Department of Vermont Health Access

Legislative Report

October 28, 2015

Potential Investment To Help With High Out-Of-Pocket Health Care Costs

Pursuant to Act 050 of the 2014 Legislative Session

Hal Cohen, Secretary

Vermont Agency of Human Services

Steven Costantino, Commissioner

Department of Vermont Health Access

Pursuant to Act 050 of the 2014 Legislative Session, the Department of Vermont Health Access (DVHA) has reviewed the capacity for managed-care entity investments to ensure that low and middle income individuals purchasing health insurance through the Vermont Health Benefit Exchange have financial protection from large out-of-pocket costs. The Department finds that there are currently insufficient funds available to support expansion of current premium and cost sharing reduction programs.

Individuals with household income over 133% of FPL can enroll in qualified health plans (QHP) purchased on Vermont Health Connect, Vermont's health benefit exchange. These plans have varying cost sharing and premium levels. There are federal tax credits to make premiums more affordable for people with incomes less than 400% of FPL and federal subsidies to make out of pocket expenses more affordable for people with incomes below 250% FPL. Despite these federal tax credits and cost sharing subsidies provided by the Affordable Care Act, coverage through these QHPs is less affordable than Vermonters had previously experienced under VHAP and Catamount. To address this affordability challenge, the State of Vermont further subsidizes premiums and cost sharing for enrollees whose income is < 300%. Vermont Premium Assistance is currently matched by federal funds under the authority of the Global Commitment Waiver as a Designated State Health Program. Cost sharing reductions are funded at 100% general fund; the State had requested to also add cost sharing reductions as a Designated State Health Program under the Waiver, but CMCS was unwilling to entertain this proposal.

The Department has explored the capacity for managed-care entity investments to further support individuals with high out of pocket costs and finds that, in the case of the Premium Assistance program, expansion of this benefit to current or additional Vermonters would require additional General Funds, which are severely constrained. Additionally, the Department has explored the capacity to match General Fund expenditures for Cost Sharing Reductions through the addition of a new managed-care entity investment. Funds for new managed care entity investments are constrained by the availability of savings under the actuarially certified per member per month (PMPM) limit set under the GC waiver. Any savings under the PMPM limit can be used for managed care entity investments. To minimize the risk of not having enough savings to cover the investments, the State has tried to keep managed care entity investments at 5-7% of total GC Waiver costs. In SFY15, managed care entity investment spending was at 8.79% of total GC costs, therefore above our target and at risk of exceeding available savings under the PMPM cap. Adding more investments will increase the % and increase the risk of not having enough savings to cover the investments.