

The Current Vermont Health Insurance Market

Submitted to the State of Vermont
by Bailit Health Purchasing, LLC
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Introduction

This report analyzes the existing health insurance market in Vermont. The report is intended to help state officials in planning for the Health Insurance Exchange (Exchange) by providing a better understanding of how the commercial health insurance market currently operates in Vermont and what changes may need to occur to comply with the federal requirements of the Exchange by January 1, 2014. To complete this report, Bailit interviewed staff and obtained current information from the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and Bailit interviewed the three largest insurers in the state. The report is divided into two sections:

Section 1 of the report looks at readily available information from BISHCA with regard to health insurers offering comprehensive major medical coverage for insured and self-insured plans, and includes what markets (group vs. non-group etc.) they operate in, the number of lives they cover, and the amount of premium they collect.

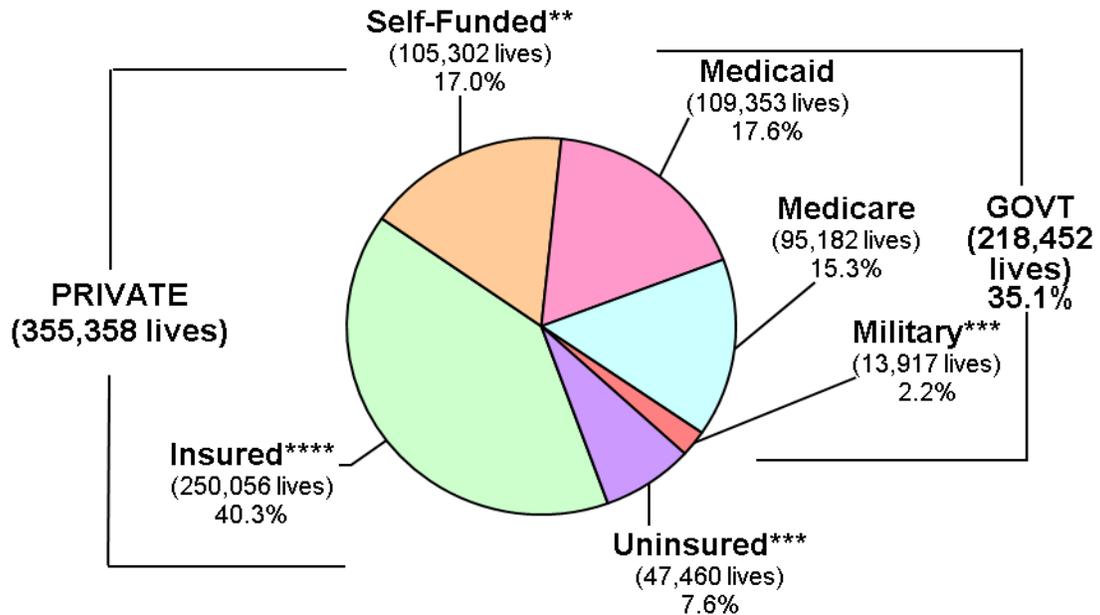
Section 2 of the report provides summary information obtained in interviews with leading health insurers in Vermont including: Blue Cross and Blue Shield of Vermont, MVP and CIGNA about their products, their arrangements for paying providers and their thoughts regarding the Exchange design and operation. This section also includes information obtained by interviewing staff from BISHCA.

Section 1: Profile of Vermont Health Insurers and the Vermont Health Insurance Market

In 2009, out of a total of 621,270 Vermont residents, 57.3% (355,380) had private insurance as their primary source of coverage, including insured group plans (233,535 lives), insured non-group plans (16,521 lives including Catamount Health Insurance), and self-funded employer plans (105,302 lives including the Federal Employees Health Benefit Plan). Approximately 95,182 of Vermonters (15.3%) were enrolled in the federal Medicare program. Over 17% of Vermonters (109,353 individuals) were enrolled in the state Medicaid program, including the Vermont Health Access Plan. The count for Medicaid does not include individuals covered under the prescription drug and Long Term Care programs. In addition to the 109,533 individuals eligible for Medicaid, an additional 19,000 Vermonters) were dually eligible for Medicare and Medicaid, but are counted only as Medicare enrollees to avoid duplicate counting. Figure one below, from BISHCA, depicts how Vermonters receive insurance coverage. Figure Two from BISHCA, details the associated premium dollars for the privately insured market.

Figure One

PRIMARY SOURCE OF HEALTH INSURANCE ALL VERMONT RESIDENTS, 2009 N=621,270 VT Residents*



* 2009 Vermont Household Insurance Survey that used the U.S. Census Bureau state-level annual population estimate to weight the files.

** BISHCA does not regulate or collect data on Self-Funded. This is an estimate of the total Vermont lives covered by Self-Funded plans which includes Federal Employees Health Benefit Plan

*** 2009 Vermont Household Insurance Survey

**** This number includes 62,061 Vermonters covered by health plans licensed in other states.

Private Insurance Market, Vermont Residents 2009		
Health Insurance Market Insurance	Covered Lives	Earned Premium
Insured Non-Group ¹	16,521	\$65,872,129
Insured Group ²	233,535	\$703,649,104
Self-insured Employer Plans ³	105,302	Not fully reported
Privately Insured Total	355,358	
¹ Includes Catamount Health plans offered by BCBS VT and MVP Health Plan.		
² Includes Large Employer, Small Employer, Associations, and Vermonters covered by health plans licensed in other states. BISHCA does not have premium information from insurers that are not licensed in Vermont.		
³ BISHCA does not regulate self-insured plans and this estimate is based on the BISHCA Annual Statement Supplement Report and the Vermont Healthcare Claims Uniform & Evaluation System.		

Figure Two

Insurance Market Lives (Insured and Self-funded)

BISHCA does not regulate the entire insurance market when approving rates and policy forms. According to the 2009 Annual Statement Supplement Report, ASSR, filed with the BISHCA, 40.3% of Vermont residents, or 250,056 have health insurance through insurance companies that are regulated by the state of Vermont or another state's department of insurance. Of the 250,056 Vermonters with health insurance, 187,995 Vermonters were covered by 41 insurance companies licensed in Vermont to write and issue private comprehensive major medical health insurance coverage in the insured market. Of the 187,995 Vermonters mentioned previously, 185,359 (or 98.5%) of these Vermonters were covered by just four of the 41 companies: Blue Cross and Blue Shield of Vermont, The Vermont Health Plan¹ CIGNA and MVP Healthcare. The remaining insured lives (62,061) are Vermonters covered by out-of-state health plans or plans licensed in other states.

The private commercial insurance market is clearly dominated by a small number of insurers in Vermont. These same insurers have consistently been part of the insurance market in Vermont for many years. Appendix one provides a summary of the distribution of covered lives in the insurance market in Vermont between 2004 -2009.

Table one below describes the administration of nearly 80% of Vermont's self-insured market, excluding, among others, the Federal Health Benefit Plan. This data comes from the Vermont Healthcare Claims Uniform Reporting and Evaluation System VHCHURES database.²

¹ In 1997, Blue Cross and Blue Shield of Vermont combined efforts with the state's largest hospitals to form The Vermont Health Plan (TVHP), a managed care organization (HMO)

² VHCHURES includes information from over 70% of the commercial insurance market in Vermont and continues to work towards 100% reporting compliance.

Table One:

Insured and Self-Insured Enrollment, Vermont Residents*						
Incurred Claims Period: Jan-Dec 2009						
Insurer Name	Self-Insured	Insured	Total	Percent of Self-Insured	Percent of Insured	Percent of Total
Connecticut General Life Insurance Company	49,759	32,925	82,684	60.9%	17.9%	31.1%
Blue Cross Blue Shield of Vermont	4,389	79,199	83,588	5.3%	42.5%	31.1%
The Vermont Health Plan	0	29,995	29,995	0.0%	15.8%	10.8%
LMF Health Insurance Company	0	19,490	19,490	0.0%	10.8%	7.3%
LMF Health Plan, Inc.	0	14,334	14,334	0.0%	7.8%	5.4%
Comprehensive Benefits Administrator (CBA Blue)	10,995	0	10,995	13.1%	0.0%	4.0%
Aetna Life Insurance Co-VT Members	7,499	2,537	10,036	9.2%	1.4%	3.8%
United Healthcare Insurance Company	0	5,297	5,297	0.0%	2.9%	2.0%
LMF Select Care, Inc.	5,233	0	5,233	6.4%	0.0%	2.0%
Other Insurers Combined	4,184	2,498	6,682	5.1%	1.3%	2.5%
	81,705	183,925	265,630	100.0%	100.0%	100.0%

*VCHURES includes over 70 categories of the commercial insurance market.
Source: Vermont Healthcare Claims Uniform Reporting & Evaluation System

Additional information on health insurance coverage and the commercial market is included on BISHCA's website.³

Insurance Premiums and Per Member per Month (PMPM) Costs

BISHCA completed its own review of insurance premiums in Vermont utilizing its VCHURES database.⁴ Based on a review of claims from 2007 to 2009, total expenditures by insurers and members have increased substantially, specifically, comprehensive major medical increased 11.8 percent and the PMPM expenditure increased 14 percent from \$317 to \$362. Table Two below describes expenditures by service categories and relative increase in spending. Between 2008 and 2009, the relative share of paid claims shifted 4% towards inpatient and outpatient hospitalization, and 4% away from non-mental health professional services and pharmacy.

Table Two⁵

Category of Services ⁶	Percentage of All Claims Expenditures
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³ See, for example, www.bishca.state.vt.us/health-care/health-insurers/marketshare-reports-earned-premiums-year; and, www.bishca.state.vt.us/health-care/health-insurers/vermont-healthcare-claims-uniform-reporting-and-evaluation-system-vhcure#VHCURES_Reports.

⁴ This work was conducted on behalf of BISHCA by Onpoint.

⁵ Source: BISHCA Vermont Healthcare Expenditure & Utilization Report: Summary of Findings 2007- 2009. Study Population Commercially Insured Vermont Residents, Aged 0-64.

⁶ A description of the categories of services used to determine PMPM expenditures are included as Appendix Two.

	(2009)
All services	100%
Outpatient Hospital	35%
Non-Mental Health Professional Services	26%
Pharmacy	21%
Inpatient Hospital	15%
Non-Hospital Mental Health Professional Services	2%
All Other Services	2%

As shown in Table Two above, hospital outpatient services account for the largest percentage of spending in 2009. Within hospital outpatient services, Outpatient Radiology accounted for nearly 30% of all outpatient hospital expenditures in 2009, at \$117,601,971.

Section 2: Perspectives on Health Insurance Market Reform Based on State Agency and Health Insurer Interviews

This section of the report includes information from a series of interviews with staff from BISHCA and the major commercial health insurers. This section provides the perspectives and insight on health insurance market reforms from both BISHCA and the three largest commercial health insurers – BCBSVT/TVHP, MVP Healthcare and CIGNA.

Limited Benefit plan coverage

The state has an “informal” definition of limited benefit plans which was intended to be included in a rewrite of Regulation 80-1. “True” limited benefit plans are permitted in Vermont. However, limited benefit plans that appear to be comprehensive medical plans are not permitted. The state has seen instances where benefits are stacked so that they appear to be comprehensive (and the consumer believes them to be comprehensive) but they are not. In addition, some companies attempt to avoid the statutory mandates and regulations that accompany a comprehensive medical plan by suggesting it is a limited benefit plan.

Limited benefit plans include those plans that offer dental, vision, or limited medical coverage. Typically they are offered by employers in addition to primary comprehensive major medical coverage. The 2009 Vermont Annual Statement

Supplement indicates that 46,759 Vermonters are covered by a limited benefit plan. As shown in Table Three below, 98% of these Vermonters are covered by 6 companies with one company dominating the market with purely vision benefits.

Table Three

Carrier	Lives	Earned Premium
Vision Services Plan	31,060	\$1,685,203
National Union Fire Insurance Company of Pittsburgh, PA	9,312	\$46,558
American Family Life Assurance Company of Columbus	2,915	\$494,614
Markel Insurance Company	1,039	\$5,211
Connecticut General Life Insurance Company	885	\$17,460
Fidelity Security Life Insurance	613	\$36,657

Medicare and Medicare Supplemental Coverage

In 2009, 37,133 Vermonters or 34% of the total Medicare eligibles (110,129),⁷ purchased a Medicare supplemental insurance policy.⁸ Table Four below provides detailed information on carriers offering Medicare supplemental coverage in the state, the earned premiums, and Vermont lives covered. Increasing numbers of Vermonters may purchase Medicare supplemental insurance over time as more baby boomers in Vermont turn 65 and enroll in Medicare.

Table Four: Top Five Medicare Supplemental Coverage Carriers in Terms of Earned Premium (source: 2009 Vermont Annual Statement Supplement)

Carrier	Earned Premium	Vermont Lives
United Health Care Insurance Company	\$33,170,737	18,447
Blue Cross and Blue Shield of Vermont	\$13,898,731	6,123
Bankers Life and Casualty Company	\$7,434,162	4,144
Mutual of Omaha	\$3,432,830	2,093
American Progressive Life and Health Insurance Co. of NY	\$2,292,696	1,347

⁷ Source: Kaiser Family Foundation

⁸ Source: BISHCA 2009 Annual Statement Supplemental Report.

Insurance Mandates

The ACA sets out requirements for Essential Health Benefits and dictates that any state mandated benefits that are not included within the final Essential Health Benefits requirements must be paid for within the Exchange with state-only dollars. A factor in making the decision about continuing Vermont's mandates will be determining the amount and source of state funding to subsidize coverage for the tax credits associated with Exchange plans. The state must complete this analysis and make a recommendation to the general assembly for next legislative session. As described below, the insurance company representative's provided estimated costs of mandates; aggregate amounts of premium impact reported by the plans vary from no impact to 5% premium impact.⁹

Alignment of state of Vermont market rules with PPACA

Vermont insurance law is largely as or more protective as the standards set in the ACA. Examples of pre-existing market reforms now required federally by the ACA include fair premium rates, guaranteed acceptance and renewability, discrimination based on health status, and coverage for individuals in clinical trials. In Vermont, rates can vary by age, but only by 20%. Since the ACA passage, Vermont changed its requirements to eliminate any pre-existing condition exclusions for children. BISHCA continues to analyze the ACA requirements and corresponding regulations as they are released to ensure compliance with the federal law.

Differences in the insurance market

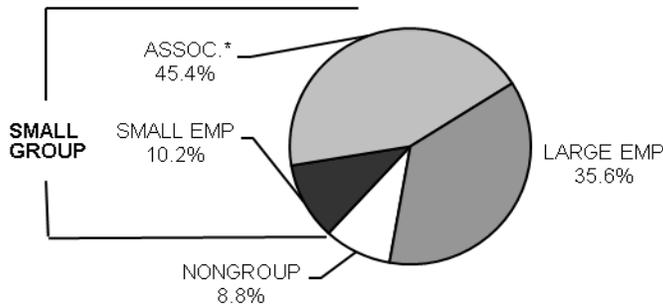
MVP, TVHP, BCBSVT and CIGNA are all approved to market and sell health insurance in the small group market. Table Five below provides a list of large group carriers, including covered lives and annual earned premiums.

Table Five: 2009 Annual Statement Supplement Report Data for Large Employers

Carrier	Earned Premium	Vermont Lives
Blue Cross and Blue Shield of Vermont	\$112,369,911	24,427
MVP Health Plan Inc.	\$41,989,455	7,169
The Vermont Health Plan, LLC	\$35,786,705	9,214
Connecticut General Life Insurance Company	\$34,670,796 13	13,631
MVP Health Insurance Company	\$32,404,522	10,424

⁹ A list of current insurance mandates in Vermont is included in Appendix 3

**ENROLLMENT IN INSURED PLANS BY MARKET
SEGMENT: VERMONT, 2009
N=187,995**



Data Source: 2009 Annual Statement Supplement
*Association includes Trusts and Discretionary Categories

As illustrated by the chart above, the private insurance market of insurers licensed in Vermont consists of 187,995 Vermont lives covered by comprehensive major medical insurance in the insured market. This does not include 105,302 lives covered under self-insured employer plans offered by many private sector, state and federal employers, nor does it include 62,061 Vermonters who are referenced in figure one who are covered by insurers that are licensed in other states.

The small group market includes both association plans and small employers. In 2009, the largest insured market segment was Associations, accounting for 45.4% (85,397 lives) of the insured market, while small employers only accounted for 10.2% of the insured market. Associations are a group of similar businesses that purchase as a group. Examples of such associations include www.vermontada.org the Vehicle and Auto Distributors Association, www.access-vermont.com/vacce or VACCE the Vermont Association of Chamber of Commerce Executives. While associations are classified as part of the small group market, an association may include employers who otherwise would purchase in the large group market due to their size. The state does not monitor which businesses purchases as part of associations. Outside of associations, the small group market is made up of business with 50 or fewer employees and self-employed individuals.

Large employers, those with 51 or more employees that do not participate in association plans, account for 35.6% (66,876 lives) of the insured market. The non-group or individual market was the smallest segment in 2009, accounting for only 8.8% (16,521 lives). The individual market includes Catamount Health. Currently Catamount Health is separately rated from the rest of the insurance market.

Insurance market changes

BISHCA tracks changes in enrollment by market segment and changes in health insurance market share by market segment through the Annual Statement Supplement reports. While the report shows increases and decreases in enrollment across plans over the 5-year period between 2005 and 2009, there has not been specific analysis to pinpoint the reasons for the shift in market share.

In the past decade, some insurers offering comprehensive major medical coverage left the individual and small group markets. For example, Mutual of Omaha, North American Preferred and Allianz all left the individual and small group market. These insurance companies left Vermont nearly 10 years ago due to a variety of factors including declining market share and increasing insurance regulatory requirements, such as community rating.

Plan designs have changed over time in Vermont. Specifically, in recent years there have been increasing offerings and take-up rates of high deductible health plans coupled with health savings accounts, more preferred provider organizations (PPOs) and more focus on prescription drug cost sharing. Since Health Savings Account (HSA) plans became available under federal law on January 1, 2004, their popularity with employers has grown significantly. An HSA provides employees with the option to set aside pre-tax dollars to fund out of pocket health care expenses, however, in the Underinsured Study, some employees reported their income was insufficient to set aside these funds. With this option, employers have increased their offerings of high deductible health plans that are coupled with the HSA. As of December 31, 2009, approximately 39,740 Vermonters (11.2% of the insured market) were enrolled in an HDHP.¹¹ This is the highest number of Vermonters to date to be covered by HDHP's and is a 23.7% increase from 2008.

Health insurance plan representatives all indicated that high deductible plans are increasingly popular with businesses. These types of plans, however, may increase the number of underinsured in Vermont because of the high level of contribution required by the employee. In addition, the final essential health benefits regulations, once released and implemented, will impact the extent that high deductible plans will continue to be feasible in the future.

Medical Loss Ratio

Vermont law requires that managed mental health organizations (e.g., Magellan and CIGNA Behavioral Health) meet the Medical Loss Ratio (MLR) requirements of the ACA.¹⁰

Insurance Ratings

Under Vermont law, both small group and non-group plans must be community rated and sold on a guaranteed issue basis. In practice, that means that each individual or small group buying a plan from a carrier will pay the same premium regardless of health risk factors, age or other underwriting factors and that insurers must offer a plan

¹⁰ See 8 VSA 4089b(g)(2).

to any individual or small group willing to pay the premium. Individuals and groups cannot be turned away because of the health of their members.

When a product is "community rated," the risks of all insured persons in a defined "community" are blended together to develop the premiums for health insurance. A "community" is made up of all individuals having a particular insurance plan in that market. Community rating spreads the cost of insurance evenly among all the individuals in a community within that plan, instead of charging significantly higher or lower costs for a person or group based on risk or individualized claims experience. Vermont law requires that each insurer set community rates in the small group and nongroup markets. Within the insured market, 64.4% of the lives were enrolled in community-rated products in the small group and non-group markets. Vermont's community rating requirements include an age rating that is limited to 20%. While Vermont does not have a specific Regulation 2008-05 allows for healthy life style rating variation in the non-group market limited to 15% of premium, with a total maximum of 30% for all allowable rating factors. Similarly, in the small group market a healthy life style rating variation can exist to 15%, with a total maximum of 20% for all allowable rating factors.

ACOs, the Blueprint and the future

The fact that there are several hospital-owned practices in Vermont might enhance the prospects for the creation of one or more Accountable Care Organizations (ACOs) in Vermont. Whether the ACOs are paid on a shared savings basis, a global payment with risk corridors basis or a pure global payment arrangement remains uncertain. The state of Vermont and varying provider groups are having conversations about these possibilities and are reviewing the recently released guidance from CMS on ACOs. It is unclear what the impact will be of ACOs on the Blueprint payment methodologies at this point in time. As the Blueprint rolls out this year and becomes a statewide effort due to funds from the Medicare multi-payer demonstration more analysis will need to occur to determine this impact.

BISHCA: Overall perspectives

BISHCA staff interviewed for this report indicated that it is too early to determine the impact of ACA reforms on the insurance market in Vermont because the federal rules regarding the Exchange have not yet been released. Likewise, it is too early to determine the impact of combining risk pools in an Exchange on premiums until additional data analysis is conducted. Data to conduct this analysis has been submitted by BCBSVT, MVP and CIGNA.

However, BISHCA staff indicated that combining small group and non-group markets together is likely to have some impact upon the market due to the current number of enrollees in both groups and the current requirements for both groups. According to data from BISHCA there were 16,521 individuals in the non-group market in 2009. Of this amount this includes both 5,221 individuals who purchased their own individual policies and 11,300 individuals who were covered by Catamount Health. The non-

group market is small so it appears that the real concern is not about pooling the non-group and small group market, rather it is related to raising the threshold for the small group market. BISHCA staff stated that the current state statutory and regulatory requirements will need to be reviewed and/or modified if small groups in Vermont were increased to 100.

Section 2: Interviews with Vermont's major health insurance companies and staff from the Department of Banking, Insurance, Securities and Health Care Administration

VI. Health Insurer Informational Interviews

As part of the assessment of the current insurance market, Bailit interviewed representatives of the three largest insurers in the comprehensive coverage group market in Vermont. Interviews with representatives of BlueCross BlueShield of Vermont (BCBS) (Kevin Goddard, Vice President of External Affairs) and MVP Health Care (Bill Little, Vice President for Vermont and Susan Gretkowski of Maclean, Meehan & Rice LLC) were conducted in person. The CIGNA interview was conducted by phone and included Don Curry, President and General Manager for New England, Katie Wade, Regulatory and State Government Affairs, Dave Tobin, Pricing Actuary, and Joe DiRenzo, Vice President for Network and Provider Contracting. The insurer representatives were asked a uniform set of questions regarding their current products, their arrangements for paying providers, the anticipated impact of PPACA requirements, and their thoughts regarding the Exchange. Both the questions and the answers follow.

1. How do current state mandated benefits impact state health insurance premiums?

Insurer estimates of the impact of current state mandated benefits on premiums ranged from approximately 1% (CIGNA) to more than 5% (MVP). CIGNA, which does business nationwide, noted that Vermont is on the low end of their national average. They described mandates as incremental to their standard offerings. Among the newest mandates, the eligibility of same sex spouses and civil union partners added a minor increment, while mandates for developmental disorders and autism are more costly.

MVP estimated a 5% impact on their Vermont premium rates. They noted that, while each increment may look minor, the impact of mandates is additive, with higher premiums resulting. Mandates with first dollar coverage (e.g., colonoscopy, mammography) are costly.

BCBS also estimated that approximately 5% of premiums are due to the total aggregate number of mandates in the state of Vermont. They noted, like their colleagues at MVP indicated, that the mandates were additive and the costs of the mandates needed to be passed onto the customers directly.

2. How do current community rating requirements impact premiums? How do insurers anticipate ACA community rating requirements impacting premiums?

BCBS and MVP spoke of the benefits of community rating (e.g., more stable rates for the overall population, helps manage populations that are otherwise difficult to manage, creates a pool that benefits small employers). BCBS supports carrying community rating forward into the Exchange.

CIGNA, on the other hand, sees community rating as a challenge and estimates that community rating increases rates nationally by 5-10%. Association accounts (e.g., the Vermont Association of Chamber of Commerce Executives (VACCE)) add a level of protection for the insurer.

Because Vermont already has community rating, ACA requirements will have a minimal impact. Community rating by region (e.g., Burlington region) may be a trend in the future.

CIGNA further discussed the potential impact of future restrictions based on the ACA, including requiring not more than a 3:1 age band. Under this age rating band, younger groups will be required to pay more as part of a cross-subsidation of older individuals. The age group of 20-30 year olds, especially men, will see the highest increases, but CIGNA estimates that all individuals between the ages of 20-60 will pay more. It is CIGNA's belief that the loss of age rating will hurt the Vermont insurance market; however clarification from the federal government in terms of the federal rules for the Exchange will hopefully address this issue. , CIGNA also noted that removal of gender differences, now allowed in Vermont, may increase rates 5-10%, but this is not yet modeled.

3. What has been/will be the impact of benefit changes within the ACA on premiums:

a. Already implemented:

All three insurers stated that the premium impact of the ACA-required changes that have already been implemented is insubstantial.

- i. Dependent coverage to age 26**
Insurer's estimates range from 1 - 2 or 3%.
- ii. No lifetime limits allowed on policy coverage**
Insurer's estimated approximately 0 - .25% impact.
- iii. No pre-existing conditions exclusions for children**
Insurer's estimated approximately 0 - .2% impact.

- iv. **No discrimination in insurance offerings based on salary**
Insurer's estimate no impact on premiums.
- v. **Appeals and reviews**
Insurer's estimate no impact on premiums.
- vi. **Coverage of preventive care without cost-sharing**
Estimates from insurer's is 0 - 2 or 3%, depending on the plan.

b. Effective January 2014

- i. **No pre-existing condition exclusions for adults**
Insurer's estimate no impact on premiums.
- ii. **No annual limits on policy coverage**
Insurer's estimate no impact on premiums.
- iii. **No deductibles beyond ACA limit (noted above)**
Insurers indicated that this will be determined when the caps are known.
- iv. **No out of pocket costs above ACA standards**
Insurers indicated that this will be determined when standards are known.
- v. **No employee waiting period of longer than 90 days**
Insurers indicated that there is no impact (waiting period is usually driven by the employer).

4. How do you assess the cost impact on premiums of the following PPACA requirements:

- a. **administrative simplification rules?**
The impact is likely to be insignificant although it may increase administrative costs, IT development and implementation costs
- b. **development of uniform explanation of coverage documents and standardized definitions?**
The impact is likely to be insignificant, and a one-time cost.
- c. **having to produce annual reports of quality improvement benefits and reimbursement structures?**
The impact is likely to be insignificant.
- d. **coverage for routine costs associated with clinical trials?**
Based on experience with Vermont's current mandate, this is not a significant cost. If participation in clinical trials increases appreciably, the impact could be greater.

5. How many of the insurance plans that you are offering do you anticipate will be "grandfathered" from ACA requirements? How long do you believe these plans will remain grandfathered?

The insurers anticipate that few plans will be grandfathered, and that grandfathered plans will convert in the short term.

6. Do you anticipate to offering coverage through an Exchange if so permitted by the state?

BCBS and MVP plan to offer coverage through the Exchange. CIGNA will not make the decision until the final rules have been issued.

7. How do you think that interstate compacts impact provision of insurance in VT?

As a national insurer that is able to offer coverage in all 50 states, CIGNA does not anticipate cross-border problems. MVP has an agreement with CIGNA that covers MVP members through CIGNA when they travel to other states.

BCBS raised several concerns regarding the potential use of interstate compacts.

- What will be the mechanism in the Exchange for Vermont residents who work for out of state employers? MVP echoed this concern.
- BCBSVT's agreements with BCBS organizations in other states save money for both individuals and BCBS when members receive care in other states because they are billed at discounted rates, not charges.
- If out-of-state insurers are allowed to sell insurance in Vermont, they may be able to set up in a less regulated state, thus avoiding mandates that Vermont-based insurers must meet.

8. Do any of small group insurer plans offerings have deductibles of more than \$2000 for individuals or \$4000 per family?

All three insurers offer small group plans with deductibles above \$2000 for individuals and \$4000 per family. MVP deductibles range from \$500/\$1250 (individual/family) to \$5,000/\$10,000. 8 of CIGNA's 10 small group plans have deductibles higher than \$2000/4000, with a high end of \$5000/\$10,000. BCBS cited a \$3000/\$6000 deductible as an example.

CIGNA stated that it is "imperative" for them to be able to offer small group plans with deductibles above \$2000. They offer high deductible plans because customers like them and want to purchase them. They noted that ACA caps on deductibles will result in the potential for significant increase in premiums that will provide consumers with an unfair burden and result in a negative impact on the insurance market. Low deductible caps may force employers to drop coverage or opt out of the Exchange.

9. What strategies are you employing regarding provider payment arrangements?

a. Roughly speaking, what percentage of your a) physician and b) hospital payments are:

i. P4P (performance incentive) payments?

CIGNA's incentive payments and capitation are generally limited to narrow offerings (e.g., lab), with fee-for-service payments the general rule for physicians and hospitals.

MVP has offered P4P to primary care and ob/gyn doctors for some time; these payments account for less than 5% of their provider payments.

BCBS indicated that they had a very limited percentage of pay for performance incentive payments.

ii. Blueprint payments?

CIGNA and Blue Cross indicated that the Blueprint payments were insignificant percentage of payments.

MVP estimates approximately 2%, and anticipates growth in the next few years.

iii. Capitation (global) payments?

CIGNA and BCBS stated that capitation payments currently in Vermont were a very small percentage of payments.

MVP estimates that roughly 50% of their payments go through a global budget process because they have three Physician Hospital Organization or PHO arrangements. These are similar to ACOs in that they agree on a budget and pay claims on an ongoing basis.

iv. Other FFS alternative(s)?

CIGNA and BCBS indicated they had an insignificant amount of fee for service alternative payments.

MVP offers discounts, fixed rates, case rates, and DRGs, but did not provide a percentage estimate.

b. Do you anticipate contracting with ACOs?

The insurers all noted that any responses to questions about accountable care organizations are highly speculative.

BCBS, MVP and CIGNA are all uncertain about contracting arrangements with ACOs. They questioned whether Vermont has the critical mass for ACOs to succeed all around the state.

BCBS noted that their members currently have a choice of receiving care at FAHC and DHMC; that choice would be potentially lost with ACOs.

Upon further discussion, all of the insurers gave "To be determined" as their response to questions about when they would contract with ACOs, how many, for which products, and for what percentage of their network and membership.

c. Will the ACOs be paid on a shared savings basis, global payment with risk corridors, or pure global payment?

This, too, is to be determined. MVP responded that they would use global payment with risk corridors if they are given that option. BCBS

responded that they would probably use global payment with relatively narrow bands of risk sharing, and noted that a large PHO such as Vermont Managed Care is very different from a small physician practice. CIGNA indicated they are waiting for the requirements to determine next steps regarding payment options.

d. What do you anticipate will be the impact of ACOs on the Blueprint supplemental payments to primary care practices?

All three of the insurers agreed that it is premature to speculate what impact ACOs will have on Blueprint supplemental payments to primary care practices.

Findings: limited benefit insurers (CIGNA Only)

1. What activity do you witness with respect to requested waivers of the annual limit restrictions set forth by the PPACA?

CIGNA stated they believed the number of waivers for the annual limit restrictions set forth by the PPACA would be small around the country.

2. What are your strategies for this market segment given the scheduled prohibition of limited benefit plans effective January 1, 2014?

CIGNA is reviewing their limited benefit plans looking to see if plans can exist in 2014 when the waiver ends. They might look to moving products to an AFLAC cancer plan.

CIGNA did receive a federal HHS waiver for 2011, and they anticipate having a waiver for 2012 as well. They believe that limited benefit plans are viable and very important for part-time and low paid employees, especially those who aren't eligible for other insurance. Without these plans, people would be forced to be uninsured. Premiums are often \$500 per year rather than \$4000 per year. Small amount is taken out of an employee's weekly paycheck. Benefits are often capped annually at \$200,000; and there may be limits on hospital coverage. There are lower loss ratios with these policies however; they force the member to pay more for the coverage. When one looks at the % of premiums paid it looks high but claims expenses are the same compared to comprehensive benefits. The biggest difference is maximum annual amounts of coverage and other cost sharing differences.

Report Appendix

#1	Distribution of Covered Lives Across Carriers, 2004-2009
#2	Categories of Service Included in PMPM Expenditures
#3	Vermont's Mandated Benefits

Appendix 1: Distribution of Covered Lives Across Carriers, 2004-2009

The 2004-2009 data presented in Table #1 are derived from the Annual Statement Supplemental Report submitted to BISHCA from the Insurers. CBA-Blue and VT residents covered by Out of State Plans are reported to BISHCA separately.

COMPREHENSIVE MAJOR MEDICAL - COVERED LIVES - PRIVATE MARKET SEGMENTS							
Insurer	Market	2004	2005	2006	2007	2008	2009
BCBSVT	Associations	84,030	82,690	84,319	65,827	51,534	48,177
CIGNA	Associations	-	12,700	14,683	18,036	28,108	23,618
TVHP (hmo)	Associations	4,996	5,548	5,740	12,492	13,895	12,745
MVP HI	Associations	-	-	-	-	334	501
MVP HP (hmo)	Associations	-	-	-	-	414	250
Other	Associations	7,276	184	182	159	149	106
	Subtotal	96,302	101,122	104,924	96,514	94,434	85,397
BCBSVT	Catamount Health	-	-	-	1,105	6,015	8,806
MVP HI	Catamount Health	-	-	-	377	1,765	2,494
	Subtotal	-	-	-	1,482	7,780	11,300
BCBSVT	Large Employer	29,827	34,242	35,606	35,518	27,167	24,427
CIGNA	Large Employer	31,953	21,335	12,979	18,413	12,764	13,631
MVP HI	Large Employer	279	560	666	1,796	1,559	10,424
Out of State Plans	Large Employer	41,000	45,043	56,857	51,842	53,264	62,061
TVHP (hmo)	Large Employer	10,111	10,432	9,938	8,104	7,163	9,214
MVP HP (hmo)	Large Employer	17,879	14,813	14,204	12,183	12,234	7,169
Other	Large Employer	2,492	1,799	2,264	1,627	1,886	2,011
	Subtotal	133,541	128,224	132,514	129,483	116,037	128,937
BCBSVT	Non-Group	8,005	7,138	6,277	5,266	4,009	3,265
MVP HI	Non-Group	1,974	2,005	1,835	2,073	1,958	1,801
MVP HP (hmo)	Non-Group	50	38	20	14	9	6
Other	Non-Group	237	241	172	129	116	149
	Subtotal	10,266	9,422	8,304	7,482	6,092	5,221
BCBSVT	Small Employer	528	406	230	165	109	104
TVHP (hmo)	Small Employer	7,226	6,504	6,098	6,129	5,962	7,380
MVP HI	Small Employer	45	100	106	460	1,347	7,234
MVP HP (hmo)	Small Employer	14,930	13,685	10,598	8,737	7,170	4,096
CIGNA	Small Employer	35	17	54	3,983	1,166	17
Other	Small Employer	1,561	939	412	207	579	370
	Subtotal	24,325	21,651	17,498	19,681	16,333	19,201

COMPREHENSIVE MAJOR MEDICAL - COVERED LIVES - PRIVATE MARKET SEGMENTS							
Insurer	Market	2004	2005	2006	2007	2008	2009
BCBSVT	Self Insured ^{1 & 3}	15,350	15,788	16,000	18,164	18,282	17,963
CIGNA	Self Insured ³	52,325	52,646	40,787	66,646	66,376	52,900
MVP HI	Self Insured ³				-	137	16
Other	Self Insured ^{2 & 3}	25,830	40,495	38,559	12,860	46,399	34,423
	Subtotal	93,505	108,929	95,346	97,670	131,194	105,302
Comprehensive Major Medical Total		357,939	369,348	358,586	352,312	371,870	355,358

¹ includes Federal Health Benefit Employee Plan

² includes CBA-Blue as reported in filings with BISHCA outside the Annual Statement Supplement

³ TPA/ASO insurers categorized as Self Insured with Delta Dental excluded.

Appendix 2: Categories of Service used to determine PMPM Expenditures

Category #	Category Name
1	Hospital Inpatient
2	Mental/Substance Inpatient
3	Private Psych Hospital
4	Other Hospitals
5	Maternity-related and newborns
6	Surgical
7	Medical
8	Hospital Outpatient
9	Mental/Substance Hospital Outpatient
10	Observation Bed
11	Emergency Room
12	Outpatient Surgery
13	Outpatient Radiology
14	Outpatient Lab
15	Hospital-Dispensed Pharmacy
16	Outpatient Physical Therapy
17	Outpatient Other Therapy
18	Other Outpatient Hospital
19	Non-Mental Health Professional Services
20	Physician Services
21	Physician Inpatient Setting
22	Physician Outpatient Setting
23	Physician Office Setting
24	Physician Other Setting
25	Other Professional Services
26	Nurse Practitioners or Physician Assistants
27	Physical Therapists
28	Chiropractors
29	Podiatrists
30	Other Physician Services
31	Non-Hospital Mental Health Professional Services
32	Psychiatrists
33	Psychologists
34	Social Workers (including MSWs, LICSW, LCSW)
36	Other non-hospital Mental
37	Pharmacy
38	Pharmacy in pharmacy claims
39	Pharmacy in medical claims
40	All Other Services

- 41 Free-standing Ambulatory Surgery Center
- 44 Nursing Home
- 45 Home Based Care
- 46 Durable Medical Equipment
- 47 Mental Health Clinics
- 48 Other

Appendix #3: Vermont's State Mandated Benefits ¹¹

Health Insurance Mandates Protecting Vermont Consumers - 2011 - with either Vermont statutory and/or regulatory citation provided
<p>Alcoholism</p> <p>(1) 8 VSA § 4089b (2) Reg H-2000-03 (3) Bulletin I-116 (4) Bulletin HCA-127 (5) Rule 10</p> <p>Alcohol or chemical dependence. Mandate provides for evaluation and treatment.</p>
<p>AIDS/HIV Testing/Vaccines 8 VSA 4724(20) and Bulletin I-92</p> <p>Specific treatment or vaccine for AIDS. A vaccine is not currently available, so the mandate provides for evaluation and treatment for AIDS. Should a vaccine become available, it could include the vaccine.</p>
<p>Alzheimer's Disease 8 VSA § 8081</p> <p>Not applicable to health insurance - only LTC insurance</p>
<p>Anesthesia for certain dental procedures 8 VSA § 4100i</p> <p>A health insurance plan shall provide coverage for the hospital or ambulatory surgical center charges and administration of general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for dental procedures performed on people who meet certain criteria.</p>
<p>Antipsychotic Drugs 8 VSA § 4089b</p> <p>Brain disorder medications (e.g., schizophrenia). Mandate provides for treatment using such medications.</p>
<p>Athletic Trainer 8 VSA § 4088g</p> <p>Athletic trainers specialize in preventing, recognizing, managing and rehabilitating injuries that result from physical activity. Provides for reimbursement for services rendered by a certified athletic trainer.</p>

¹¹ Mandate definitions are general definitions from the Council for Affordable Health Insurance's *Health Insurance Mandates in the States 2010 report*, specific mandate provisions vary from state to state

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Autism 8 V.S.A. § 4088i

Autism is a brain disorder that affects three areas of development: communication, social interaction, and creative or imaginative play. Mandate provides for evaluation and treatment services.

Chemotherapy 8 VSA § 4088c and Bulletin I-116

Chemotherapy is a treatment with medications that targets cancer cells. It usually involves one or more drugs and is often used in conjunction with other therapies such as surgery, radiation, biological therapy and bone marrow transplants. Mandate provides for treatment.

Chiropractors 8 VSA§ 4088a and Bulletin HCA-105

Provides therapy that utilizes the interrelationship between the body's musculoskeletal structure and the body's function as a whole by focusing on the spinal column and the nervous system.

Cleft Palate 8 VSA§ 4089g and Bulletins I-63, I-122

Cleft lip and cleft palate are congenital defects, or birth defects, which occur very early in pregnancy. A cleft lip is a separation of the two sides of the lip. The separation often includes the bones of the upper jaw and/or upper gum. A cleft palate is an opening in the roof of the mouth in which the two sides of the palate did not fuse, or join together, as the unborn baby was developing. Treatments vary but may include several different types of services, (e.g., surgery, dental and/or orthodontic care, and speech therapy). Mandate provides for evaluation and treatment.

Clinical Trials 8 VSA § 4088b and Regulation H-2005-03

Clinical trials are investigative therapies or controlled tests of a new drug or medical device on human subjects under the direction of the FDA. Mandate (typically for cancer) requires payment for expenses associated with the clinical trial.

Colorectal Cancer Screening 8 VSA §4100g

Colon cancer (also commonly called colorectal cancer) refers to any cancer in the colon, rectum, appendix and anus. Mandate provides for evaluation.

Congenital Bleeding Disorders Regulation 80-1

Inherited bleeding condition typically associated with low levels or complete absence of a blood protein essential for clotting such as hemophilia and Von Willebrands. Mandate

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provides for evaluation and treatment.
Contraceptives 8 VSA § 4099c and Bulletin HCA-105 Birth control pharmaceuticals and devices. Mandate provides coverage for a range of FDA-approved prescription contraceptive drugs and devices.
Diabetic Self-Management 8 VSA § 4089c, Bulletin I-116 and Bulletin HCA-108 Diabetes (also called Diabetes Mellitus) is a disorder of carbohydrate metabolism. Mandate promotes self-management of the disease through payment for evaluation, supplies, education and treatment.
Diabetic Supplies 8 VSA § 4089c and Bulletin I-116 Mandate provides for evaluation and supplies of durable medical equipment and certain medicines for diabetics.
Drug Treatment (1) 8 VSA § 4089b (2) Reg H-2000-03 (3) Bulletin I-116 (4) Bulletin HCA-127 (5) Rule 10 Mandate provides for evaluation, education and treatment of those dependent on both legal and illegal drugs.
Emergency Treatment Rule 10 § 10.203(E) Mandate provides for appropriate medical care in emergency situations based upon the “prudent layperson” standard.
Home Health Care 8 VSA § 4096 Home health care is meant to allow patients more independence and avoid the higher costs of nursing homes by receiving medical care within their own home. Mandate provides for evaluation and care.
Long Term Care (1) 8 VSA § 8081 et seq and (2) Reg. H-2009-01 Not Applicable for health care just Long Term Care insurance
Mammogram 8 VSA § 4100a An x-ray of the breast used to detect breast changes in women. Mandate provides for the x-ray and evaluation.

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Maternity

- (1) Bulletin 54
- (2) Bulletins I-95, 96
- (3) Bulletin I-114
- (4) Regulation 89-1

Mandate provides for prenatal and postpartum doctor evaluation and care during pregnancy.

Maternity stay

- (1) Bulletin 54
- (2) Bulletins I-95, 96
- (3) Bulletin I-114
- (4) Regulation 89-1

Those insurers that provide coverage for maternity must allow a patient to remain in the hospital for a minimum specified amount of time (usually one to two days for vaginal delivery and three to four days for cesarean delivery) following the delivery of a baby according to federal law.

Mental Health - general

- 8 VSA § 4089a, b
- Reg's 95-2, H-2000-03, Bulletin I-116

Although most states define mental health as a state of emotional and psychological well-being, they often differ on what they include in evaluation and treatment. The mandate provides for the payment of mental health evaluation and treatment.

Mental Health Parity

- (1) 8 VSA § 4089b
- (2) Rule 10
- (3) Bulletin I-116
- (4) Bulletin HCA-127

The federal parity requirements apply only to plans that include mental health benefits in their benefit package. A health plan may not place annual or lifetime dollar limits on mental health benefits that are lower or less generous than annual or lifetime dollar limits for medical and surgical benefits offered under that plan. Due to federal law, substance abuse benefits are now included along with mental health parity benefits.

Health Insurance Mandates Protecting Vermont Consumers - 2011 - with either Vermont statutory and/or regulatory citation provided
<p>Midwifery services and home births 8 VSA § 4099d ** new mandate effective 10.1.11</p> <p>Midwife is a person formally educated and certified to practice in the two disciplines of nursing and midwifery or certified as licensed midwife.</p>
<p>Naturopaths 8 VSA § 4088d</p> <p>Provides primary health care relying on natural healing mechanisms and medicines.</p>
<p>Newborns 8 VSA § 4092</p> <p>A newborn is included under a parents' individual insurance policy for 31 days, as long as the policy already provides coverage for dependents.</p>
<p>Off label drug use (cancer only) 8 VSA § 4100e</p> <p>Coverage or offering of drugs for treating a particular disease even though they are not approved for a specific purpose by the FDA.</p>
<p>Oral Surgeons</p> <p>8 VSA § 4089g Bulletins I-63, I-122</p> <p>Performs diagnosis, surgical and related management of diseases, injuries, and defects that involve both the functional and esthetic aspects of the oral and maxillofacial regions. Includes preventive, reconstructive, or emergency care for the teeth, mouth, jaws and facial structures.</p>
<p>Orally administered Anticancer medication 8 VSA§ 4100h</p> <p>A health insurer that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is no less favorable on a financial basis than intravenously administered or injected anticancer medications covered under the insured's plan</p>
<p>Orthotics/Prosthetics 8 VSA § 4088f</p> <p>Orthotics deals with the use of specialized mechanical devices to support or supplement weakened or abnormal joints or limbs. Prosthetics deals with the production and application of artificial body parts. Mandate provides for evaluation, treatment and supplies.</p>

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<p>PKU/Formula/Metabolic Disease Foods</p> <p>8 VSA § 4089e Bulletin I-122</p> <p>Inherited metabolic diseases such as phenylketonuria (PKU), which is a genetically determined abnormality caused by a missing enzyme called phenylalanine hydroxylase. Mandate provides for evaluation, education, treatment and supplies like formula or special foods.</p>
<p>Prescription Drugs</p> <p>8 VSA § 4089j Bulletin HCA-105 Bulletin HCA-125</p> <p>Coverage for pharmaceuticals.</p>
<p>Prescription Inhaler</p> <p>8 VSA § 4089j Bulletin HCA-105 Bulletin HCA-125</p> <p>Mandates payment for prescription inhalants for people with asthma or other life-threatening bronchial ailments, as often as needed, if medically appropriate and prescribed by the attending physician.</p>
<p>Prostate Cancer Screening 8 VSA § 4100f</p> <p>Prostate cancer is the growth of malignant prostate glandular cells in the prostate gland. Mandate provides for the evaluation.</p>
<p>Reconstructive Surgery</p> <p>8 VSA § 4089g Bulletins I-63, I-122</p> <p>Mandates for treatment of certain injuries, birth defect or disfigurement issues. May include breast reconstruction or reduction, carpal tunnel syndrome, webbed toes or fingers, wound care, tumors (both cancerous and noncancerous), or facial defects (cleft lip, breathing problems, craniofacial maladies).</p>
<p>TMJ Disorders Bulletin I-63</p> <p>TMJ, temporomandibular joint disorder, is caused by displacement of the cartilage</p>

Health Insurance Mandates Protecting Vermont Consumers - 2011 - with either Vermont statutory and/or regulatory citation provided

where the lower jaw connects to the skull. Mandate provides for evaluation & treatment.

Tobacco cessation programs 8 VSA§ 4100j

A health insurance plan shall provide coverage of at least one three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an individual insured under the plan. A health insurance plan may require the individual to pay the plan's applicable prescription drug co-payment for the tobacco cessation medication.