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MEMORANDUM

To: Senator Claire Ayer, Chair, Committee on Health and Welfare

From: Jennifer G. Carbee, Legislative Counsel

Date: February 1, 2017

Subject: Vermont's health insurance market post-ACA

This memorandum looks at the Vermont health insurance legal landscape if the Affordable Care Act is repealed. Some of Vermont's health insurance laws relate to the Affordable Care Act, while others do not. Of those that rely in whole or in part on the existence of the Affordable Care Act, it is unclear whether they can continue to regulate in the absence of the Act or whether they would need fine-tuning. This memorandum does not address all health insurance laws in Vermont or all insurance market provisions in the Affordable Care Act, but looks at some of the most significant ones. It is unclear at this time which portions of the Affordable Care Act may be repealed and which may survive. This memorandum is for informational purposes only and should not be considered to constitute legal advice.

Provisions that will continue

If the insurance market provisions of the Affordable Care Act are repealed, Vermont will continue to have the following provisions in place:

- Guaranteed issue - Vermont law requires health insurers to guarantee acceptance of all individuals, small groups (100 employees or less), and employees of small groups, and the individuals' and employees' dependents, for all plans that the insurer offers. The Affordable Care Act also requires health insurers to guarantee acceptance of large groups (over 100 employees), but Vermont law does not.
- Community rating - Vermont law requires health insurers to use community rating for their individual and small group plans, which means that all enrollees in the same plan are charged the same premium, regardless of an enrollee's age, gender, health status, or other factors. Vermont law appears to permit some deviation from pure community rating, but to my knowledge no Vermont insurer has ever used it. The Affordable Care Act allows for deviation from community rating as well, but Vermont's insurers have not sought any deviations for their Exchange plans.
- Contraceptive coverage - 8 V.S.A. § 4099c requires health insurance plans to cover without cost-sharing at least one form of contraception in each of the 12 contraception methods for women identified by the U.S. Food and Drug

Administration, as well as to cover voluntary sterilization for men and women without cost-sharing. The Affordable Care Act requires coverage of the same services without cost-sharing, except for voluntary sterilization for men.

- Preventive services - 8 V.S.A. §§ 4100a and 4100g require health insurance plans to cover mammograms and colonoscopies, respectively, without cost-sharing.
- Mental health parity - 8 V.S.A. § 4089b requires parity between insurance coverage for treatment of mental conditions and for other health care services. This requirement applies across all of Vermont's health insurance markets. The Affordable Care Act expanded federal parity requirements to individual markets for the first time, but Vermont's markets were already in compliance.

Provisions that would no longer apply

If the insurance market provisions of the Affordable Care Act are repealed, the following provisions would no longer apply to Vermont insurance markets:

- Annual out-of-pocket maximum - the Affordable Care Act imposes annual cost-sharing limitations across the individual, small group, and large group markets that cap the total amount an insured individual/family would have to pay out-of-pocket in co-payments, coinsurance, and deductibles (the limit does not include premiums) in a plan year. For the 2017 plan year, the maximum out-of-pocket limit for health care expenses is $7,150.00 for an individual plan and $14,300.00 for a family plan. No similar provisions exist in Vermont law.
- Preexisting condition exclusion ban - the Affordable Care Act prohibits health insurance plans from refusing to cover a health condition that existed before the date of enrollment for coverage. Prior to the Affordable Care Act, health plans in Vermont's individual and small group market could impose a 12-month preexisting condition exclusion unless the enrollee could provide evidence that he or she had had continuous health insurance coverage during the preceding nine months without a break in coverage of 63 days or more (for an individual plan) or during the preceding six months without a break in coverage of 90 days or more (for a small group plan). Preexisting condition exclusions are not currently addressed in Vermont's individual and small group market insurance laws except for the grandfathered plans, of which there are few if any remaining.
- Bans on annual and lifetime limits for essential health benefits - the Affordable Care Act prohibits all individual, small group, and large group health insurance plans from imposing annual and lifetime limits on the amount they will cover for essential health benefits, which is the benefit package for the benchmark plan on which all Exchange plans are based. No similar provision exists in Vermont law.
- Ban on cost-sharing for preventive services - the Affordable Care Act prohibits health insurance plans in the individual, small group, and large group market from imposing co-payment, coinsurance, or deductible requirements for preventive services that have received an A or B rating from the U.S. Preventive Services Task Force, including a number of screenings and immunizations for all adults, contraceptives and mammograms for adult women, and several screenings and

immunizations for children. As noted above, Vermont only requires coverage without cost-sharing for colorectal cancer screening, mammography, contraceptives for women, and voluntary sterilizations for men and women.

- Coverage for young adult children up to 26 years of age - the Affordable Care Act requires all individual, small group, and large group health insurance plans to allow children to stay on their parents' health insurance plans until their 26th birthday. No similar provision exists in Vermont law.

Essential health benefits, market structure, and actuarial value requirements

As a result of the Affordable Care Act, Vermont's entire individual and small group markets are in a single risk pool with the same health plan offerings. The Act gave states the option to merge their individual and small group markets into a single market, which Vermont elected to do. It is unclear what options states may have if the Affordable Care Act is repealed and whether Vermont will have the option to maintain its Exchange or its Exchange plan configurations. In addition, it is unclear whether the requirements to offer an essential health benefits package and to offer plans with at least a 60 percent actuarial value will continue to apply. The actuarial value of a plan is the average percentage of health care expenses, excluding premiums, that the health insurance plan pays. The remainder is the out-of-pocket responsibility of the enrollee.

Vermont's individual and small group markets will remain merged in a single risk pool with common plan options unless legislative action is taken to separate the markets after consideration of the inherent risks and benefits. Vermont's current laws authorizing the sale of individual and small group market plans are predicated on the existence of a requirement to provide the essential health benefit package required by Section 1302(a) of the Affordable Care Act, which resulted in the standardization of most covered services across all plans. The laws also presume adherence to the bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent) actuarial value tiers established in the Act. If those provisions are repealed, Vermont will, at a minimum, need to revisit its statutes related to health benefit plans for individuals and small groups.

Self-funded plans

While the Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating the benefits that private sector employers offer in self-funded plans, the federal government retains the authority to regulate them. The Affordable Care Act applies several of the insurance market reforms applicable to fully insured plans to self-funded plans as well, including the requirement for coverage of preventive health services without cost-sharing, the ban on preexisting condition exclusions, the annual out-of-pocket spending limits, the bans on annual and lifetime limits for essential health benefits, and the requirement to continue coverage for young adult children up to 26 years of age. If these provisions of the Affordable Care Act are repealed, Vermont cannot require private sector self-funded plans to continue offering these benefits to their employees.