










**Insurance Exchanges: State Options and Implementation Choices within Federal Reform
and CHOICES MADE IN H. 202**







How To Read This Table:

1. **The federal ACA gives states many options in how to implement the Exchanges.** We list each of the issues where there are options and identify them as **A through T**.
2. The **options given to the states** are listed for each item in the two columns “**State Option 1**” and “**State Option 2.**”
3. The **blocks that are shaded** show which options the **Shumlin administration has put into H. 202.**
4. In the last column (“**BRS ANALYSIS**”) we indicate by a “**thumbs-up/thumbs-down**” whether we agree with the option selected in H 202 as **introduced**, and give our reasons why.




ISSUE	ID	STATE OPTION 1	OR...STATE OPTION 2	BRS ANALYSIS of H. 202 Choices
Administration: <i>Who operates the Exchange?</i>	A	May be operated by state of VT §1801 p. 18	OR VT may let federal government operate Exchange for residents	 State should operate. VT should not cede choices to a federal agency.
	B	May be operated only by/for Vermont §1801, p. 18	OR VT may participate in multi-state regional exchange(s)	 State should operate sole-state Exchange. VT will be more nimble than if joined with other states. We have excellent experience from operation of Catamount. Costs in other states are higher; we have nothing to gain.
	C	May be operated by a Vermont state government agency §1803 p. 21 assigned to DVHA	OR may be operated by a non-profit organization or authority designated by the state	 State government should operate Exchange. Apparatus already exists from Catamount enrollment. More accountability if part of Executive Branch.

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Structure: <i>How many Exchanges in the state?</i>	D	Exchange may operate on a statewide basis	OR may operate Exchanges in more than one geographic region	 Statewide Exchange Economies of scale. No need to break up regionally, since most of enrollment/ selection done electronically.
	E	May operate as two completely separate exchanges (One for individual market plus one for small group market)	OR both Exchanges may be combined into single exchange portal. §1803. creates single Exchange AND also pools individual and small group markets	 Run two Exchanges but use single point-of-access/portal. We do not want the Individual and Small Group Markets pooled in any respect (See "G" below), but VT can enjoy economies of scale in using same portal, rather than design parallel enrollment systems.
Enrollment and Subsidies <i>Who handles these tasks?</i>	F	Exchange may conduct all enrollment and/or assess eligibility for subsidies	OR Exchange may contract with state Medicaid agency <i>Exchange is made part of Medicaid agency.</i> §1805. p24	 Use the current system in place for Catamount. We've already paid for development of this system; it works. Transfer it from Catamount to be the Exchange agency.
Risk Sharing <i>Should VT combine the current individual and small group markets?</i>	G	Merge individual and small employer markets for Exchange rating and risk sharing	OR do not merge the individual and the small group market	   Do not merge the two markets. <u>Study done for Vermont legislature (Wicks, 2009)</u> clearly shows association plans will already face markedly increased costs with single community rate for small groups. ¹ Now is not the time to drive up costs for a majority of covered Vermonters in order to reduce costs for very small number in the individual market. Target costs in individual market by <u>actually lowering</u> costs, not by cross-subsidizing costs. e.g. Abolish individual market and make those people eligible for Catamount Health without a waiting period (e.g. they show proof of prior coverage).




¹ <http://www.leg.state.vt.us/CommissiononHealthCareReform/VT%20Merger%20Final%20Report%201-09.pdf>





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SHOP² eligibility: <i>What size employer is eligible to purchase through the SHOP Exchange?</i> <i>(In other words, how is "Small Group Market" defined?)</i>	H	From 2014 to 2016, Vermont may limit participation in SHOP Exchange to businesses with <u>< 50</u> employees	OR 2014 to 2016, VT may enroll businesses <u>< 100</u> . (This means redefining "small group market" to from M<50 to <100 employees.) §1804. p. 23	 Limit Exchange participation to <50. Maintain established division between small & large group market. Large group market is competitive & not in "need" of Exchange. Very disruptive to combine these pools. <u>If Exchange fails to provide satisfactory low-cost plans, nearly entire private market at risk of failure.</u>
	I	After 2017, may continue SHOP at original enrollment limit (<100) §1804 p 23	OR after 2017, may expand SHOP to employers >100.	 Limit to federal limit of <100 from 2017 on. See comment immediately above.
	J	Use only size as eligibility criterion §1803 p. 23	OR establish other criteria for business participation that exist in private market (e.g. minimum contribution, minimum employee participation, etc)	 Employers participating in SHOP Exchange plans must meet same participation requirements for all insurance (contribution, participation) These are important factors for maintaining stability of pool, avoiding adverse selection.
Benefit design <i>What health services are covered by Qualified Plans?</i>	K	Exchange qualified Plans need to cover only the "essential health benefits" (to be defined by US Sec of HHS)	OR require plans to cover more than federal minimums, e.g. state mandates. (Note: ACA requires <u>state dollars must fund subsidies for any coverage beyond federal minimums</u> , such as state mandates not in federal minimums.) §1806(b) p. 28	  Cover only the essential health benefits defined by US Sec of HHS Vermont cannot sustainably fund state subsidies above the federal subsidies. Also, for individual not eligible for subsidies, covering mandated benefits drives up their costs for Exchange-qualified plans.
	L	Provide abortion coverage beyond that permitted with federal funds. H. 202 is silent on this. Defined per "K" above.	OR do not cover abortion except as permitted with federal funds. (fed \$ limited to only save the life of woman and in cases of rape or incest)	 Provide abortion coverage beyond that permitted with federal funds Consistent with current Vermont law and insurance coverage.

² "Small Business Health Option Programs" (SHOP) is the name used in ACA for the Exchange for small groups/small employers.

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Certification of “Qualifying Plans” <i>What operational standards do insurers have to meet to be sold on the Exchange?</i>	M	Implement federal minimums for certification of qualified insurers	OR impose more standards (market conduct, payment reforms, Blueprint participation/subsidy, cost containment, any willing provider, consumer protections beyond federal standards, etc.) §1806 p 23-32	 Implement federal minimums plus only VT-specific standards if they do not raise the premium cost of the plan. There are no abusive insurance carriers in Vermont. The Exchange will not bring more (or abusive) carriers into VT. Why maintain a cost-driving regulatory apparatus that raises costs without adding value? (e.g. the old Rule 10 managed care regulations).
	N	Implement “open” qualification (any carrier that meets state’s standards)	OR go out to bid and competitively select carriers, negotiating pricing OR <u>require</u> all licensed plans to participate.	 Implement open qualification of more than one carrier, with plan rates reviewed by regulator. The Exchange is required by federal law to be a “marketplace.” Vermont already has a very limited market and the Exchange should attempt to broaden, not limit, market participation. Make sure the Exchange model works before narrowing choice of carriers to a single carrier.
High Deductible Health Plan <i>Does VT allow selling of federally defined catastrophic plan?</i>	O	Offer catastrophic plan to enrollees < 30 yrs or those who otherwise be exempt from the individual mandate purchase coverage because premium exceeds 8% of their income. ³	OR do not offer this type of plan through the Exchange <i>Section 8(1)(A) delegates to Sec of Admin to report to legislature whether necessary to do this. p. 48.</i>	 Offer the catastrophic plan. Also allow this type of plan to be offered outside of the Exchange. 40% of current small group market is purchasing HSA/HRA qualified plans. The largest remaining group of uninsured individuals are young working people. We need a range of options to maximize the number of people insured.

³ According to KFF, “These plans would offer less coverage but at a lower premium—their coverage level would be set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible.” Recall that the current new requirement for coverage of adult children on the parents’ plan expires in 2014, due to an assumption that young adults will have access to coverage through Exchanges.

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<p>Plan cost</p> <p><i>How are premiums set in the Exchange?</i></p>	P	Review rate change justifications only §1806(e)(1) and 1806(f)	OR negotiate rates with plans	<p> Review rate change justifications</p> <p>When the state holds all the cards, there is little “negotiation” possible, the state holds all the cards. <u>As we’ve seen with Catamount, the government’s rate management has forced carriers to underprice</u> and lose millions. Let plans compete with each other to keep rates low; that will be more effective than rates set by “negotiation” (which effectively would be by government fiat.)</p>
<p>Underwriting</p> <p><i>What factors can be used to adjust premiums from the pure community rate?</i></p>	Q	Allow permitted age ratings (up to a 3-to-1 ratio), ratings based on tobacco use (up to a 1.5-to-1 ratio), and wellness rewards (premium reductions up to 30%)	<p>OR do not allow rating on age, tobacco use and/or wellness rewards</p> <p><i>This is not allowed now, and doesn’t appear to be changed by H.202</i></p>	<p> Allow rating based on tobacco use and wellness rewards</p> <p>Vermont’s elimination of age rating is one of the measures that has kept our number of uninsured well below national averages, by making coverage more affordable for working-age adults. We should not go back on that. However, rating based on tobacco use and wellness allows creation of meaningful incentives for health status improvement.</p>
	R	Allow plan rate variation by area	<p>OR do not allow rate variation by area</p> <p><i>This is not allowed now, and doesn’t appear to be changed by H.202</i></p>	<p> Allow rate variation geographically.</p> <p>There are <u>significant</u> regional cost variations in Vermont that are “protected” by virtue of the pure statewide rate. Allowing rate variation would put downward pressure on the high cost regional providers that otherwise cannot be brought to bear.</p>

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<p>Playing Field</p> <p><i>How much competition is permitted?</i></p>	S	<p>Allow plans to offer Exchange plan designs (so-called “qualified plans”) <u>only in Exchange</u></p> <p>OR <u>permit</u> them to offer same plan in private market</p> <p>OR <u>require</u> them to offer same in private market</p>	<p>OR <u>prohibit</u> them from offering in private market</p> <p><i>Section 2(c)(3) of the bill says on 1/1/2014, “all individual and small group products will be ...sold <u>only through the exchange,” and that large group products will be regulated to align with Exchange requirements.</u></i></p> <p><i>Indicates statutory changes to do this will be part of Implementation Plan (Sec 8(1)(B) p. 49. So bill does NOT outlaw plans outside Exchange, but sets up implementation plan to do so..</i></p>	<p> Allow offering of “qualified plans” inside and outside of the Exchange.</p> <p>Because the risk will be pooled inside and outside of the Exchange anyway, we see no need to limit the market to only the Exchange.</p> <p>Limiting coverage only to what’s in the Exchange, and satisfies the strict and possibly expensive requirements set by the state, means that more affordable plans will effectively be “outlawed.”</p>
	T	<p>Allow plans to also offer <u>non-qualified</u> (i.e. not meeting Exchange standards) plans <u>outside</u> of the Exchange.</p>	<p>Prohibit any insurance plans to be offered outside of the Exchange</p> <p><i>See description in “R” immediately above.</i></p>	<p>   Allow offering of non-qualified plans outside the Exchange.</p> <p>We believe that ACA prohibits a state from limiting the choice of insurance to <i>only</i> qualified plans, and <i>only</i> to purchasing through the Exchange. We are concerned that the standards set for “qualified plans” could make them unaffordable. Preserving a market outside the Exchange is preferable to people going uninsured because they can’t afford the coverage, even with an Exchange subsidy.</p> <p>And if the Exchange fails, unless there is a market outside of the Exchange, people will have nowhere to go for coverage. (“Plan B”)</p>

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