

Health Reform Update- May 2011

Vermont's Key Decisions on Design of Health Insurance Exchanges

While the federal health care reform law (the Affordable Care Act, Public Law No: 111-148) establishes the overall design and function of the Health Insurance Exchanges that will begin to offer insurance to Americans in 2014, many of the details are left to states to decide. Each state legislature and governor must come to agreement on those options, and start setting up their Exchange sometime this year, in order to qualify for federal funding for design and implementation. (States may also choose to give up responsibility to the federal government to operate an Exchange for their citizens.)

While much of the attention in the 2011 Vermont legislative session, both by the press and the public, focused on the "road to the single payer" aspects of H. 202, many employers, carriers and brokers focused instead on the key decisions for the Vermont Exchange. This was in part because of the great uncertainties that Vermont can ever actually establish a "single payer," given the eight Congressional waivers of federal law that would be required, and also the undeniable cost impact of imposing some kind of taxes to raise the necessary \$2 billion plus to fund such an endeavor.

Regardless of whether Vermont could ever launch the single payer, it's certain that on January 1, 2014, there will be an Exchange launched in Vermont. If the single payer fails to launch, it's the Exchange that Vermont will have to live with, indefinitely. Therefore, how that Exchange is structured will have significant, possibly existential impact on employer sponsored health insurance and the private insurance market.

Governor Shumlin and his staff on reform made it clear from the outset that their concept for the Exchange was to make it a stepping stone to the single payer.¹ The bill they drafted for introduction in the Vermont House contained many elements to bear that out:

- The Vermont Exchange, contrary to the federal ideal of a "dynamic marketplace of choices for consumers," was intended to contract with only one carrier.
- There would be only one benefit plan offered by Vermont, with the only variable being the amount of consumer copay required.
- The Exchange would be open to all employers with up to 100 employees.
- All individuals and all employers with up to 100 employees would have no other choice for purchasing their health insurance; the market outside the Exchange would be eliminated.²

The 80-page bill was introduced in the House on February 2nd and taken up by the House Health Committee.³ After just over a month⁴, it moved on through Appropriations (there being a \$1 million plus pricetag for the studies and other planning activities required for the fiscal year starting July 2011) and passed the House by a 92/41 vote on March 24th. Many amendments proposed to reshape the Exchange to something more like a marketplace for consumer choice were defeated, largely on party-line votes.⁵

¹ A statement of purpose in Sec. 2 of the bill as introduced says: "The intent of the general assembly is to establish the Vermont health benefit exchange in a manner such that it may become the foundation for a single-payer health system."

² There are 21,819 Vermont employers who employ 49 or fewer employees. They employ 125,698 workers. There are 426 employers who employ 51 or more employees. They employ 28,965 workers. H. 202 as introduced would have limited 98% of Vermont businesses, and 81% of employed individuals, to purchasing the plan available on the Exchange, *only*.

³ The first sign of the extraordinarily close relationship the legislative and executive branches would have on H. 202 was that the sole sponsor of the Governor's bill was the House Health Committee chair, Rep. Mark Larsen. More signs: a staff person handling a surprisingly significant portion of drafting for the legislative committees and legislators (even for those requesting amendments) was an employee of the Division of Health Care Administration, within BISHCA. This work is usually done only by a staff member of the Legislative Counsel. Also, the Governor's special advisor on health care reform became the spokesperson for the bill as it moved through the legislative process.

⁴ The legislature only works Tuesday – Friday in the early days of the session, so the six weeks the Health Committee had the bill represents 24 actual working days.

⁵ The complete legislative history of the bill, including votes on floor amendments, can be found at:
<http://www.leg.state.vt.us/database/status/summary.cfm?Bill=H.0202&Session=2012>

The Senate Health and Welfare Committee officially received the bill on March 29, and voted it out two weeks later, on March 18. The bill flew through Finance and Appropriations, and the full Senate took up the bill on March 21. Once again, no significant amendments were accepted regarding the Exchange.

The Governor and reform staff vision of the Exchange as stepping stone to single payer remained largely intact. Comparing the final outcome to the four original goals (listed above) makes this clear:

Governor's Original Proposal	Final Outcome – H. 202 as passed
<ul style="list-style-type: none"> An implication that the Vermont Exchange would contract with only one carrier, contrary to the federal goal of a "dynamic marketplace" and "increased choices for consumers." 	<ul style="list-style-type: none"> The administrator "shall make a reasonable attempt" to contract with at least two carriers, but is not required to solicit "out of state" for said second carrier. Even if there is more than one carrier, H. 202 specifies that the Exchange may contract "with a single entity to administer all qualified health plans," reducing the role of the carriers to providing funds for another single entity to actually pay the claims.
<ul style="list-style-type: none"> There would be only one benefit plan offered by Vermont, with the only variable being the amount of consumer coinsurance required.⁶ 	<ul style="list-style-type: none"> One benefit plan, three levels of copayment. The legislature will be informed of the plan design will be recommended to the legislature for 2012 session.
<ul style="list-style-type: none"> Exchange would be open to employers up to 100 employees. (Federal option allows up to 50, only). 	<ul style="list-style-type: none"> A recommendation will be brought back to 2012 session on advantages and disadvantages of 50 versus 100.⁷
<ul style="list-style-type: none"> All individuals and all employers with up to 100 employees would have no other choice for purchasing their health insurance; the market outside the Exchange would be eliminated. 	<ul style="list-style-type: none"> A recommendation will be brought back to 2012 session on advantages and disadvantages of allowing employers and individuals the choice of purchasing coverage inside or outside of the Exchange. That is, whether the market outside the Exchange would be eliminated or allowed to compete with the single plan available on the Exchange.⁸

The two key decisions that were postponed until next year (50 versus 100, and markets outside the Exchange) are critically important, and will shape what coverage is available to virtually all Vermonters not covered by government plans. The "compromise" of postponing those two decision in favor of further study was seen by many as simply "kicking the can down the road" in order to gather enough support to pass H. 202 by the adjournment deadline this year. Because the research and drafting of the study will be done by the Governor's staff, it's not difficult to speculate what the recommendation to the legislature will contain. And it's quite clear that the majority leadership of both the House and Senate are leaning in the direction of the Governor's original proposal as well.

⁶ The ACA spells out four levels of consumer co-insurance: Bronze (consumer liable for up to 40% of actuarial value of plan) Silver (plan responsible for 70% of actuarial value); Gold (plan = 80%); and Platinum (plan = 90%). As an example, the Catamount Plan, structured like a BCBS Freedom Plan, with a \$500 deductible, is estimated by Hsiao to be approximately 88%, or a high silver/low gold level of benefits. Many legislators seemed to assume that the Exchange plan would be much like Catamount in what is covered. Only the coinsurance levels will vary.

⁷ See also footnote #2.

⁸ A member of the Governor's reform staff noted during the session that Vermont could require any plan sold outside the Exchange to be identical to the plan on the Exchange, so there would be no need anyway to allow this "choice." See also footnote #2.

Here are some of the other policy choices for the Exchange as established by H. 202.

Issue	Federal Law	Vermont
Federal, regional, or state	Exchange can be set up by federal government, state, or regional consortium of states	H. 202 established the Vermont Health Benefit Exchange
Structure	The exchange can be either a government agency or a nonprofit organization	The Department of Vermont Health Access shall establish the Exchange. (DVHA operates Catamount and Medicaid, and is also home to the Blueprint for Health. It is within the Agency of Human Services.) The Exchange will be a Division within the Department.
Governance	No specific guidance	The Exchange will be headed by a Deputy Commissioner, who reports to the Commissioner of DVHA, who reports to the Secretary of the Agency for Human Services. The Green Mountain Board must approve the "qualified health plan" design offered on the Exchange, but does not otherwise govern the Exchange.
Number of exchanges	Individual and small-group exchanges can be pooled or separate	There will be, for all practical and administrative purposes, a single exchange, although the rates set for plans will continue to be established separately.
Size of small businesses	Small-group market can be limited to 50 employees before 2016	To be determined; report required for 2012 session on whether to limit to 50 or allow up to 100.
Payment of premiums	Consumers may pay premiums to insurers or to the exchange	Exchange will collect premiums from individuals and employers, "including collecting premium payments from multiple employers of one individual for a single plan covering that individual."
Purchasing Strategy	Broad range of options from passive (allow any carrier who meets minimum standards) to active (selectively contract)	Vermont will have an extremely active purchaser strategy: the Exchange will selectively contract with as few as one, perhaps as many as two, insurance carriers, excluding all others. ⁹
Reducing adverse selection	All plans participating in exchange must offer silver and gold plans	The original proposal would have eliminated any possibility of adverse selection by allowing only one plan to be sold by one carrier, at one rate. No other plan would be available either inside or outside of the Exchange for 98% of businesses. Most of the decisions affecting this issue will be made by legislature in 2012, however these issues

⁹ The criteria established by H. 202: "Prior to contracting with a health insurer to offer a qualified health benefit plan, the commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate." There are numerous and specific requirements that a carrier must follow to offer a "qualified health plan." H. 202 allows the Commissioner to be as selective as s/he sees fit, with the added legislative history of potentially contracting with only a single carrier, or a single entity to administer plans.

		<p>are settled in H. 202:</p> <ul style="list-style-type: none"> • Only one plan design will be available in Exchange. • Carrier(s) in Exchange must offer Silver and Gold, and may offer Platinum levels, of that plan design. • Same rate must be charged to anyone, whether offered inside Exchange or not (although the question of whether anything is allowed to be offered outside Exchange is open.)
Coordination with public programs	Exchange must inform individuals of eligibility for public programs	<p>Exchange must help coordinate enrollment in public programs</p> <p>Must assist in providing continuity of coverage for people who lose eligibility for subsidies or public programs</p> <p>Community-based health plans (Medicaid managed care plans) able to participate in commercial exchange</p>
Exchange funding	After initial grants, must be self-sustaining by 2015; can be funded by surcharge on premiums, assessment on plans, businesses or individuals or state general fund dollars	<p>Activities funded primarily by an assessment of fee on insurers who participate</p> <p>Exchange required to refund assessment if it exceeds annual budget (cannot amass surplus)</p>

[For analysis of the bill as it moved through the legislature, the many proposed amendments, and the actions and reactions of Governor's staff and legislators, please consult Jeanne Keller's blog: "Toward Evidence-Based Health Care Reform" – <http://vtreform.wordpress.com>]

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