A HIGH LEVEL OVERVIEW

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January 2025

DISCLAIMER:
A QUICK NOTE ABOUT THE DATA IN THIS PRESENTATION

We attempted to use the most up to date data available at the time of creating this presentation.

Given that different sources collect different data at different times, the year associated will be indicated whenever possible.

Much of the information in this presentation comes from the Vermont Household Health Insurance Survey (VHHIS) which is published by the Vermont Department of Health.

- The most recent survey was conducted in 2021. This is the most recent data we have regarding insurance coverage in Vermont.
- It is anticipated the next survey will be conducted this year.

This presentation will cover:

- Insurance Coverage: High-level market overview
- Insurance Basics
  - Actuarial value
  - Cost-sharing & Out-of-pocket costs
  - HRAs, HSAs, FSAs
  - Risk pooling
  - Premiums
  - Market Share
- Health Insurance Regulation
  - Rate Review
  - Solvency

INSURANCE COVERAGE: High-Level Market Overview

INSURANCE COVERAGE

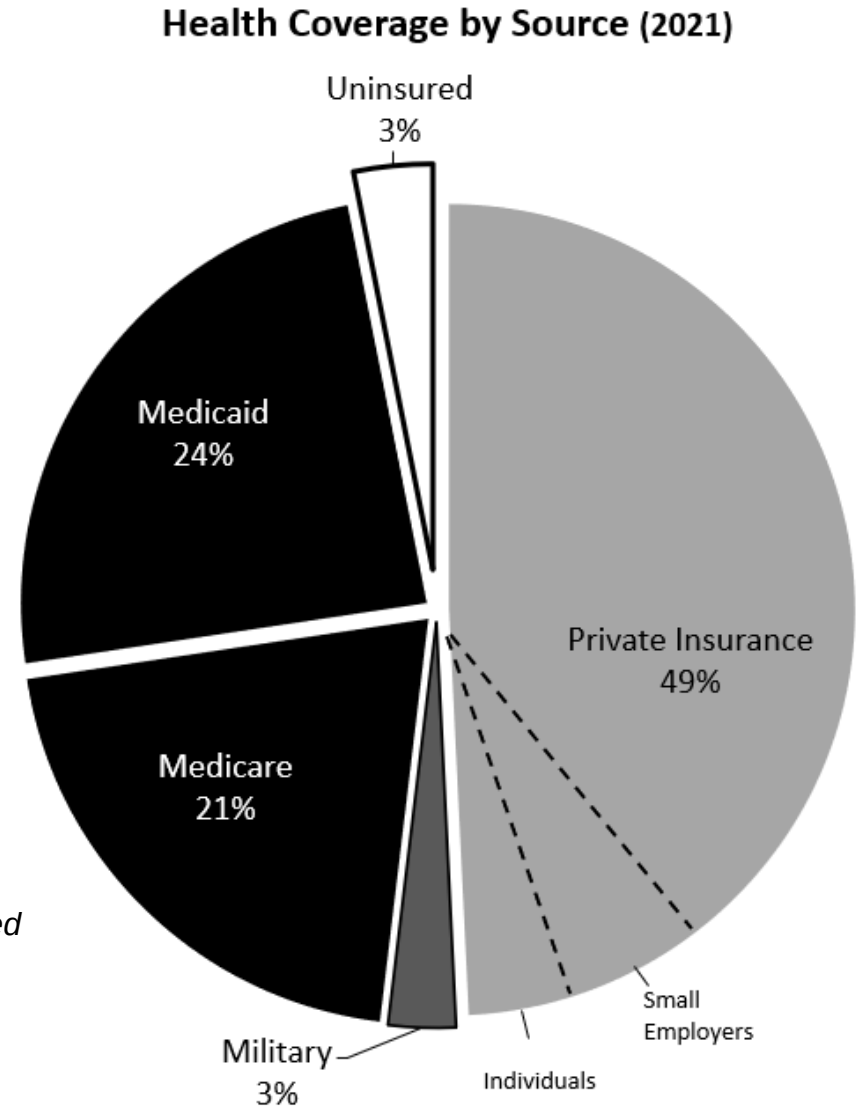
Private / Commercial Insurance

- Employer-based
- Individual Market

Government

- Medicare
- Medicaid

Military

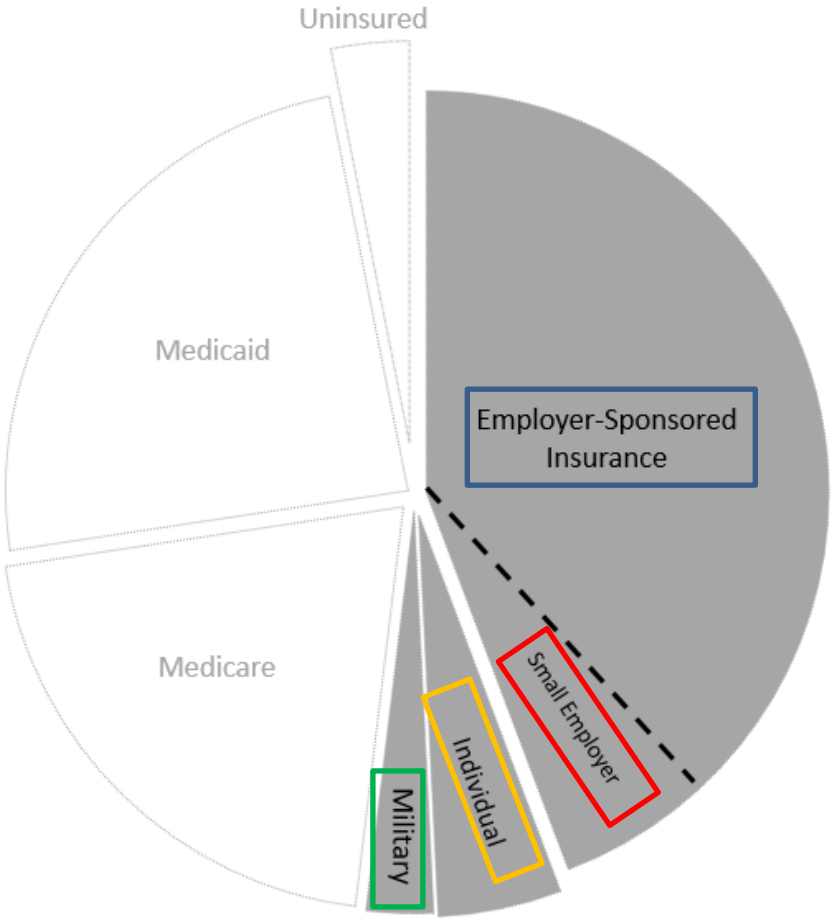


Notes:

1) Chart = Primary source of health coverage by source (Vermont Household Health Insurance Survey, 2021)

2) Public employees (such as State employees and teachers) are treated as "private" insurance, not "public" insurance, in this and other documents because they are administered by private insurance companies acting as third-party administrators.

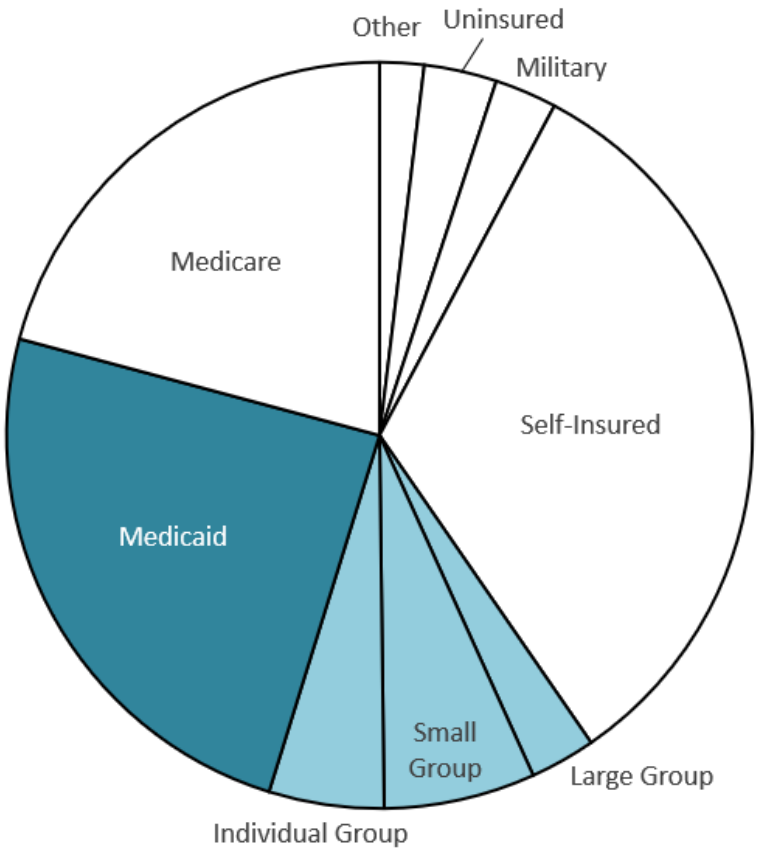
PRIVATE/COMMERCIAL INSURANCE



- **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

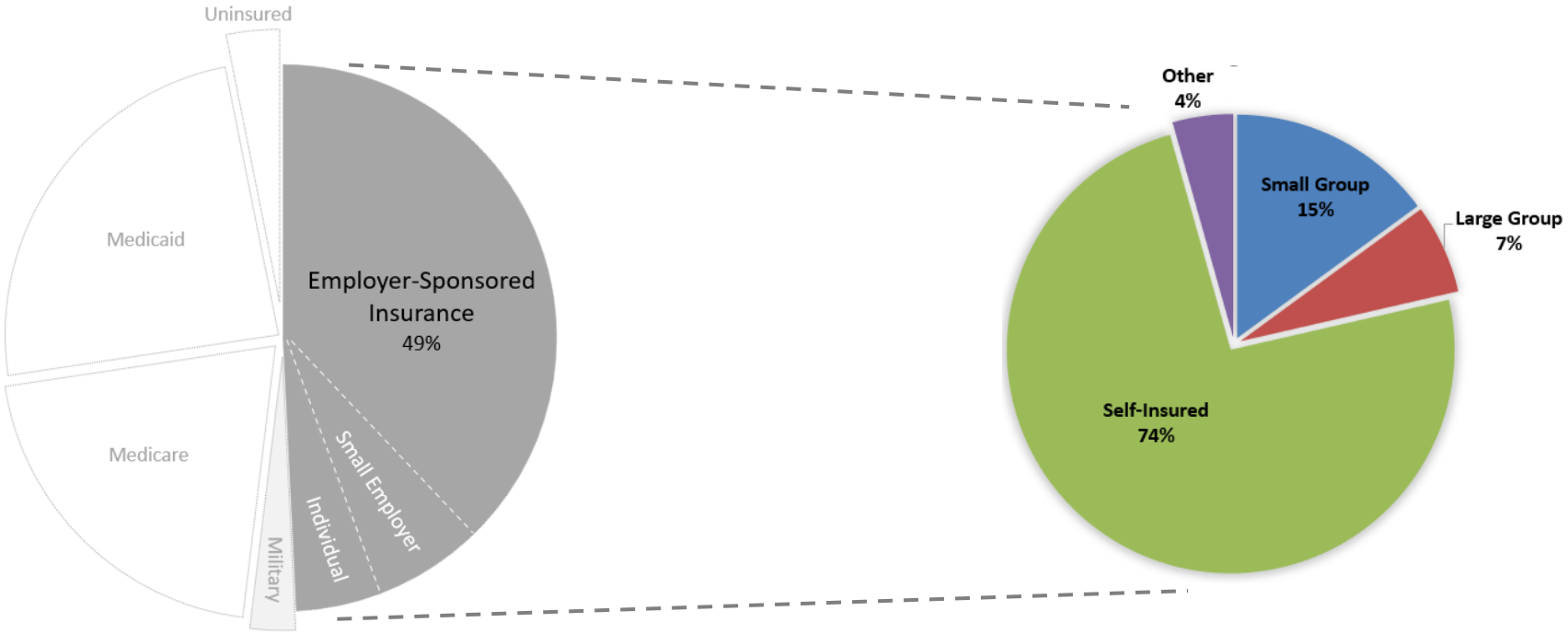


- **Regulated/Influenced by the State**
  - Individual Market
  - Small Group
  - Large Group
  - MEDICAID (through State Budget)

- **Not Regulated/Influenced by the State**
  - Self-Insured Employer Plans
    - Except for the State Employee Plan
  - Medicare
  - Military

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

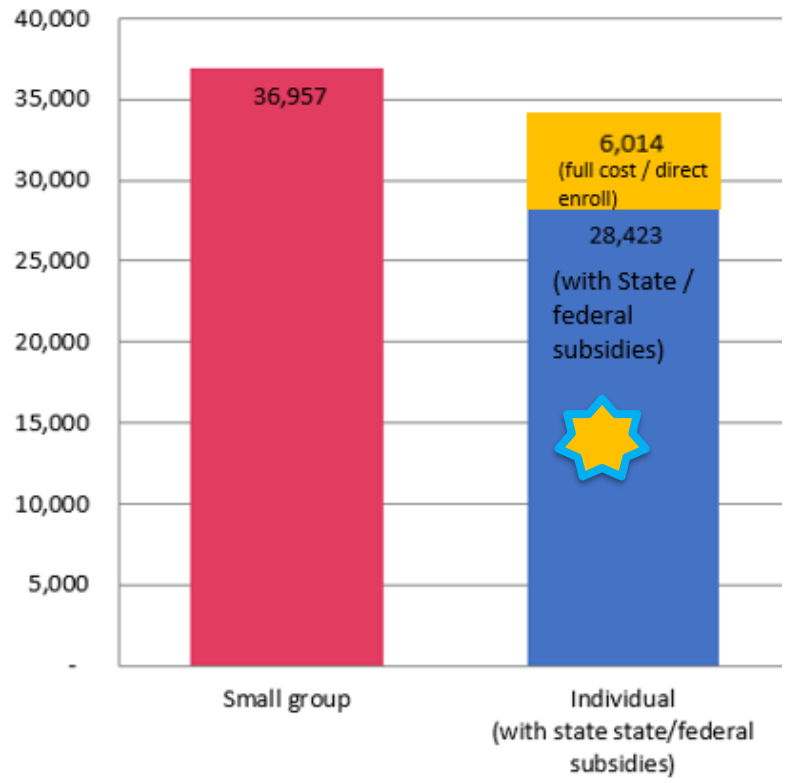
- INSURER bears ALL (or most) of the financial risk
- Employer purchases coverage from a regulated health insurance company
- Insurer is subject to state regulations
- *Small, Individual and Large group markets plans are insured plans.*

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
- *Self-insured plans are usually administered though a third-party administration (TPA)*

PRIVATE / COMMERCIAL INSURANCE
Individual and Small Group Markets

Enrollment in the Individual & Small Group Markets
(June 2024)



Source: Dept. of Vermont Health Access, Health Insurance Map – June 2024

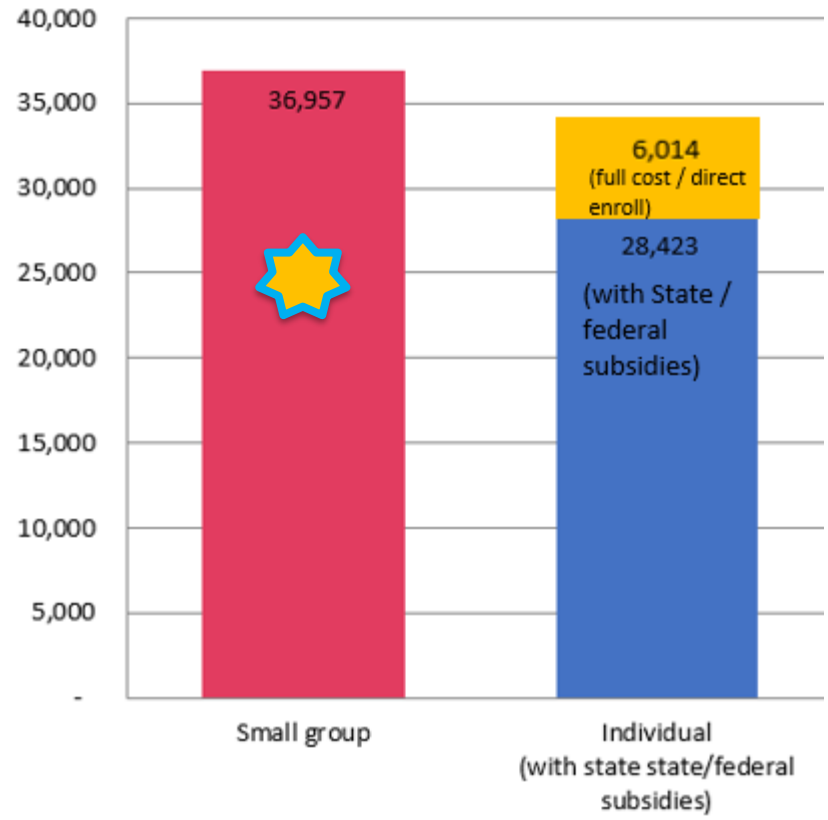
Individual Plans

- Approx. 34,437 people were covered by individual plans (June 2024)
- 82% were receiving financial assistance (state and/or federal).
  - Federal advanced premium tax credits (APTC)
  - Additional state tax credits available up to 300% FPL
- State & Federal cost-sharing assistance also available up to 300% FPL.
- Individuals not receiving financial assistance can buy directly from the carriers although many still purchase through VHC.

NOTE: FPL Chart on the last slide of this presentation

PRIVATE / COMMERCIAL INSURANCE
Individual and Small Group Markets

Enrollment in the Individual & Small Group Markets
(June 2024)



Small Group Plans

- defined as up to 100 employees
- Approx. 37,000 people were covered by small group plans (June 2024)

Large Group Plans

- At least 101 or more employees
- 17,493 in 2020. More recent data forthcoming.

Source: Dept. of Vermont Health Access, Health Insurance Map – June 2024

A QUICK NOTE:

Health Benefits Exchange

("The Exchange")

VERMONT HEALTH CONNECT
Find the plan that's right for you.

- Established under the Affordable Care Act (ACA)
- Online marketplace for **Individuals** and **Small businesses** (≤100 employees) to purchase health insurance plans and access financial assistance (if eligible).
- ***Vermont Health Connect (VHC)*** is Vermont's Health Benefit Exchange.
- VHC is administered by the Department of Vermont Health Access (DVHA)
  - DVHA is part of the Agency of Human Services (AHS)

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

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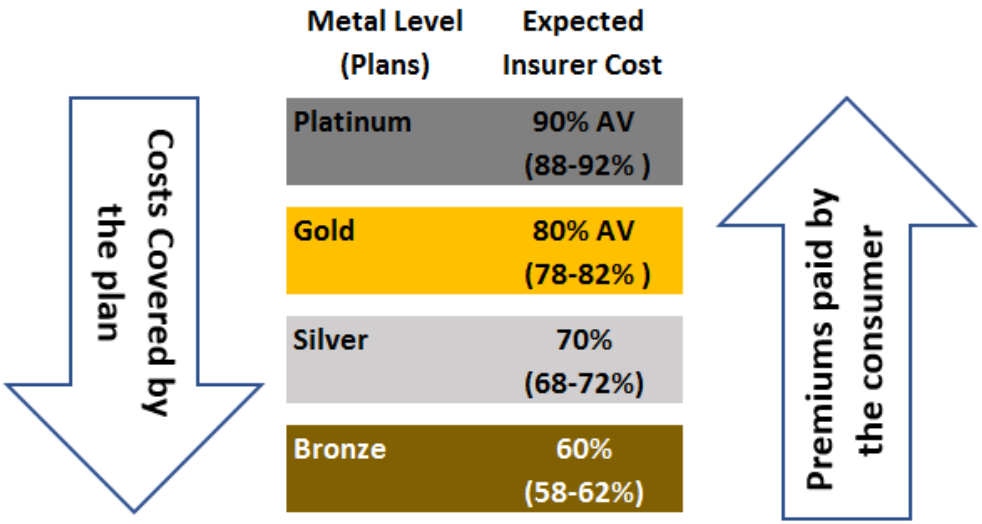
Metal Levels under the Affordable Care Act (ACA)

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



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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.

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Example: 2025 Standard Plans – 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	$3,500	$7,000	$1,400	$2,800	$450	$900
Rx Deductible	$1,100	$2,200	$500	$1,000	$200	$400	$0	$0
Med. OOP[1] Max.	$9,200	$18,400	$9,200	$18,400	$5,600	$11,200	$1,500	$3,000
Rx OOP Max.	$1,600	$3,200	$1,600	$3,200	$1,600	$3,200	$1,600	$3,200
Integrated OOP	Yes		Yes		No		No	
Office Visit (PCP/MH)[2]	Ded., then $35		$40		$20		$15	
Office Visit Specialist	Ded., then $90		$90		$55		$40	
Emergency Room[3]	Ded., then 50%		Ded., then $250		Ded., then $150		Ded., then $100	
Rx Generic	$15		$15		$15		$10	
Rx Preferred Brand	Ded., then $85		Ded., then $70		Ded., then $60		$50	
Non-Preferred Brand	Ded., then 60%		Ded., then 50%		Ded., then 50%		50%	

Monthly Premium (before Subsidy)								
BCBSVT	$852.65	$2,395.95	$1,390.77	$3,908.01	$1,219.41	$3,426.54	$1,432.43	$4,025.13
MVP	$807.97	$2,270.40	$1,276.53	$3,587.05	$1,145.36	$3,218.46	$1,366.00	$3,840.15

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

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OUT-OF-POCKET (OOP) COST

In 2023, the median annual out-of-pocket (OOP) costs for Vermonters with:*

- Individual plans = $260
- Family plans = $2,000

Annual Out-of-Pocket Costs	Individual Plans	Family Plans
None	30%	4%
Less than $100	38%	7%
Less than $250	49%	14%
Greater than $1,000	29%	64%
Greater than $2,500	11%	45%
Greater than $5,000	3%	12%
Greater than $10,000	0.01%	2%

* JFO analysis using VHCURES data. Based on claims for beneficiaries with at least one full-year of continuous coverage in their health insurance plan.

OUT-OF-POCKET (OOP) COST

- The use of employer-funded Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) has increased significantly over the years.
- The data (see previous slide) do not differentiate whether source of OOP spending was through HSAs, HRAs or directly by beneficiaries. As such OOP costs directly by consumers may be overstated.

- According to the 2021 Vermont Household Health Insurance Survey (VHHIS), for residents between 18 to 64 years old with private insurance:
  - 34% had an HSA
  - 13% had an HRA
  - 9% had both.
  - These numbers have likely changed over the past 4 years

What exactly are HSAs and HRAs?

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

<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 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 $3,300 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 $660 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 $4,300 single; $8,550 family (2025)	Employer can set limits subject to IRS/health care reform requirements ($3,300 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

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
  - 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

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RISK POOLING (continued)

- Vermont was one of only two states that had merged its individual and small group markets at the time (circa 2017)
  - These are temporarily unmerged but will re-merge 1/1/2026
    - Individual Group = 30,019
    - Small Group = 41,303

    } 71,322 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

Source: https://dvha.vermont.gov/sites/dvha/files/documents/202406-VT-HealthCoverage-Map.pdf

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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

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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

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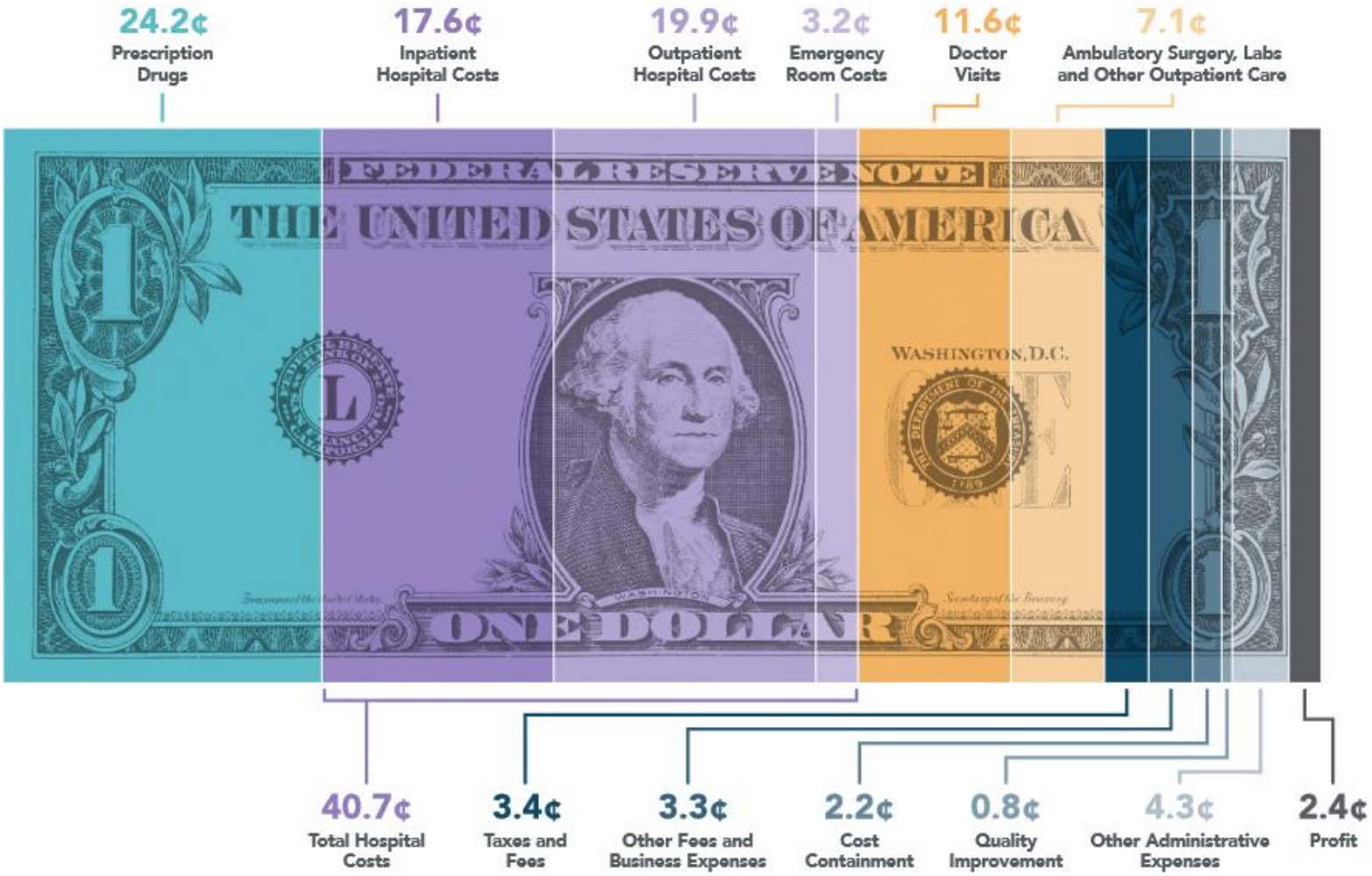
Where Do Health Care Dollars Go?

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 2020-22 benefit years. Totals may not add up to 100% due to rounding.

AHIP
Guiding Greater Health

https://ahiporg-production.s3.amazonaws.com/documents/202410-AHIP_HealthCareDollar.pdf

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.

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MARKET SHARE
(2021)

- Blue Cross Blue Shield of Vermont (BCBSVT) had the largest market share in Vermont – approx. 60-68% of earned premiums for Major Medical insurance [1]
- MVP Health Plan had the second largest market share (approx. 25%), followed by CIGNA (approx. 5%).

Blue Cross Blue Shield of Vermont is the only Vermont-based health insurance company.

- Created by statute and subject to comprehensive regulatory oversight:
  - 8 VSA Chapters 123, 125

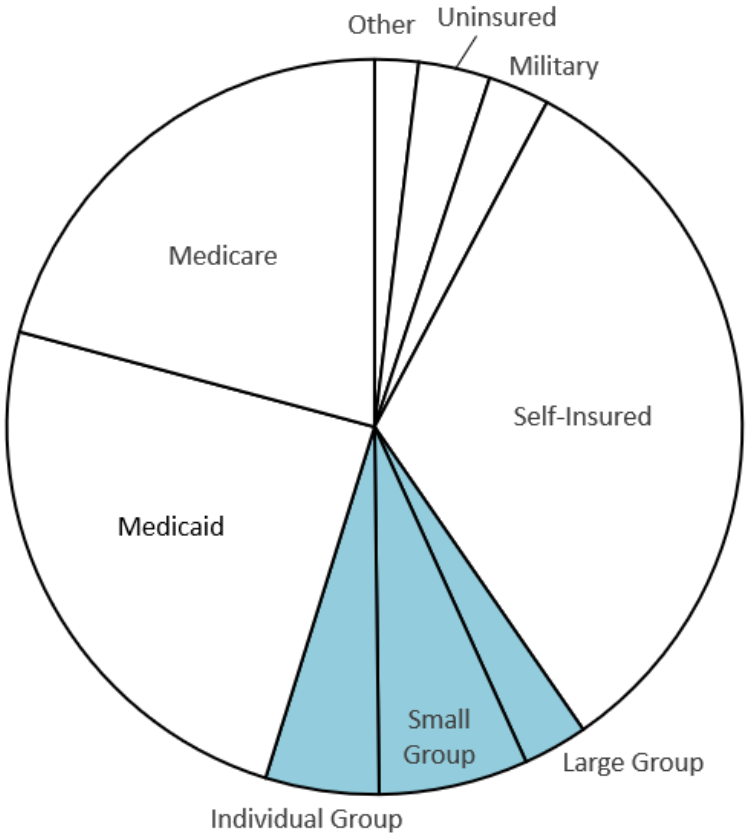
[1] Major medical does not include dental, Medicare advantage plans, Medicare Supplement, Long Term Care, third party administrator plans, etc.

HEALTH INSURANCE REGULATION

HEALTH INSURANCE REGULATION IN VERMONT

Green Mountain Care Board ⟹ Health Insurance Rate Review

Dept. of Financial Regulation (DFR) ⟹ Solvency



= segments of the health insurance market regulated by the State

HEALTH INSURANCE RATE REVIEW: *PROCESS*

Green Mountain Care Board (GMCB)

- **Filing –** Insurance carriers submit filings to the 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

HEALTH INSURANCE RATE REVIEW: *STANDARDS*

Green Mountain Care Board (GMCB)

- **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

HEALTH INSURANCE SOLVENCY

Department of Financial Regulations (DFR)

- Vermont law requires DFR to protect consumers by ensuring "the solvency, liquidity, stability, and efficiency" of businesses that offer financial services and products. This includes health insurance companies.

- Specifically, DFR "considers insurer solvency to be the most fundamental aspect of consumer protection, since it directly relates to an insurer's ability to pay policyholder claims."

- A critical part of determining an insurers solvency is monitoring their surplus
  - Surplus is the amount of assets remaining after accounting for all liabilities it must (or may have to) pay out.

A list of **USEFUL INSURANCE TERMS** can be found at the link below:
https://info.healthconnect.vermont.gov/learn-more/health-insurance-basics/list-terms#C

THE END
(for now)