REPORT TO THE VERMONT LEGISLATURE

Department of Vermont Health Access

A Technical Analysis Relating to Vermont's Health Insurance Markets

In Accordance with Act 113 of 2024, Sec. E.306.1

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare
Senate Committee on Finance

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The Agency of Human Services' mission is to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

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Executive Summary

Background. As directed by Act 113 (H.883) of 2024, Section E.306.1, this report presents the findings of a technical analysis related to Vermont's health insurance markets. Specifically, this report examines:

- The potential advantages and disadvantages to individuals, small businesses, and large businesses of modifying Vermont's current health insurance market structure, including impacts on premiums and access to health care services;
- Potential affordability mechanisms to address the expiration of federal enhanced advance premium tax credits (APTCs)[1] for plans issued through the Marketplace (known as Vermont Health Connect) in 2026; and
- The feasibility of creating a public option or other mechanism through which otherwise ineligible individuals or employees of small businesses, or both, could buy into Vermont Medicaid coverage.

Methodology. To examine each of these issues, the Department of Vermont Health Access (DVHA) and the Department of Financial Regulation (DFR) partnered with Manatt Health and Wakely to provide qualitative and quantitative analyses of these three topic areas for the State of Vermont (the State). The project team also held listening sessions with interested parties, including the Green Mountain Care Board (GMCB), the Health Care Advocate, Blue Cross Blue Shield of Vermont (BCBSVT), and MVP Health Care (MVP), to discuss each aspect of the analysis. These sessions provided an opportunity for the State to gather input, test assumptions, and refine recommendations based on external perspectives. Additionally, the project team presented preliminary findings at a public Medicaid and Exchange Advisory Committee meeting in early December, allowing for additional feedback on this report's early findings.

Findings. Based on the results of Wakely's actuarial analyses, Manatt's analysis, and external engagement sessions, DVHA shares the following findings related to maintaining the stability, affordability, and accessibility of Vermont's health insurance market, both in light of the potential expiration of the enhanced Affordable Care Act (ACA) subsidies under the Inflation Reduction Act (IRA) at the end of 2025, and in the interest of Vermont's health insurance market in the long term.

- **The unmerged market structure likely remains beneficial.** DVHA recommends keeping Vermont's insurance markets unmerged, primarily to prevent rate increases in the small group market. Because premiums are lower in the small group market than in the individual market, remerging the markets would increase small group premiums and decrease individual market premiums. This trade-off is not advisable because Vermont has fewer

[1] The federal Marketplace tax subsidy is referred to as APTC in this report. Wakely projections are based on the amount of APTC. Note that APTC is reconciled on an individual's tax return for the year received to arrive at the final premium tax credit (PTC). APTC is also adjusted to arrive at PTC in the pass-through funding calculation for 1332 waivers and in BHP methodology.

levers to counter premium increases and improve affordability in the small group market than it does in the individual market. Most significantly, substantial federal APTCs are available in the individual market, but not in the small group market.[2] The federal APTC substantially reduces premiums for those eligible, as does Vermont's state subsidy through the Vermont Premium Assistance (VPA) program. In addition, the ACA's section 1332 waiver process can be used to finance programs such as reinsurance, which reduces gross individual market premiums and captures the attendant federal APTC cost savings as "pass-through" funding to offset state expenses and/or use for additional subsidies. Pass-through funding is not available for 1332 waivers that reduce small group premiums, since premium reductions in the small group market do not generate any federal savings.

- **State subsidy changes and reinsurance may be helpful if federal enhanced subsidies expire.** If Congress fails to renew the IRA enhanced APTC subsidies, Vermonters will lose roughly $65 million in APTC subsidies annually, according to Wakely modeling. The populations most affected will be those with income below 200% of the federal poverty line (FPL) (roughly $30,000 for a single person in 2025) or above 400% FPL (roughly $60,000 for a single person in 2025). Modeling suggests that it may be prohibitively expensive to make all enrollees whole for the resulting premium increases, but that those negative impacts could be partially offset by targeted changes in the VPA or adoption of a reinsurance program through a 1332 waiver.
    - **VPA subsidies could be modified to target low-income populations.** Based on modeling from Wakely, revising the VPA program to fully address the loss of affordability at all income levels following the expiration of IRA subsidies would cost $65 million annually. Vermont could partially compensate for the loss of IRA subsidies by replacing some portion of the subsidies at all income levels. Fully backfilling the enhanced subsidies for people with income up to 200% FPL and partially backfilling the subsidies for people with higher income could cut the cost in half since most of the enhanced subsidies go to people with income above 400% FPL. It may be possible to leverage federal funds to offset a portion of this cost for higher income people, but that would require an amendment to the state's Medicaid 1115 waiver, which may not be feasible at this time. On the other hand, if VPA subsidies were revised to focus on preserving affordability for the population with income up to 300% FPL, Wakely projects that the total cost would be $9 million, with the state funding $3.8 million and the federal government funding the

[2] The ACA also created a federal Small Business Health Care Tax Credit, which provides financial assistance to employers who: 1) have fewer than 25 full-time equivalent employees; 2) pay average wages of less than $65,000 (for tax year 2024); 3) offer a qualified health plan to its employees through a Small Business Health Options Program Marketplace (or qualify for a limited exception to this requirement); and 4) pay at least 50% of the cost of employee-only health care coverage for each employee. The maximum credit is 50% of premiums paid for small business employers and 35% of premiums paid for small tax-exempt employers. The credit is available to eligible employers for two consecutive taxable years.

balance. This could still advance the State's goals of addressing affordability impacts for low-income enrollees in particular.

- **A state reinsurance program could help higher-income individuals who are no longer eligible for subsidies.** If VPA subsidies were targeted to low-income enrollees, Vermont could consider a reinsurance program to help those with income above 400% FPL. If the IRA enhanced subsidies expire, individuals with income above 400% FPL will no longer be eligible for any subsidies, creating a significant affordability cliff. A reinsurance program reduces gross (unsubsidized) premiums to provide a direct benefit to unsubsidized consumers. Based on Wakely modeling, the State could implement a reinsurance program for the individual market through a 1332 waiver with a target premium reduction of 10% at a cost of $37.5 million. The State share would be approximately $10.3 million (27%), with the remaining $27.2 million (73%) covered by federal pass-through funding. Were the program extended to the small group market, the total cost of achieving a 10% reduction would roughly double and the State's share of that cost would increase to more than 50%, since the State would only get pass-through funding for the premium reductions in the individual market.

- **A Basic Health Program (BHP) could provide a Medicaid-like program for those with income under 200% FPL, but there are complex dynamics to consider.** There continue to be discussions about broader changes to support access and affordability for low-income Vermonters. Pursuing an additional Medicaid expansion is one approach, but the State match for this option increases at higher income eligibility levels. While the State receives an enhanced federal medical assistance percentage (FMAP) rate of 90% for expanding Medicaid to include adults with income up to 133% FPL, Vermont's FMAP drops back to 58% for adults with income above 133% FPL. A second approach is to leverage federal funding for a "public option" on the Marketplace. Two states—Colorado and Washington—have created a "public option" using highly-regulated private insurance plans to compete with, rather than replace, other Marketplace plans. While these programs show some promise, premium reductions have been relatively minor to date. Even if those reductions were greater, they would not directly benefit subsidized enrollees, since their premiums are determined based on income rather than the gross premium. (The State, however, could potentially seek a 1332 waiver to capture the federal savings from the public option and use that pass-through funding to fund state subsidies.) The BHP is a third approach to provide more affordable coverage to individuals with incomes from 133 to 200% FPL. The BHP can be built as a lower-cost, Medicaid-like program and return to the State 95% of the federal funds that would have been spent on APTC, subject to certain adjustments.

    - **A BHP could be an option for Vermont under the right conditions.** The BHP model, established under section 1331 of the ACA, allows states to cover individuals with income between 133 and 200% FPL through a state program and

receive 95% of the federal APTCs that BHP enrollees would have received had they enrolled in the Marketplace. A BHP would allow Vermont to help address affordability and access issues for one of the State's most vulnerable populations through a Medicaid-like program with low or no premiums and cost-sharing. Wakely modeling indicates that a BHP could be financially advantageous to Vermont under the right funding conditions with relatively modest State expenditures for program administration. However, a notable challenge with the BHP is its impact on the Marketplace. Because of complex dynamics related to silver loading, the BHP may reduce subsidies for consumers with incomes above 200% FPL. It may be necessary to address those impacts before implementing a BHP. Overall, the findings indicate the potential long-term advantages of a BHP, if silver loading concerns are mitigated, and imply the need for its continued study as a way to increase access to affordable, comprehensive coverage in Vermont.

I. Examining Vermont's Market Structure

The ACA gave states the option of merging their individual and small group markets[3], and Vermont was one of two states, along with Massachusetts, to implement this option in 2012. At the time, there were concerns about the viability of ACA Marketplaces in low population states like Vermont where the individual market, which typically covers about 5% of a state's population, would be in the 30,000 lives range. Merging the markets also created certain regulatory efficiencies and contributed to Vermont's broader goal of unifying the overall health insurance marketplace. Market merger became less attractive over time as differences between the markets, especially higher costs and larger federal subsidies in the individual market, made it more advantageous to regulate the two markets separately. When Congress expanded individual market subsidies through the American Rescue Plan Act (ARPA) in 2021, Vermont's General Assembly unmerged the health insurance markets into separate individual and small group markets beginning in plan year (PY) 2022, which decreased small group premiums and increased individual market premiums. The premium increases experienced in the individual market were then largely offset by the availability of expanded federal ACA subsidies.

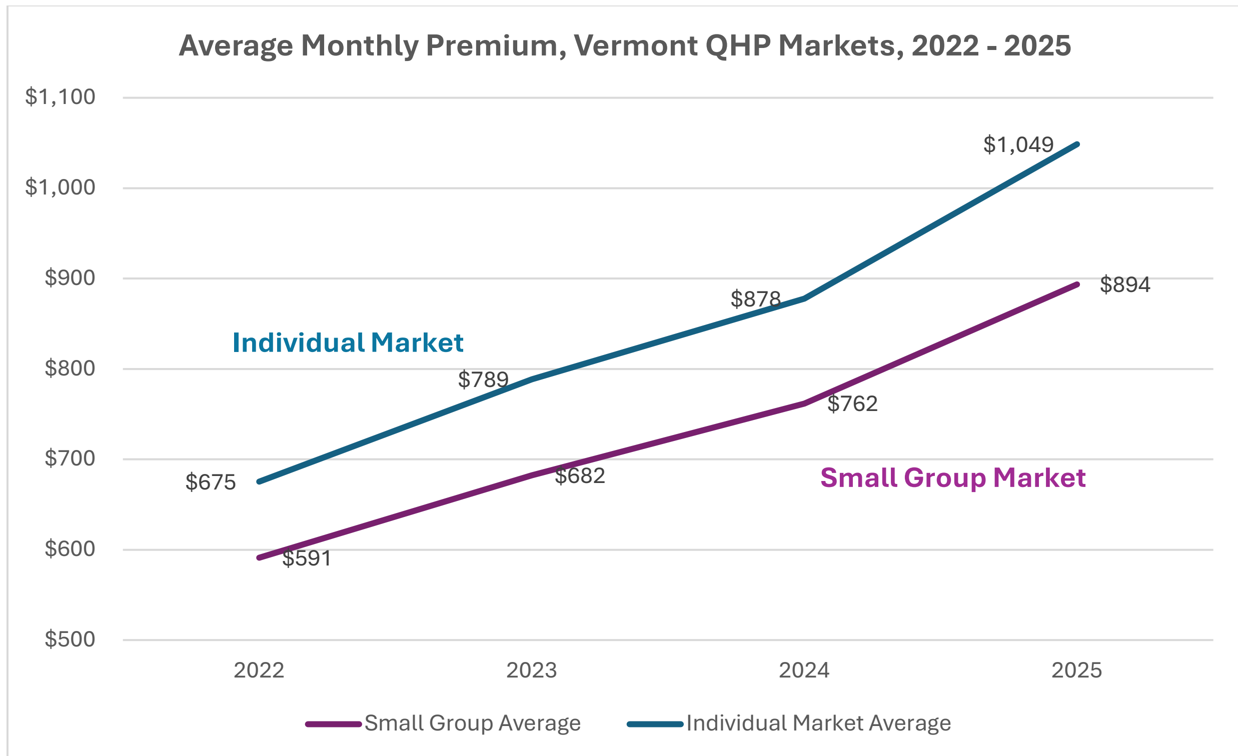
A working group was also convened by DFR and DVHA in 2022 to consider whether the State should continue to keep the markets separate in light of the slated expiration of expanded ARPA subsidies in 2023. However, when the IRA extended the enhanced federal subsidies through 2025,[4] workgroup members then recommended the State retain separate markets for the small group and

[3] The small group market is available to employers with not more than 100 employees.
[4] Recommendations to Address Vermont's Health Insurance Market Structure. Department of Vermont Health Access (2023). Available from: https://legislature.vermont.gov/assets/Legislative-Reports/Recommendations-to-Address-Vermonts-Health-Insurance-Market-Structure-2023.pdf

individual markets until IRA subsidies were set to expire.[5] Now, in light of the potential expiration of the expanded ACA subsidies at the end of 2025, Vermont is again considering whether to keep the individual and small group markets separate or to re-merge them.

Since separating the markets in PY 2022, small group premiums have continued to increase more gradually than individual market premiums, as shown in Figure 1. In 2025, the average small group premium in the Vermont QHP market is 17% lower than the average individual market premium.

Figure 1. Average Vermont Individual and Small Group QHP Market Premiums, 2022 – 2025[a]



[a]Analysis of rate filing data, 2022-2025.

If the state were to re-merge its individual and small group markets in an effort to improve affordability within the individual market, premiums in the small group market would rise substantially. Estimates based on the 2025 rate filings show that re-merging the markets would cause individual market premiums to decrease by an average of 7%, but small group premiums would increase by approximately the same percentage, representing $23.2 million that could not be recovered in subsidies.

There are multiple reasons why decreasing individual market premiums at the cost of increasing small group market premiums is not advisable.

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[5] Act No. 7. Vermont Legislature (2023). Available from: https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT007/ACT007%20As%20Enacted.pdf

- There are very limited federal subsidies for the small group market, and the State has limited tools of its own to address affordability for small groups. Affordability concerns have led many small employers with healthier workforces to pursue various forms of self-insurance, which increases premiums for those employers who cannot qualify for self-insurance. In this context, it makes sense to avoid actions that increase small group premiums unless there is a strong rationale for doing so.
- The situation is reversed for the individual market. There are substantial federal subsidies for the individual market and those subsidies are structured to limit enrollee premium contributions to a fixed percentage of the enrollee's income. This defined contribution approach gives the State options, such as silver loading, to increase federal APTCs by increasing gross premiums in ways that benefit rather than harm subsidized enrollees. Increasing gross premiums does make affordability worse for unsubsidized enrollees, but unsubsidized enrollees do have options, such as purchasing plans at other metal levels, or directly from QHP issuers, that do not include silver loading. (See box: What is Silver Loading? below for more information.)
- There are other affordability mechanisms, as discussed in section II below, designed to benefit the individual market.
- Having separate individual and small group markets may benefit the small group market beyond rate mitigation by allowing for flexibility in plan offerings and the opportunity to design QHPs specifically for small employers.

Consistent with the legislative charge, the project team also considered the potential advantages of expanding the QHP marketplace to include large groups. The project team found that the conclusions of a 2016 study, commissioned by the GMCB, remained persuasive.[6] That study found that a market merger including large groups would increase large group rates by 9% in a merged risk pool, and also noted that Vermont may not have the legal authority under the ACA to add large group to a single risk pool with the individual and small group markets. In addition, the study found that 75% of large groups were self-insured and that a market merger would likely increase this trend since federal law prohibits states from regulating premiums and most other aspects of self-insured group plans. Since the time of that analysis, the share of large firms that self-insure has likely increased.

Finding. DVHA recommends retaining separate individual and small group markets. This structure provides the most flexibility to preserve affordable coverage options so that Vermonters can access the health care they need. With small group premiums in Vermont remaining lower than individual market premiums under a separated market, and the availability of various affordability mechanisms to address rising premiums in the individual market, even if the IRA subsidies expire

[6] Report on the Impact of Expanding Vermont Health Connect to Include Large Group Employers (2016). Available from: https://legislature.vermont.gov/assets/Legislative-Reports/VT-LG-Study-LE-Final.pdf

at the end of 2025, retaining separate markets enables the State to address individual market premium increases without increasing premiums for the small group market.

DVHA further recommends the exploration of additional affordability strategies for the small group market in future studies. Over the course of this analysis, the project team heard a great deal of feedback about affordability challenges in the small group market. In particular, the Office of the Health Care Advocate has vocalized the need to examine the small group market and explore affordability mechanisms specific to this sector. There has been concern of adverse selection in the small group market because of increasing self-insurance among employers. In 2025, DFR will undertake revisions to the health care stop-loss rule to analyze and minimize impacts of adverse selection in the small group market. At the same time, small employers may benefit from alternative coverage options, such as health reimbursement arrangements or simply directing employees to take advantage of the subsidies on the individual market. The Departments suggest the Legislature dedicate additional resources to studying health care affordability mechanisms for small employers.

What is Silver Loading?

Silver loading is a state innovation dating back to 2017 when the first Trump Administration terminated payments to carriers to cover their costs for providing cost-sharing reductions (CSRs) to enrollees with income up to 250% FPL who purchase silver plans. Because the ACA required carriers to continue providing CSRs, the states had to find an alternative means of compensating carriers for their CSR costs. Vermont joined nearly all other states in allowing carriers to raise silver plan premiums to cover their CSR costs (“silver load”). Ironically, raising the cost of silver plans benefits all subsidized enrollees, not solely those eligible for CSRs. The silver benchmark plan (the enrollee’s second-lowest cost silver plan) is the basis for calculating APTCs. A higher silver benchmark gives enrollees higher APTC and more “purchase power” in shopping for other plans.

State silver loading policies have varied. Some states allow carriers to set their own silver load based on their specific CSR costs, while other states have been more prescriptive. Vermont recently shifted to the latter approach and roughly doubled plans’ required silver load in 2025. As a result, the silver benchmark premium now exceeds the cost of most gold plans, making those plans with lower out-of-pocket costs more affordable for subsidized enrollees.

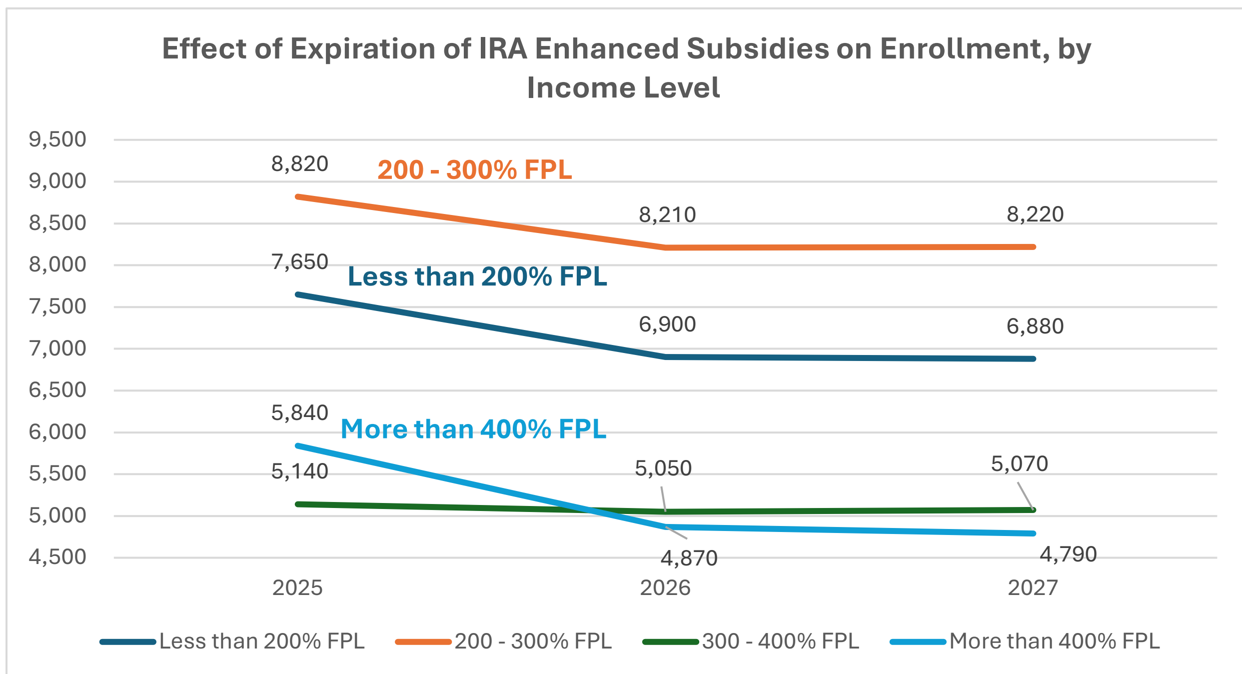
CMS has largely deferred to the states on silver loading policy, but this could change with the new administration. A variety of changes are possible, but those under consideration could reduce the current purchasing power of subsidized enrollees and, as noted throughout this report, would require new analyses of the policy choices available to the state in seeking to maximize premium affordability.

II. Marketplace Affordability Options to Address Expiration of Federal Enhanced APTCs

As discussed above, the IRA's enhanced premium subsidies are slated to expire at the end of 2025. Enhanced federal APTCs substantially improved the affordability of Marketplace premiums in a few ways. First, the law increased the amount of federal premium assistance provided to eligible enrollees across the board. This included subsidies that allowed Vermonters with income under 150% FPL to purchase silver benchmark plans for premiums of less than $1, which has been a highly motivating factor in enrollment. Second, it removed the ACA's subsidy cliff at 400% FPL to allow higher-income individuals to receive premium assistance and pay no more than 8.5% of income toward premiums. For Vermonters with income over 400% FPL, this means a premium subsidy of roughly $850 per month—two-thirds of the total premium. If the IRA's enhanced subsidies expire at the end of 2025, that help ends.

Wakely estimates that expiration of the IRA subsidies would decrease Marketplace enrollment by 8.3% in 2026, or nearly 2,400 people.[7] Coverage loss is prominent among APTC- eligible people with income below 200% FPL. (See Figure 2.) Ten percent fewer people in that cohort would enroll in PY 2026. Wakely also projects a significant increase in the unsubsidized population in Vermont's individual market beginning in PY 2026, owing in part to the end of subsidies for individuals with income above 400% FPL.

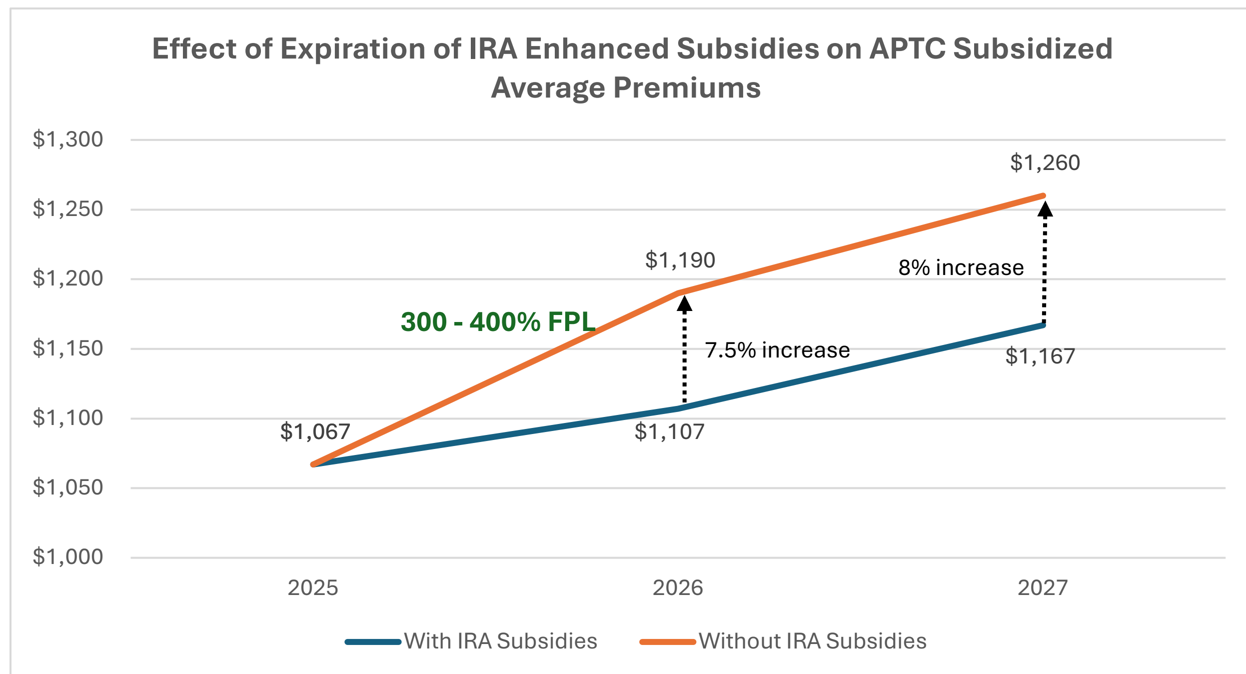
Figure 2. Projected Effect of Expiration of IRA Enhanced Subsidies on Enrollment, by Income Level



[7] Figures are based on Wakely's modeling using Vermont data. Some national models project a higher loss of Marketplace coverage, such as the model by the Urban Institute at https://www.urban.org/data-tools/health-insurance-premium-tax-credit.

Premiums on and off the Marketplace would increase if the IRA subsidies sunset. In PY 2026, Vermonters who enroll in the Marketplace with APTC will pay 7.5% more than they otherwise would, as would unsubsidized individuals purchasing Marketplace coverage. (See Figure 3.)

Figure 3: Effect of Expiration of IRA Enhanced Subsidies on APTC Subsidized Average Premiums



The overall effect of the loss of IRA subsidies on enrollment and premiums could, however, be cushioned by Vermont's approach to silver loading, taking effect in PY 2025. Under this technical revision, insurance carriers raise silver plan premiums significantly to reflect the impact of CSRs on base silver plan rates.[8] Having a higher silver premium raises the value of the APTC and increases the purchasing power of everyone eligible for APTCs. Of course, silver loading cannot cushion the impact for individuals with incomes above 400% FPL who would be ineligible for APTC after the IRA subsidies expire.

Some have speculated that silver loading could be ended or curtailed by the federal government. If Vermont's silver loading policy ended and reverted to the policy in effect in 2024, an APTC-eligible enrollee's average monthly net premium ("net" meaning amount paid after subsidy) in 2026 would be $183, more than double the $82 monthly net premium under the current guidance. If silver loading is ended or limited by the federal government *and* IRA subsidies expire, Marketplace

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[8] For a discussion of CSR loading, see https://gmcboard.vermont.gov/sites/gmcb/files/documents/CSR%20Load%20Options.pdf; Guidance on Silver Loading, Vermont Green Mountain Care Board. Effective Date: March 8, 2024. Accessed November 11, 2024. Available at: https://ratereview.vermont.gov/sites/dfr/files/documents/2024%20Guidance%20on%20SIlver%20Loading.pdf

enrollees would essentially face two premium cliffs that could raise net premiums. Wakely modeling indicates that Vermont would lose $65 million if IRA subsidies expire; if Vermont's 2025 silver load was cut back to the 2024 silver load, the value of Vermonters' APTC would fall by a total of $118 million[9].

Vermont examined two potential mechanisms for addressing enrollment and affordability within the individual Marketplace if the IRA subsidies expire, including (1) revising VPA, and (2) implementing a reinsurance program through a section 1332 waiver.

Vermont Premium Assistance

VPA is a state premium subsidy program that has been in place in Vermont since 2014. VPA reduces individuals' expected premium contribution by an additional 1.5% for Marketplace enrollees with income up to 300% FPL.[10] (See Figure 4.) VPA is funded by state and federal dollars under the state's Medicaid 1115 waiver. In 2024, Vermont paid $5.7 million in State funding and received $9.7 million in federal funding to supplement federal APTCs for eligible Vermont Marketplace enrollees with income up to 300% FPL.

Figure 4. Percentage of Household Income Paid Toward Premiums, 2021 - 2025

Income Level[a]	Under IRA	Current VPA[b]
Under 138% FPL	0%	-1.5%
133% – 150% FPL	0%	-1.5%
150% – 200% FPL	0 – 2%	-1.5 – 0.5%
200% – 250% FPL	2 – 4%	0.5 – 2.5%
250% – 300% FPL	4 – 6%	2.5 – 4.5%
300% – 400% FPL	6 – 8.5%	Same as federal
Above 400% FPL	8.5%	Same as federal

[a] 2021-2025 Applicable Percentages. Vermont Health Connect (2022). Available from: https://info.healthconnect.vermont.gov/sites/vhc/files/doc_library/2021-2025%20applicable%20percentages%20for%20GCR%20Oct%202022.pdf
[b] If a member has a negative applicable percentage, DVHA will apply VPA to any remaining portion of a member's monthly premium that is not covered by APTC.

There are multiple options for using VPA to supplement federal premium subsidies if the IRA subsidies expire, any of which would require legislative action. One option is for the State to increase VPA funding to fully replace the IRA subsidies. Based on modeling from Wakely, closing

[9] In this scenario, Wakely modeled the impact of reinstating the CSR loading in effect prior to PY 2025. In 2024, the average market-wide CSR load was estimated at 1.174, and the actual loading factors varied by issuer. This approach illustrates the impact of a single potential CSR change in the context of IRA expiration; other approaches include a return to federal funding of CSRs or a replacement of silver loading with a broad metal loading, but these were not part of the scope of this analysis.
[10] Applicable percentages scale proportionately to income levels. For example, Vermonters at 250% and 300% FPL have applicable percentages of 2.50% and 4.50% respectively, so an eligible Vermonter at 275% FPL would be expected to contribute 3.50% of their income to the cost of the benchmark plan, with federal APTCs and VPA covering the rest of the cost.

the subsidy gap at all income levels following the expiration of the IRA subsidies is estimated to require a $65 million State investment, which would be heavily weighted toward filling the gap for people with income above 400% FPL who would lose their APTC entirely. This approach could be cost prohibitive.

Wakely also modeled two options for partial replacement for the IRA subsidies. The first would scale the subsidy so people with income up to 200% FPL have the entire subsidy gap filled by VPA, while people with higher incomes receive a lesser VPA based on their income (see Figure 5). The total funding required for this scenario would be nearly $32 million, two-thirds of which would be used to subsidize people with income over 400% FPL.

It may be possible to collect some share of that cost from the federal government. Today, the VPA program is partially funded by the federal government as part of the State's Medicaid 1115 waiver according to the State's 58% FMAP rate, so the portion of the VPA that applies to people with income under 300% FPL could be changed without amending the waiver. However, expanding VPA to supplement premiums for people with income over 300% FPL would require a federal amendment to the waiver's standard terms and conditions (STCs).[11] If the waiver amendment was approved, the program would cost approximately $13.4 million in State general funds, with a $18.5 million federal match. If the waiver amendment was not approved, the State would bear its share of the cost for people with income up to 300% FPL and the entire cost for subsidies for those with income above 300% FPL.

Alternatively, VPA subsidies could be targeted exclusively at preserving affordability for the population with income up to 300% FPL, sidestepping the need for any 1115 waiver amendment (see Figure 5). Increasing the amount of VPA assistance provided to individuals with income up to 300% FPL is estimated to cost $9 million ($3.8 million in State general funds and $5.2 million in federal funds, if the State is able to incorporate the revised program parameters under its 1115 waiver).

[11] See STC 8.1 here: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/vt-global-commitment-to-health-appvl-tech-correct-09112024.pdf. "STC 8.1. State-Funded Marketplace Subsidies Program. The state may claim as allowable expenditures under the demonstration the payments for premium subsidies made through its state-funded program for individuals who purchase health insurance through the Marketplace. Premium subsidies will be provided on behalf of individuals who: 1. are not Medicaid eligible; 2. are eligible for the advance premium tax credit (APTC) on the Marketplace; and 3. whose household MAGI [modified adjusted gross income], as determined for APTC and consistent with all applicable federal laws, is at or below 300 percent of the FPL."

Figure 5: Sample Scenarios for an Enhanced VPA that Compensates for IRA Subsidy Expiration

Income Level	Scenario 1: Partial VPA Enhancement for People at All Income Levels		Scenario 2: Enhanced VPA for People with Income Up to 300% FPL	
	Percentage of IRA Gap Filled	*Total Funding Required (millions)*	*Percentage of IRA Gap Filled*	*Total Funding Required (millions)*
Under 133% FPL	100%	$0.1	100%	$0.1
133% – 150% FPL	100%	$0.9	100%	$0.9
150% – 200% FPL	100%	$4.0	100%	$4.0
200% – 250% FPL	90%	$1.9	100%	$2.1
250% – 300% FPL	80%	$1.4	100%	$1.9
300% – 400% FPL	50%	$0.6	0%	$0
Above 400% FPL	50%	$22.8	0%	$0
Total		**$31.9*** *$13.4 State* *$18.5 Federal*		**$9.0*** *$3.8 State* *$5.2 Federal*
*Some portion of this funding may be eligible for federal matching funds. The total funding figures in the final row for scenarios 1 and 2 are mutually exclusive.				

Finding. If IRA subsidies expire, the State could help to mitigate the premium impacts for Vermonters by modifying the VPA subsidy at various income levels, with greater benefits provided to those with modest incomes. VPA is scalable based on program design and the funds available. Scenarios that subsidize people with income over 400% FPL require more state investment since no federal subsidy is available. Scenarios that subsidize only or primarily lower-income populations have lower overall costs. A key factor in the analysis is whether it is feasible to amend the 1115 waiver to extend the federal matching rate to individuals with income over 300% FPL. Any change to VPA would require legislative action as well as significant implementation efforts at DVHA. While DVHA is not recommending a specific change at this time, upcoming affordability challenges present an opportunity to reshape this program for the further benefit of Vermonters either through future study, the next 1115 waiver negotiation, or both.

Reinsurance Program

Reinsurance programs provide payments to insurers to help offset the expenses associated with high-cost enrollees. Because insurers do not have to cover the full cost of high-cost claims, they are able to keep premiums at lower rates for all enrollees. The ACA included a three-year federal reinsurance program that is widely credited with reducing Marketplace premiums by 10-15% from 2014-2016. By covering a significant share of the most expensive claims, the program also made the ACA Marketplaces less volatile and more stable for insurers concerned about the risk of incurring a larger portion of sicker people with expensive claims than their competitors. The

program was financed by a per-person fee on all health insurers and third-party administrators[12] to spread the costs across the fully-insured and the self-insured market.

When the federal program expired, states began exploring state-based reinsurance programs and were able to leverage substantial federal funding for their programs through 1332 waivers.[13] Under 1332 waiver rules, states are entitled to "pass-through" funding equal to federal PTC savings when a program reduce premiums. To date, CMS has approved reinsurance waivers for 17 states with varying levels of pass-through funding.[14]

Vermont has not pursued a reinsurance waiver to date for a variety of reasons.[15] As noted above, a federal reinsurance waiver has reduced value in a merged market such as Vermont's prior to 2022. Reinsurance would apply to the entire merged market, whereas federal pass-through funding through a 1332 waiver is only available for the individual market. This means the State would need to pay a greater share of the cost, as compared to developing a reinsurance program for the individual market alone. In addition, reinsurance does not improve affordability for subsidized consumers since the amount they owe toward premiums is based on their income and does not change when gross premiums increase or decrease. If enhanced federal subsidies are renewed for 2026, most Marketplace enrollees will continue to be subsidized and will therefore not receive any direct benefits from having a state reinsurance program in place.

If IRA subsidies expire, a state reinsurance program would help address the loss of subsidies for people with income above 400% FPL. Currently, under the IRA, a person with an annual income of $60,240 (single household with income at 400% FPL for PY 2025) would pay no more than 8.5% of their income in premiums for Marketplace coverage, which translates to a maximum monthly premium of $427. If the IRA sunsets at the end of 2025, enrollees with income above 400% FPL will not be eligible for any subsidy and will have to pay the full premium. In many cases, this "affordability cliff" will more than double the enrollee's monthly costs. Unlike subsidized Marketplace consumers, these higher-income enrollees would directly benefit from lower gross premiums.

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[12] Third-party administrators are organizations that perform administrative functions, such as claims processing, premium collection, and utilization review, for health insurers and self-funded plans.
[13] The Benefits and Limitations of State-Run Individual Market Reinsurance. The Commonwealth Fund (2020). Available from: https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/benefits-limitations-state-run-individual-market-reinsurance
[14] States with section 1332 waivers for reinsurance programs include: Alaska, Colorado, Delaware, Georgia, Idaho, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, and Wisconsin. Source: Data Brief on State Innovation Waivers: Section 1332 Waivers. Centers for Medicare & Medicaid Services (2024). Available from: https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf
[15] State-Based Reinsurance Options for Vermont. Vermont Agency of Human Services (2018). Available from: https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Health%20Care/Health%20Insurance/W~Ena%20Backus~Agency%20of%20Human%20Services,%20State-Based%20Reinsurance%20Options%20for%20Vermont,%20September%2028,%202018~2-13-2019.pdf

To consider mechanisms to address the loss of IRA subsidies, DVHA asked Wakely to model a state reinsurance waiver aimed at reducing premiums by 10% compared to what premiums would have been without a waiver. Such a program would cost $37.6 million dollars annually (not including start-up and ongoing administrative costs), with federal pass-through funding covering $27.2 million (72.5% of the total), leaving $10.3 million for Vermont to cover (see Figure 6). The enhanced silver loading increases the overall pass-through amount by $3.7 million and the overall pass-through percentage by 2.6% over what it would have been without the enhanced silver load.

Figure 6. Projected Annual Reinsurance Premium Reduction Target and Funding (PY 2026)

Premium Rate Reduction Target (%)	Total Funding ($)	Federal Pass-through Funds	State Funds
10%	$37.6 million	$27.2 million	$10.3 million

If Vermont pursues a reinsurance program, the State will need to find an appropriate funding source for the ongoing state share of the reinsurance program. State reinsurance programs use varying mechanisms to fund the state share, including insurer assessments, general appropriations, individual mandate penalty dollars, or similar funding sources.[16] In general, a funding source that draws primarily on entities outside the individual market will be more effective at reducing the assessment and hence the premiums. It is also worth noting that any funding source for reinsurance could potentially be used to fund direct consumer subsidies instead, depending on which approach is preferred. Vermont also would need to consider the administrative cost and the timeline for standing up a reinsurance program. This has been another challenging factor in past discussions of state-based reinsurance. While CMS has granted expedited review to reinsurance waivers in the past, the State must first enact legislation authorizing a 1332 waiver, work with interested parties to develop program parameters and governance, conduct an actuarial study, and have the program in place early enough in the year prior to implementation for DFR to coordinate with carriers ahead of the annual rate review cycle.

Finding. A reinsurance program would help address the loss of affordability for Marketplace enrollees if IRA subsidies expire—especially for individuals above 400% FPL. Such a program would leverage substantial federal dollars but would require a state funding source and administrative resources. In the scenario modeled by Wakely, a reinsurance program designed to reduce premiums by 10% would cost Vermont $10.3 million, supplemented by $27.2 million in federal pass-through funds. If IRA subsidies are extended, Vermont may still wish to consider a

[16] The Benefits and Limitations of State-Run Individual Market Reinsurance. The Commonwealth Fund (2020). Available from: https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/benefits-limitations-state-run-individual-market-reinsurance#:~:text=States'%20reinsurance%20programs%20receive%20substantial,funding%20mechanisms%20to%20do%20so

reinsurance program, but the program would have less impact on consumer affordability, given the limited number of enrollees that would remain unsubsidized within Vermont's individual market.

III. Public Option or Other Mechanism to Buy into Vermont Medicaid Coverage

Regardless of whether IRA premium subsidies are renewed, affordability will continue to be a challenge for low-income Vermonters who have trouble affording premiums and the cost-sharing needed to use their insurance. To address this, Vermont could consider a longer-term solution to expand Medicaid-like coverage to additional Vermonters. Vermont has explored Medicaid expansion and a public option in the past, and these remain options today. However, the State could also investigate creating a BHP, which would allow it to leverage federal funding, depending on the tools available to address the impact on the population over 200% FPL remaining in the Marketplace.

Medicaid Expansion or Public Option

Medicaid Expansion. Vermont's Medicaid and Children's Health Insurance Program (CHIP) provide affordable health insurance coverage for adults with income up to 133% FPL ($1,733[17] a month for a single-person household in 2024), pregnant women with income up to 208% FPL ($3,628 a month for a two-person household in 2024), and children ages 0 through 18 with family income up to 312% FPL ($5,400 a month for a two-person household in 2024).[18] As of September 2024, Vermont had a total Medicaid and CHIP enrollment of nearly 168,000 people, making Medicaid the largest health insurance program in Vermont.[19]

The Legislature has indicated interest in expanding Vermont Medicaid as a potential strategy for extending affordable health insurance coverage to more low-income adults. However, there are a number of challenges with doing so. While the State receives an enhanced FMAP rate of 90% for expanding Medicaid to include individuals with income up to 133% FPL, Vermont's FMAP drops back to 58% if the State expands its Medicaid program to include individuals with income above 133% FPL.[20] Previous studies have estimated the cost of expanding the State's CHIP program to cover all Vermonters up to age 25, regardless of income, to range anywhere from $343 million (in a

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[17] Modified Adjusted Gross Income (MAGI) limits are subject to an additional 5% income disregard over state levels.

[18] Dr. Dynasaur was created by Act 94 of the Acts and Resolves of 1989 and refers to Vermont Medicaid coverage for children and pregnant individuals.

[19] Health Insurance Map. Department of Vermont Health Access (2024). Available from: https://dvha.vermont.gov/sites/dvha/files/documents/202406-VT-HealthCoverage-Map.pdf

[20] 1902(a)(10)(A)(ii)(XX). Source: https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-above-133-fpl-under-age65.pdf

70% enrollment scenario and provider reimbursement levels set to Medicare rates) to $667 million (with a 100% enrollment scenario and provider reimbursement levels set to commercial rates).[21]

A more recent proposal, H.721 was passed by the House of Representatives in March 2024.[22] That bill ultimately proposed a narrowed Medicaid expansion that would include only young adults ages 19 and 20 years of age and pregnant individuals up to 312% FPL. It had an estimated annual cost of $16.35 million gross (of which $6.9 million would be from the General Fund).[23]

The policy mechanism for an income expansion of Vermont Medicaid would be an amendment to Vermont's Medicaid State Plan, which is a somewhat routine federal approval process as compared to the comprehensive negotiation of a demonstration waiver. However, any proposal to substantively change the health care coverage map in Vermont should be considered holistically. There are sustainability challenges in the individual market, and removing a young, healthy population from commercial coverage could destabilize the market. The vision for public health care coverage in Vermont is currently articulated in the Global Commitment to Health 1115 Waiver which, as discussed above, establishes VPA as a wrap program in the commercial market for those over income for Medicaid but under 300% FPL.[24] There are numerous considerations to reimagining the health coverage landscape for Vermont.

Public Option. There are other approaches through which otherwise ineligible individuals could buy in to Medicaid or Medicaid-like coverage in Vermont, such as through a public option. A public option refers to an insurance coverage program that is designed to leverage the state's position as a purchaser or regulator to create additional coverage options. Whereas a traditional Medicaid expansion would replace commercial coverage, a public option could be offered alongside commercial coverage as a means to either broaden coverage options or enhance competition among carriers.[25] States that have implemented public options to date include Colorado and Washington State; Nevada has been approved to implement a public option beginning PY 2026. Colorado, Washington State, and Nevada have all pursued the "public-private partnership" model

[21] Modeling Dr. Dynasaur 2.0 Coverage and Finance Proposals. RAND (2017). Available from: https://www.rand.org/pubs/research_reports/RR1743.html
[22] H. 721 Bill Status. Vermont Legislature. Available from: https://legislature.vermont.gov/bill/status/2024/H.721
[23] Fiscal Note H. 721. Vermont Legislative Joint Fiscal Office (2024). Available from: https://ljfo.vermont.gov/assets/Publications/2023-2024-House-BIlls/c8a3ca8d83/GENERAL-374922-v9-2024_H_721_Medicaid_Expansion-HOUSE-PASSED.pdf
[24] Global Commitment to Health 1115 Waiver. State of Vermont Agency of Human Services. Available from: https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver
[25] Improving Affordability and Accessibility by Reducing Health Care Costs for Consumers and Businesses in Vermont. Health System Transformation, LLC (2022). Available from: https://legislature.vermont.gov/Documents/2022/WorkGroups/TaskForceAffordableHealthCare/Documents%20and%20Testimony/W~Joshua%20Slen~Task%20Force%20Final%20Report~4-4-2022.pdf

of a public option, where the state-designed public option plan is delivered by commercial insurers.

Designing a public option that is intended to compete with commercial plans, rather than replace them, requires careful balancing to preserve a competitive landscape. States like Colorado give the public option certain advantages, including a process for capping provider rates if necessary to achieve premium reduction targets, but also aim to limit those advantages to avoid a scenario in which commercial plans are driven out of the market. In Vermont, market affordability strategies that rely on limiting provider reimbursement could put pressure on the remainder of the market through the State's hospital budget review process.

In addition, having a public option—even one with premium rates that are lower than other commercial plans—does not necessarily translate to lower net premiums for individuals purchasing coverage in the Marketplace since, under the ACA, individuals pay income-based premiums. This means that a subsidy-eligible person who purchases a benchmark silver plan will pay the same amount for coverage irrespective of the total premium cost. Colorado pursued its public option through a 1332 waiver to collect as pass-through funding any savings generated by the program and put those funds towards subsidies that would lower net costs for certain groups in a way that the public option alone would not. Despite the strengths of Colorado's approach (namely, giving the insurance commissioner the authority to set provider rates when required), the public option's savings have been limited so far.

Another option is to allow small groups to buy into a State-created, Medicaid-like public option. This could offer a more affordable insurance option for small employers, but with no federal subsidies available to offset premiums, costs could still be unaffordable for many small businesses. In addition, establishing a public option for small employers would require extensive start-up and operational costs for the State, such as building a plan design and establishing a provider network. As with individual-market public options, a small-group public option could have ramifications on the commercial small group market by driving out insurers and limiting plan choice and on providers, if rates are lower than commercial levels.

Finding. Medicaid expansion's high program costs and limited federal match rate will continue to pose barriers for the State. A public option that seeks to maintain a competitive landscape poses different challenges, and may be especially difficult in a state with limited insurer competition. While there are some promising signs in Colorado's 1332 waiver, there is no proven path to achieving significant savings through a public option, and even with a successful public option, any savings must be harnessed for subsidized people to experience greater affordability.

Basic Health Program

Background. Section 1331 of the ACA provides states with the option to implement a BHP, which is a health insurance coverage program for individuals with household from 133-200% FPL who would otherwise be eligible for subsidized coverage through the Marketplace. BHP rules require

everyone eligible for the BHP to be covered by the BHP, meaning that BHP-eligible enrollees currently in the Marketplace must migrate to the BHP, though the migration can take place over two to three years for current Marketplace enrollees who do not make changes in their Marketplace coverage. States that operate a BHP receive federal funding equal to 95% of the federal PTCs that otherwise would have been provided on behalf of individuals who enrolled in Marketplace coverage, with several adjustments applied. (For more detail on these adjustments, see the Appendix.) BHP transfers are stored in a trust fund, with excess funds available to make other improvements for that population, such as lowering premiums or cost sharing, improving benefits, and increasing provider reimbursement.

Because APTCs are based on the premium of the second lowest cost silver plan (SLCSP), the BHP revenue formula benefits states with community rating. For example, New York has more favorable BHP funding than Minnesota and Oregon because New York's community-rated premiums generate higher APTCs than states with age rating. Vermont 's community-rated premiums give the State a similar advantage over states with age-rated premiums. States with BHPs have the flexibility to design the plan structure, and benefits and cost sharing offered to enrollees can be made more generous than Marketplace coverage. States can choose to design the plan to be more "Medicaid-like" in design, with minimal (if any) cost sharing, or more "Marketplace- like," with modest cost sharing. A BHP is generally administered by contracted commercial carriers based on their participation in Medicaid managed care or the Marketplace. The program design provides an opportunity to improve continuity of care and use state purchasing power to create a smoother glide path between Medicaid and commercial insurance for individuals transferring between program eligibility levels. The BHP can be designed with no cost-sharing or premium contributions, or it can have tiered consumer contributions based on income, with no or minimal contributions at the bottom of the income spectrum and increasing contributions toward the higher end of the range.

To date, BHPs have been established in New York[26], Minnesota, and, most recently, Oregon. All three state programs provide robust benefits for individuals with incomes between 133 and 200% FPL and feature low-to-no-premiums and cost sharing for enrollees. New York and Minnesota have demonstrated strong and consistent enrollment in the decade since they were established as well as high quality ratings and member satisfaction levels.[27] Oregon launched its BHP in July 2024 and is showing strong enrollment as well.

The BHP provides states with an opportunity to design a Medicaid-like offering targeted to individuals with income up to 200% FPL that would otherwise be ineligible for Medicaid, while also

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[26] Using a 1332 waiver, New York suspended its BHP in April 2024 and moved enrollees to a BHP-like program, in order to capture pass-through funds, which have more flexible uses than savings in the BHP trust fund.
[27] Urban Institute. The Basic Health Program. Available from: https://www.urban.org/research/publication/basic-health-program

offering a favorable federal funding opportunity. DVHA engaged Wakely to conduct an analysis to examine the feasibility of a BHP in Vermont.

Analysis. Wakely modeled the BHP implementation and how a BHP would impact Vermont's individual market in 2027. The modeling used current state and federal subsidy levels (including enhanced IRA subsidies). The modeling used Medicare reimbursement rates for BHP providers and assumed no premium contributions from enrollees and no enrollee cost sharing. Key results included the following:

- ***Morbidity***. Wakely used claims data to estimate that the BHP population (133-200% FPL) would have 7% higher morbidity than the remaining Marketplace population (above 200% FPL), which increases both BHP revenues and costs and decreases Marketplace premiums. Morbidity refers to the relative health of a population, with higher morbidity meaning that the population is less healthy.
- ***Enrollment*.** Wakely estimates that an additional 1,100 people who would otherwise be uninsured would enroll in Vermont's BHP. Roughly 6,600 Marketplace enrollees would transition to the BHP, for a total enrollment of more than 7,700 people. This projected BHP enrollment correlates to a reduction of 8,680 enrollees in the Marketplace. Overall, total enrollment in 2027 in the BHP and the individual market would be 30,430 compared to 31,370 without the BHP as a result of loss of purchasing power for the subsidized members with incomes over 200% FPL, as further explained below.
- ***Revenues***. BHP revenues are the amount collected from the federal government to fund BHP coverage. After adjusting the average APTC per member per month (PMPM) by the various federal factors, Wakely projects BHP revenues to be $1,100 to $1,200 PMPM (or $104 million to $111 million annually), with morbidity projected to be 7% higher in the BHP. See the appendix for more detail on these calculations.
- ***Costs***. BHP costs are highly dependent on provider reimbursement levels. Wakely projects BHP costs to be in the $800 to $1,000 PMPM range ($77 million to $95 million annually) using Medicare rates for providers and projecting morbidity to be 7% higher in the BHP population.
- ***Impact on Marketplace***. Subsidized Marketplace enrollment would fall by nearly one-third, in most part because APTC-eligible people with income below 200% FPL would move to the BHP. Marketplace gross average premiums would decrease by 11% PMPM, based on premium reductions for improved morbidity, but that is offset by lower APTC that decreases purchasing power due to the loss of silver loading.

Figure 7: BHP Revenue, Cost, and Surplus

	PMPM	**Annual Total**
Revenues	$1,100 - $1,200	$104 million - $111 million
Costs	$800 - $1,000	$77 million - $95 million
Total Surplus		$9 million - $34 million

The $9 million to $34 million surplus (see Figure 7) of revenues over costs and administrative expenses (including taxes) would go to a BHP trust fund and could be used to increase provider rates, increase benefits to BHP enrollees, or reduce premiums and/or cost sharing for BHP enrollees (if the State includes some cost sharing in the initial program as a hedge against the risk of the program costing more than projected).

Other Marketplace Considerations. Since the BHP-eligible population is required to migrate from the Marketplace to the BHP, most of Vermont's current silver loading will be eliminated. This occurs because individuals with income under 200% FPL receive the highest CSR subsidies, which provide the actuarial basis for silver loading. Removing these individuals from the Marketplace will reduce the impact of silver loading in the State, thereby lowering the premiums of Silver-level plans and the benchmark plan that is used to determine APTCs for all Marketplace enrollees. This would have a negative impact on enrollment levels.

Reducing silver premiums benefits unsubsidized enrollees who bear the full cost of premiums, but it has the opposite impact on subsidized enrollees, who lose the enhanced purchasing power that comes from silver-loaded premiums. Gold or bronze plans become more expensive relative to silver plans in the absence of silver loading. The loss of this enhanced purchasing power is an unintended consequence of establishing a BHP. The State will likely need a solution that preserves affordability for Marketplace enrollees who currently benefit from the enhanced silver load implemented for PY 2025,[28] to maintain or increase enrollment in the Marketplace.

It is possible that federal rules on silver loading will change, which would mitigate a BHP's impact on the Marketplace. Dynamics to watch include any changes from the federal government's current deference to states on silver loading, as well as any changes in BHP policy related to how BHP states are compensated (or not) for the loss of silver loading. Currently, the adjustment formula used to determine BHP revenue includes an increase in PTC of 18.8% to compensate for the loss of silver loading, though BHP rules recognize that silver loading can vary by state, which could be the basis for a higher increase than 18.8% in Vermont. There is currently no compensation for loss of silver loading for populations with income above 200% FPL.

In summary, while a BHP can be designed with lower premiums and cost-sharing for people with income up to 200% FPL, people with income above that level can experience a loss of purchasing power due to lower subsidies. This might mean paying higher net (post-subsidy) premiums for the same plan than they would have without the BHP, buying down to a less expensive metal level, or dropping coverage. For example, an enrollee who currently leverages sliver loading to purchase a gold plan for $38 dollars per month would have to pay $332 dollars more for the same plan or buy down to a silver plan to pay only $103 dollars. The effect would be similar for an enrollee

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[28] Guidance on Silver Loading, Vermont Green Mountain Care Board. Effective Date: March 8, 2024. Accessed November 11, 2024. Available at: https://ratereview.vermont.gov/sites/dfr/files/documents/2024%20Guidance%20on%20SIlver%20Loading.pdf.

purchasing a bronze plan and currently not paying a premium (zero cost plan), who would instead face $174 per month net premium with BHP. If a BHP were created, Vermont would need to consider how to avoid raising net premiums for people with income above 200% FPL and the resulting attrition.

Vermont's Medicaid Administrative Model and BHP Administration. Federal rules require the BHP to be a standard health plan provided by a "standard health plan offeror." A standard health plan offeror is defined in statute as an entity that is eligible to enter into contracts with the State for the administration and provision of a standard health plan under the BHP.

New York, Minnesota, and Oregon all leverage their Medicaid managed care organizations to administer and deliver the BHP in their respective states; New York also allows QHP issuers to deliver the BHP. Vermont's Medicaid administrative model is a public "managed care-like" model where DVHA is the sole managed care-like entity. The Vermont Agency for Human Services, the state Medicaid agency, oversees DVHA. Therefore, a BHP in Vermont would likely be administered by QHP issuers.

The cost effectiveness of a BHP depends on regulated reimbursement rates. This model uses Medicare reimbursement rates, which Wakely estimated to be 42% to 59% lower than current Marketplace rates for non-pharmacy services. Other options would include Medicaid rates (lower than Medicare rates), Marketplace rates, large group rates (higher than Marketplace rates), or a hybrid rate. The framework could be Medicaid-like, where the rate would be set by the State and then applied by issuers through provider contracting. Alternatively, it could be Marketplace-like, where insurers negotiate rates with providers and the State reviews the rates for compliance with state law. As with any reimbursement system, there will be concerns with how changes in one market will affect other markets. While providers generally seek to cover their costs in every market, rate changes in one market can alter regulatory and market dynamics in other markets. Depending on how the State uses its rate setting authority for public programs and how much new revenue they generate from currently uninsured people, the State will have to consider the potential impact on the Marketplace and other commercial markets, especially given the State's hospital budget review process. If, for example, providers seek higher reimbursement in the Marketplace to make up for lost revenue from a Medicaid expansion or a BHP, this could require the State to ensure that implementation of a new or expanded public program is done in a manner that preserves the stability of the Marketplace.

Process for Pursuing a BHP. If Vermont decides to pursue a BHP, the State would need to submit a Blueprint to CMS as an official request for certification. The Blueprint outlines the state's program design choices and provides a full description of the program's operations and management in compliance with federal rules. The full process for submission and certification takes approximately one year to complete. Unlike a 1332 waiver, which is subject to approval at the discretion of the federal Secretary of Health and Human Services, if all BHP requirements are met, the Blueprint will be approved and the program may be implemented.

Finding. The BHP would allow Vermont to design a program that is Medicaid-like in design with zero-premium and zero-cost-sharing coverage for low-income Vermont residents, helping to address affordability and access issues for individuals with incomes up to 200% FPL who are otherwise eligible for federal APTC. Certain policy issues would need to be resolved to make a BHP viable. Chief among them, Vermont would need to ensure that any loss of purchasing power for people remaining in the Marketplace, related to reduced silver loading, is addressed in a way that protects affordability for the remaining Marketplace population and preserves the stability of the Marketplace. DVHA recommends continuing to study this option as a potential long-term policy tool for increasing access to affordable, comprehensive coverage in Vermont.

Conclusion

This technical analysis provided a welcome opportunity to discuss member affordability in the Marketplace among interested parties and to leverage professional resources to illustrate possibilities for the State. Beyond the content of this final report, the project team identified themes of uncertainty on both the state and federal level. There is significant uncertainty around federal health insurance regulation due to the changing administration. There will be a dynamic federal environment in the coming months and years. It is clear that the continuation of the enhanced subsidies is in jeopardy. It is also possible that traditionally state-led affordability initiatives such as silver-loading could be restricted.

Additionally, the project team heard a great deal about the health care affordability dynamics in Vermont that were beyond the scope of this analysis. The Marketplace serves a critical function in Vermont's health care system; however, it only accounts for a small portion of health insurance enrollment in the state.[29] The affordability mechanisms discussed in this report could serve to shield certain Marketplace enrollees from increasing health care costs, but they do not address the root cause. There is an urgent need to examine underlying health care costs and stabilize the insurance market so that it can continue to fulfill its critical role of providing coverage options for Vermonters not eligible for Medicaid, Medicare, or employer sponsored insurance.

All of these dynamics make it challenging to pursue any of the member affordability initiatives detailed in this report in the near term. They all come with a price tag in some part of the system and significant implementation considerations. Therefore, the recommendations resulting from this analysis are limited. As discussed, DVHA recommends the Legislature act to keep the individual and small group markets separate, maintaining some mitigation of rate increases for small groups and creating more flexibility to pursue future federal pass-through opportunities. DVHA also recommends advocating for the continuation of the enhanced federal subsidies, since those do more for the affordability of QHPs than the other mechanisms combined.

[29] Health Insurance Map. Department of Vermont Health Access (2024). Available from: https://dvha.vermont.gov/budget-legislative-and-rules/reports-and-studies/health-insurance-maps

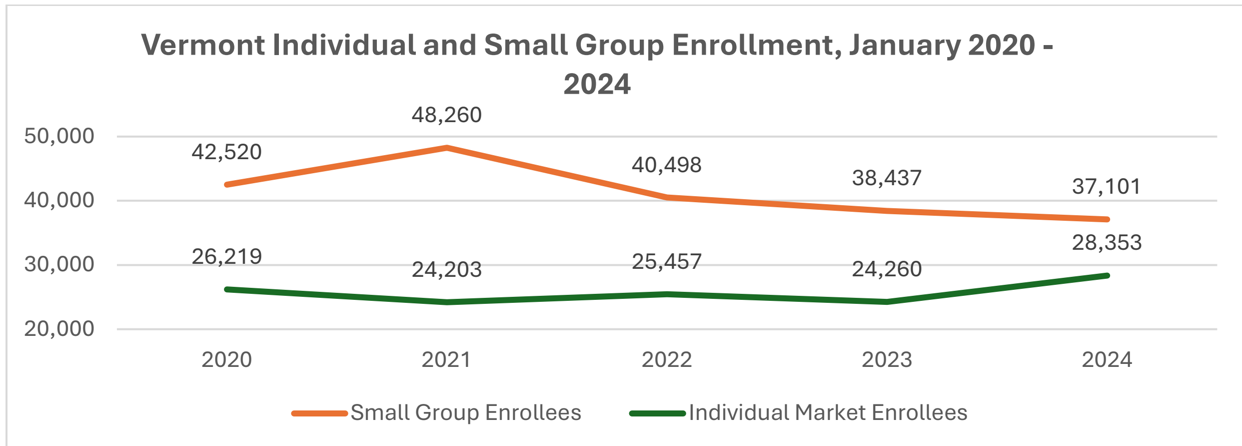
Finally, DVHA hopes that this report's findings related to other options to improve member affordability will position the State well for future discussions around reimagining the health insurance coverage map for Vermonters and enhancing access to health care in the state.

Appendix

Small Group and Individual Market Enrollment

The small group market has gradually contracted since 2021, while the individual market has increased, overall.

Appendix Figure 1. Vermont Individual and Small Group Market Enrollment, 2020 - 2024



[a] Enrollee estimates from annual January DHVA Health Insurance Maps, January annual files: https://dvha.vermont.gov/budget-legislative-and-rules/reports-and-studies/health-insurance-maps

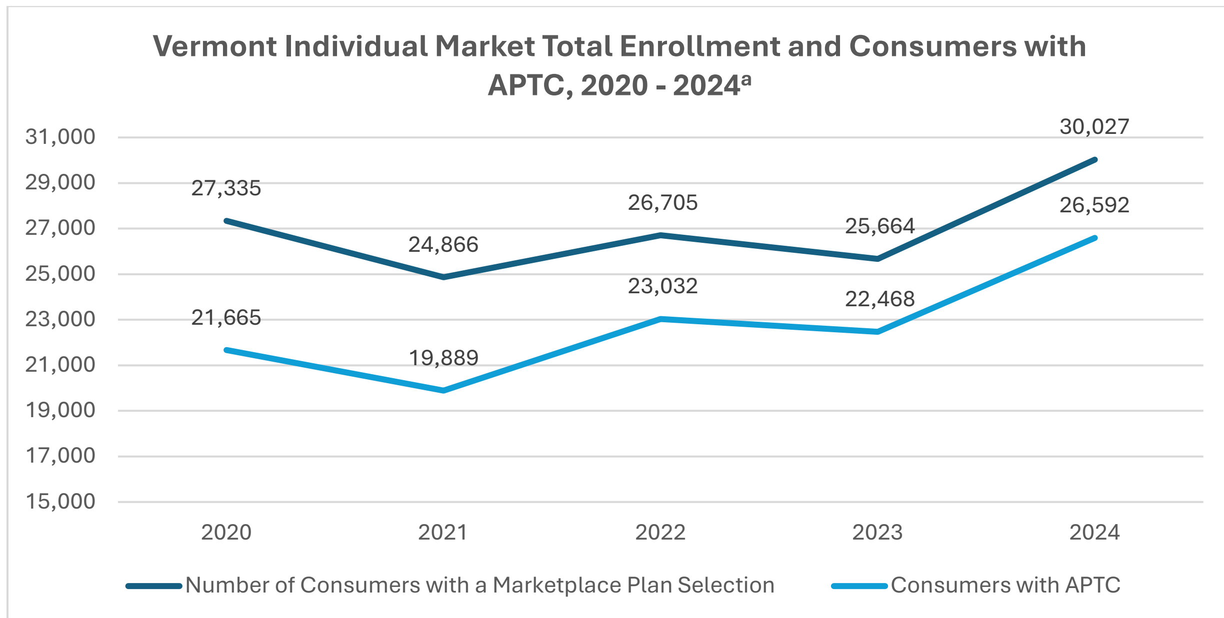
Marketplace Affordability Data

The following figures illustrate key affordability data for enrollees in the Marketplace.

Appendix Figure 2. Maximum Percentage of Income Consumers Pay for a Marketplace Benchmark Silver Premium by Income Level Under the ACA and ARPA/IRA

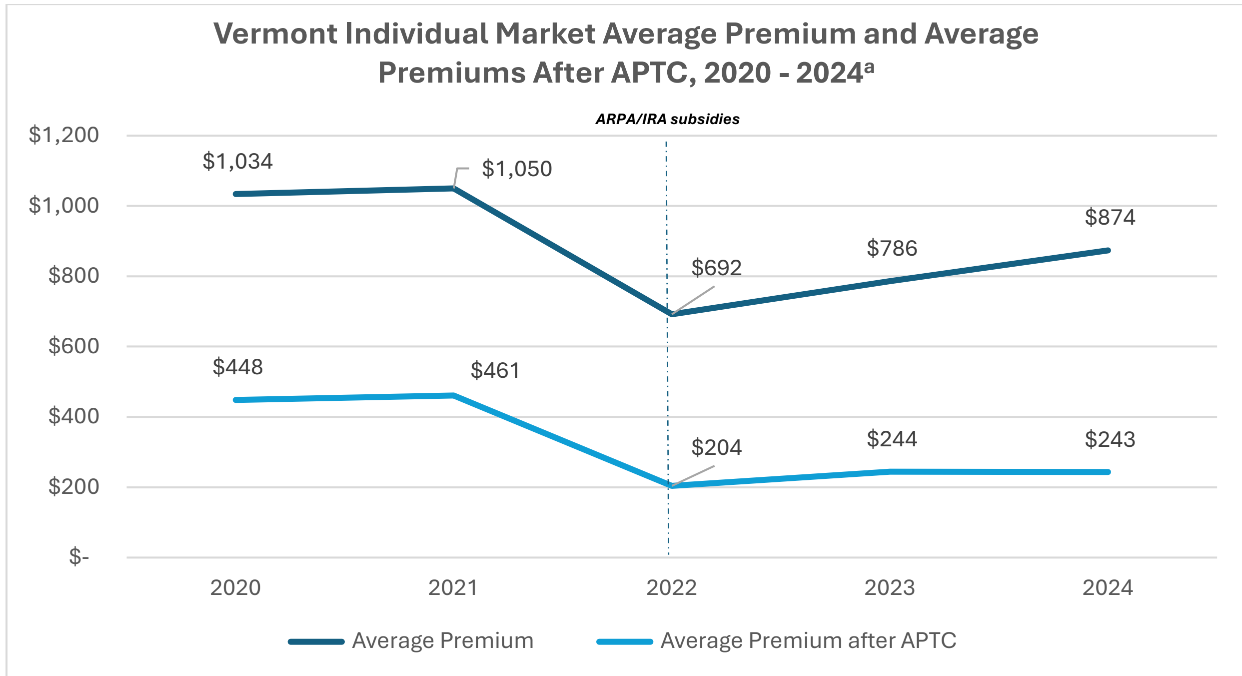
Income Level	Percentage of Income Paid Under ACA (2021)	Percentage of Income Paid Under ARPA / IRA (2021-2025)
Under 133% FPL	2.07%	0%
133% – 150% FPL	3.10 – 4.14%	0%
150% – 200% FPL	4.14 – 6.52%	0 – 2%
200% – 250% FPL	6.52 – 8.33%	2 – 4%
250% – 300% FPL	8.33 – 9.83%	4 – 6%
300% – 400% FPL	9.83%	6 – 8.5%
Above 400% FPL	Not eligible for subsidies	8.5%

Appendix Figure 3. Vermont Individual Market Total Enrollment and Consumers with APTC, 2020 - 2024



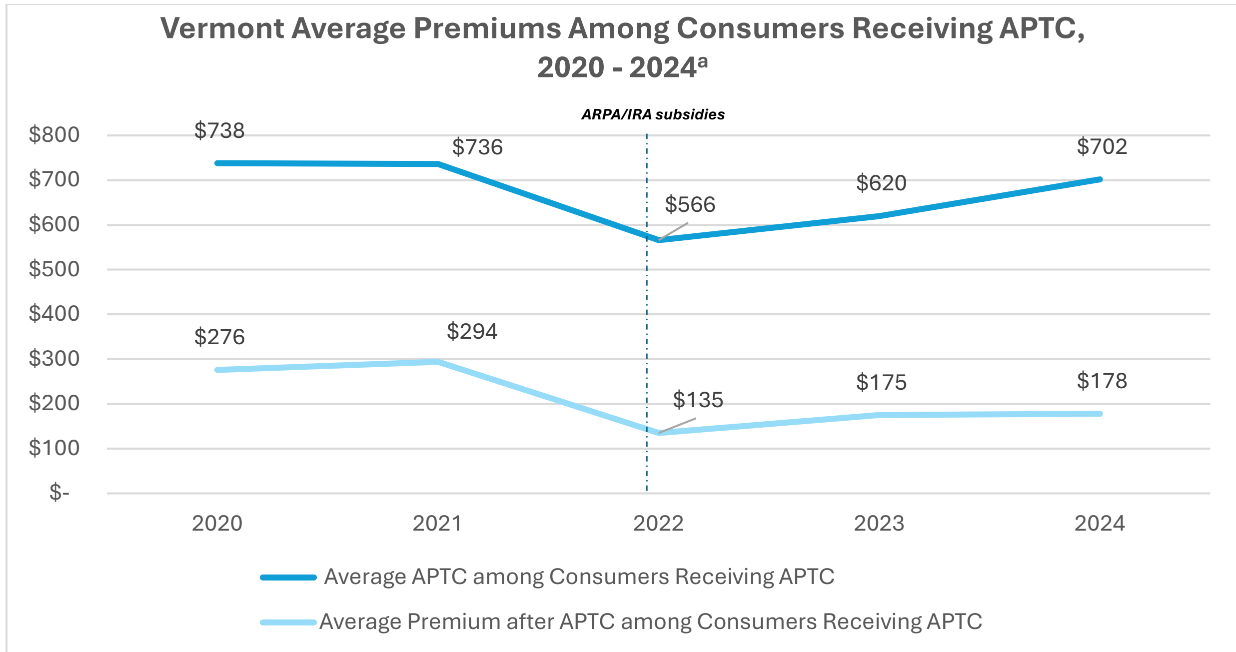
[a]Manatt analysis, data from Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. Marketplace Open Enrollment Period Public Use Files for [2020-2024], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products

Appendix Figure 4. Vermont Individual Market Premiums Among Consumers Receiving APTC, Plan Years 2020 - 2024



[a]Manatt analysis, data from Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. Marketplace Open Enrollment Period Public Use Files for [2020-2024], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products.

Appendix Figure 5. Vermont Individual Market Premiums Among Consumers Receiving APTC, Plan Years 2020 - 2024



[a]Manatt analysis, data from Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. Marketplace Open Enrollment Period Public Use Files for [2020-2024], available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products.

BHP Methodology Overview

Wakely modeled the BHP based on the current law on federal and state subsidies, which includes the subsidies provided by the IRA and a 2027 BHP start date. Wakely used historical enrollment data to project 2027 BHP enrollment and trended forward 2025 premiums to estimate 2027 PTCs.

BHP revenues are equal to 95% of the federal PTCs that would otherwise have been provided on behalf of enrolled individuals if those individuals had enrolled in Marketplace QHPs. PTCs are based on a reference premium of the second lowest cost silver plan (SLCSP). That baseline has given New York more favorable BHP funding than Minnesota and Oregon because New York's community rated premiums incentivize an older risk pool than the risk pool in states with a 3:1 age band, which results in higher premiums and higher PTCs in New York. Because Vermont premiums are also community rated, BHP funding is more favorable than it would be in an age rated state.

Several adjustments are then applied to the estimated PTCs (as demonstrated in Appendix Figure 6):

- **Premium Adjustment Factor (PAF):** Provides an 18.8% increase in PTCs (1.188) to address loss of silver loading for those 133-200% FPL. The 18.8% increase for silver loading was based on surveys of New York and Minnesota's markets and national average levels of silver loading that occurred after the federal government stopped paying CSRs in 2017. Vermont may be able to get larger PAF based on the state's current silver loading since CMS guidance focuses on what the silver load actually is state by state and that it varies by state.
- **Population Health Factor (PHF):** Provides states with the option to apply a factor that accounts for a difference in morbidity between the BHP population and the remaining Marketplace population. At default, this factor is applied at 1.0. The three current BHP states have retained the 1.0 default (i.e., did not try to document morbidity differences between 133-200% FPL and >200% FPL populations). Wakely modeling suggests that morbidity may be 7% higher in the BHP population in Vermont, which increased BHP funding.
- **Reinsurance Factor:** Provides states with an adjustment to account for premium reductions achieved by having a reinsurance program in place. This factor would not apply in Vermont unless Vermont adopted a reinsurance program.

Appendix Figure 6. Overview of BHP Federal Funding Formula

BHP Federal Funding Amount = (***PTC*** *Estimated PTC that would have been paid if BHP enrollee enrolled in a QHP, accounting for age, geography, coverage status, household size and income.* x ***Adjustment Factors*** *To account for other variables, including silver-loading due to CSR removal, reinsurance, and population health.*) ***IRF*** x ***95%***

Once PTCs are multiplied by the adjustment factors, those values are then multiplied by the **Income Reconciliation Factor (IRF),** which accounts for whether APTCs are higher or lower than reconciled PTCs. This factor is 95.20% for 2025.

To model BHP program expenditures, Wakely incorporated several assumptions, including:

- Provider reimbursement levels, based on 100% of Medicare rates;
- Seven percent higher morbidity in the BHP risk pool; and
- The impact of BHP plan design with zero premiums and zero cost sharing on induced utilization.