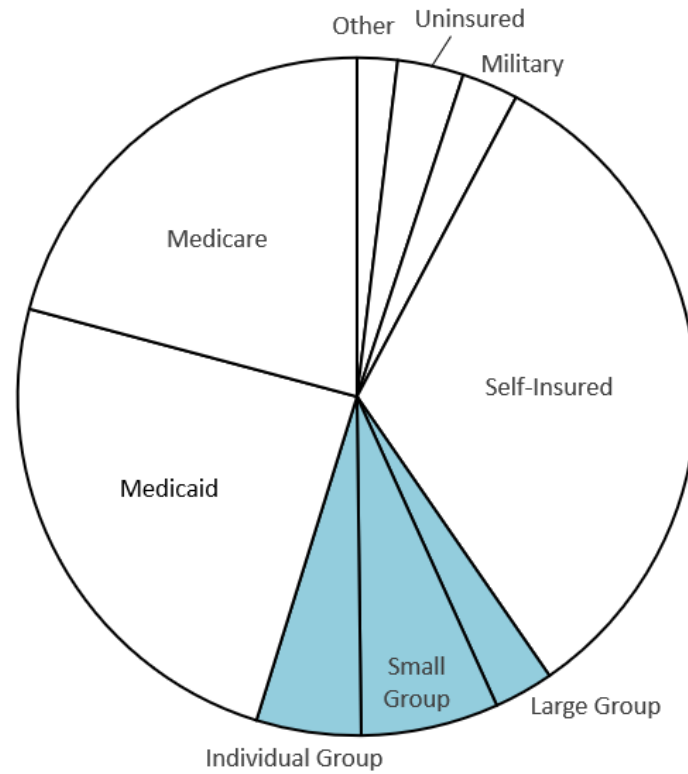
ACA Insurance Protections by Market Segment

(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%

Source: <https://theactuarmagazine.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)
 - Filings often request a rate change for a particular health insurance plan
- **Public Comment Period** – 15-day period 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 Department of Financial Regulation (DFR) regarding the impact of the requested rate change on the solvency of the health insurer
- **Public Hearing** – The GMCB holds a public hearing within 30 days of posting the GMCB and DFR opinions
 - Hearings can be waived
- **Decision** – The GMCB must decide to approve, modify, or reject a rate request within 90 days of the filing date
 - Appeals can be made to the VT Supreme Court up to 30 days after the decision

Standards for Health Insurance Rate Review

- **GMCB 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, inequitable, misleading, or contrary to state laws
 - This standard is interpreted by looking at the individual components and breakdown of the 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

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 the 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

Flexible Spending Account (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 employee's 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



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>



THE END
(for now)