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 Profile
Vermont Residents 2014-2016

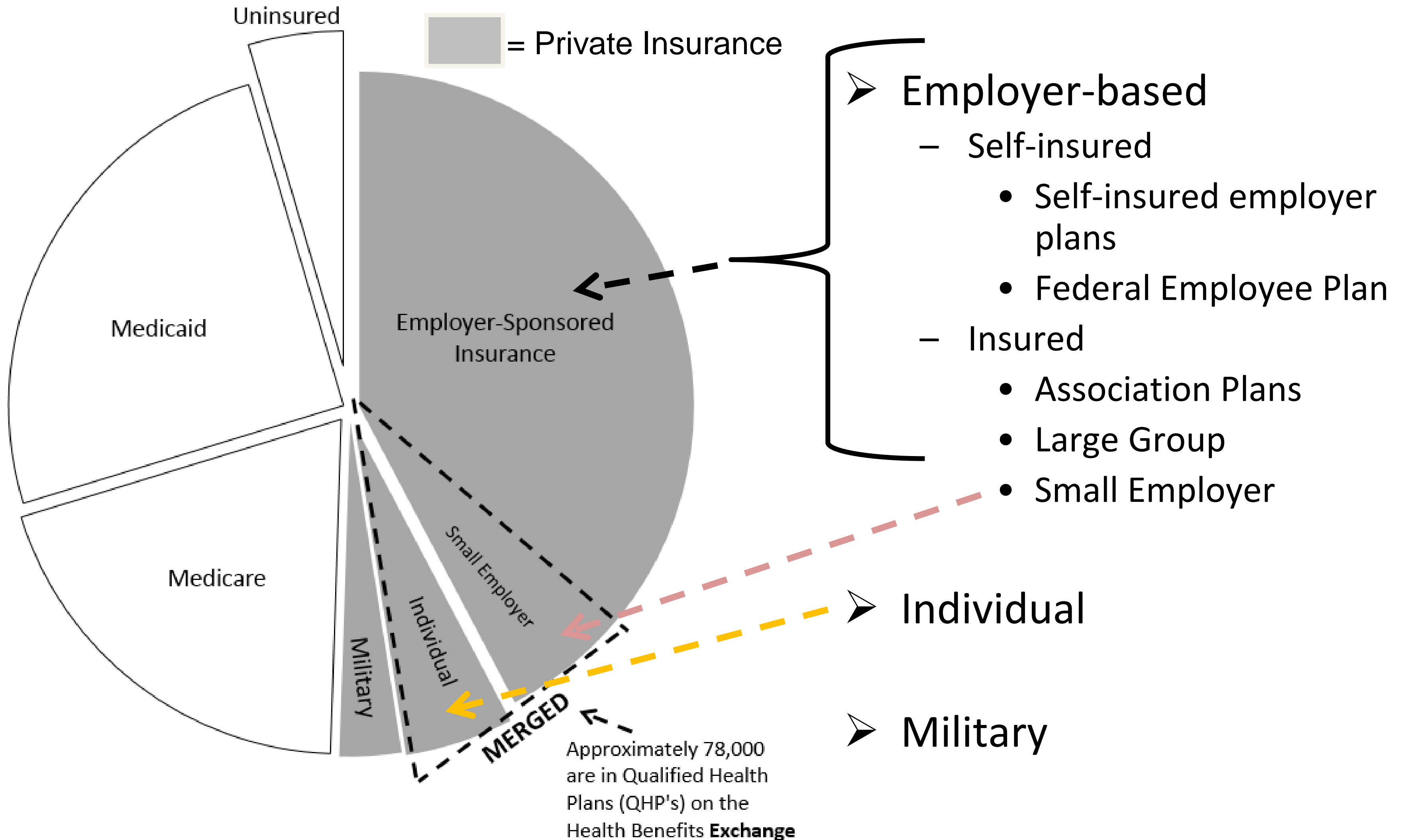
Category	2014	2015	Under Review 2016	% change
Commercial Insured Market				
Insured Plans				
Non-group	32,041	29,547	32,721	
Large Employer group	47,400	40,190	19,472	
Small Employer group	37,231	36,656	42,938	
Association	39,758	39,410	0	
Insured Market Subtotal	**156,430**	**145,803**	**95,131**	
Self-insured Employer Plans				
Self-insured Employer Plans	137,327	126,568	168,838	
Federal Employee Plan	14,535	14,666	14,685	
Military	18,578	18,578	18,578	
Self Insured Market Subtotal	**170,440**	**159,812**	**202,101**	
Other				
VT residents covered by insurers outside VT	25,143	20,077	18,276	
Other	**25,143**	**20,077**	**18,276**	
Commercial Insured Market	**352,013**	**325,692**	**315,508**	**-3.1%**
Government Coverage				
Medicaid	146,273	161,097	157,112	-2.5%
Medicare	115,649	119,477	123,433	3.3%
Government Coverage	**261,922**	**280,574**	**280,545**	**0.0%**
Uninsured				
Uninsured	**26,071**	**26,071**	**28,541**	**9.5%**
Total of Assigned Lives	**640,006**	**632,337**	**624,594**	
Duplicated Count	-13,444	-6,295		
Total Vermont Population	**626,562**	**626,042**	**624,594**	**-0.2%**

Note: at this time we do not have Data on how many Vermonters have HSAs, HRAs, or FSA's.

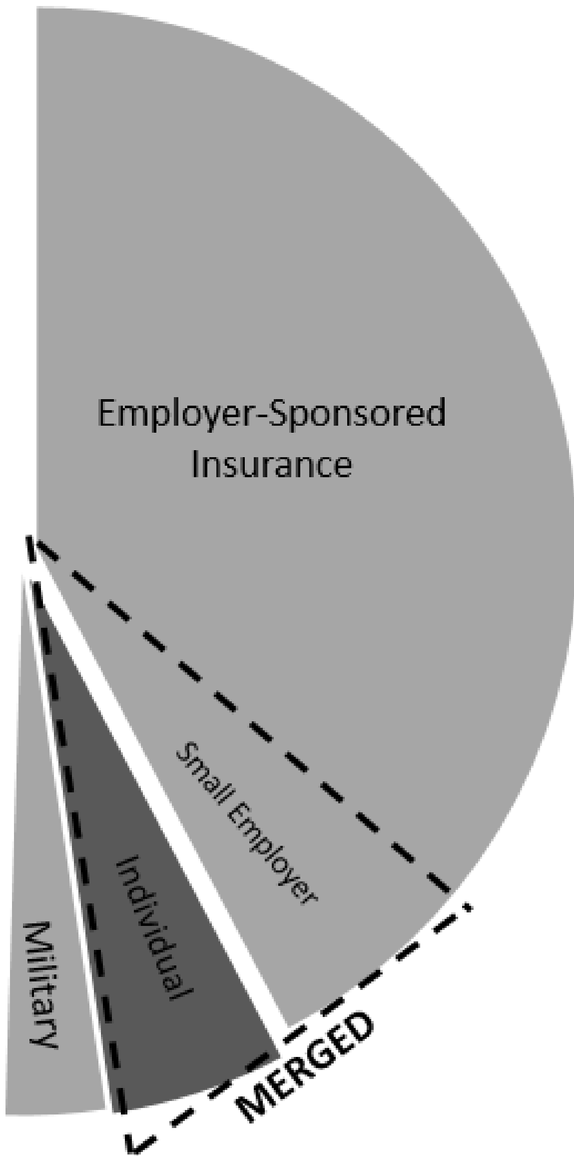
The enrollees shift across payer types may cause a "duplicated count" adjustment to be recognized.

The Vermont's all-payer claims database (VHCURES) has aided in the validation of the enrollment counts.

PRIVATE / COMMERCIAL INSURANCE



PRIVATE / COMMERCIAL INSURANCE



- Approximately half of Vermonters have private insurance*
  - Approx. 90% of private insurance was through an employer
  - Approx. 5% were individual plans purchased through Vermont Health Connect

Preliminary results from the 2018 Vermont Household Health Insurance Survey (VHHIS)

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 reinsure)
- Employer purchases administration services (TPA*)
- Not subject to state regulation

* TPA = Third Party Administrator

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

Actual 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.
- Metal levels apply across the merged market.

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 2019

	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	$5,500	$11,000	$2,800	$5,600	$850	$1,700	$350	$700
Rx Deductible	$900	$1,800	$300	$600	$100	$200	$0	$0
Med. Out of Pocket Max.	$7,600	$15,200	$7,500	$15,000	$4,700	$9,400	$1,350	$2,700
Rx Out of pocket Max	$1,350	$2,700	$1,350	$2,700	$1,350	$2,700	$1,350	$2,700
Integrated OOP	Yes		Yes		No		No	
Office Visit (PC/MH)[1]	Ded., then $35		$30		$15		$10	
Office Visit Specialist	Ded., then $90		$75		$30		$30	
Emergency Room[2]	Ded., then 50%		Ded., then $250		Ded., then $150		Ded., then $100	
Rx Generic	Ded., then $20		$15		$10		$5	
Rx Preferred Brand	Ded., then $85		Ded., then $60		Ded., then $50		$50	
Non-Preferred Brand	Ded., then 60%		Ded., then 50%		Ded., then 50%		50%	
Monthly Premium (before subsidy)								
BCBSVT	$496.39	$1,394.86	$645.34	$1,813.41	$674.23	$1,894.59	$786.86	$2,211.08
MVP	$426.12	$1,197.40	$638.82	$1,795.08	$608.39	$1,709.58	$716.54	$2,013.48

1) PC = Primary care. MH = Mental Health.

2) 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.
  - 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

- Vermont is one of only two states that has merged its individual and small group markets.
  - Individual Group = 33,456
  - Small Group = 45,140

78,596

- **Adverse selection** – when an insurer (or a market as a whole) contains a disproportionate share of unhealthy individuals.

- 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 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:

- People expected to be insured in this risk pool
- Projected medical and Rx trends
- 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

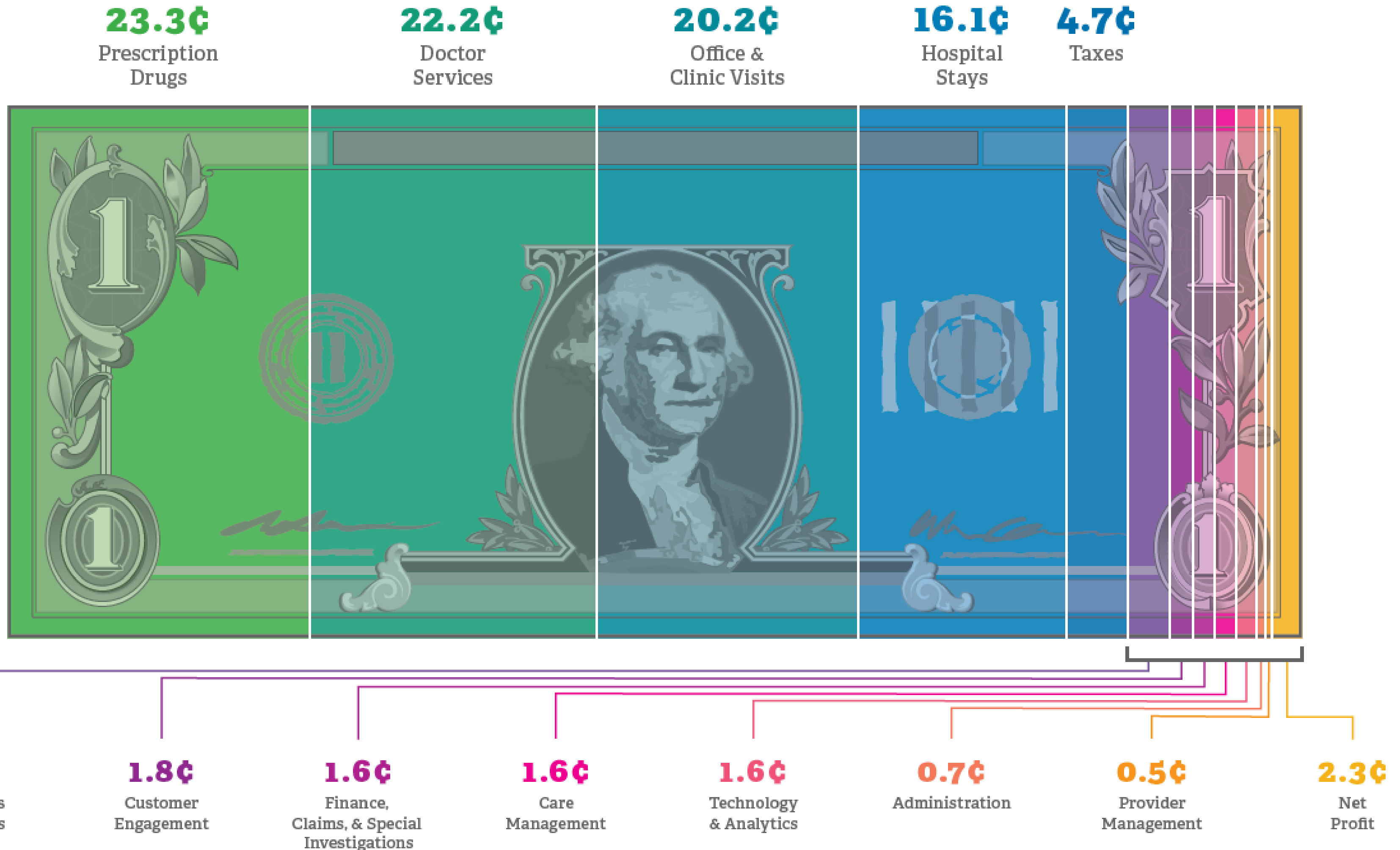
A quick not about Medical Loss Ratio

- 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 is 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.



Expenditure estimates above produced by AHIP. Distribution of spending among administrative categories and taxes. based on analysis by Milliman, Inc. Milliman's analysis is available upon request.

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AHIP

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, and "other issues at its discretion."
- The Office of the Health Care Advocate represents Vermont consumers during the rate review proceedings.

THE END
(for now)