Senate Committee on Health and Welfare
Senate Committee on Finance
House Committee on Health Care

ACT 48 INTEGRATION REPORT: Green Mountain Care

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Introduction

Act 48 creates Green Mountain Care, which is a publicly financed health care program delivering affordable, high-quality health care coverage to all residents of Vermont. Section 8 of No. 48 of the acts of 2011 (Act 48) calls for a report consisting of a series of studies to inform the development of Green Mountain Care. Prior to the implementation of Green Mountain Care, there are several milestones to be met. These milestones are outlined in 33 V.S.A. 1822 and include:

- The receipt of a waiver from the federal health insurance exchange provided for by Section 1332 of the Affordable Care Act.
- Establishing the financing mechanisms for Green Mountain Care.
- Approval by the Green Mountain Care board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.
- Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care board pursuant to 18 V.S.A. § 9375.
- A determination by the Green Mountain Care Board that each of the following conditions will be met:
    - Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.
    - When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.
    - The financing for Green Mountain Care is sustainable.
    - Administrative expenses will be reduced.
    - Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.
    - Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

This report provides information gathered since the passage of Act 48 on the following questions:

1. How to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with Green Mountain Care.
2. What is the potential for purchasing prescription drugs in Green Mountain Care through Medicaid, the 340B drug-pricing program, or another bulk purchasing mechanism?
3. How to allow employers and individuals to purchase supplemental health services from Green Mountain care and/or allowing private insurers to provide supplemental insurance plans.
4. How to enable parents to make coverage under Green Mountain Care available to young adults up to age 26 who would not otherwise be eligible for coverage under the program, including a recommendation on the amount and mechanism for collecting a financial contribution for such coverage and information on the difference in costs to the system between allowing all adult children up to age 26

to be eligible and limiting eligibility to adult children attending a college or university.

5. A determination of whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care, and if so, what is the impact, if any, on the state's bond rating.

Act 48 also requests information on aligning or integrating Worker's Compensation with Green Mountain Care. This report will be submitted under separate cover. In addition, the questions relating to the Vermont Health Benefit Exchange are included in a separate report on this issue.

1. How to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with Green Mountain Care.

The administrative integration of many payers will begin in the Exchange. For example, individuals eligible for Medicaid may use a web-based portal designed for the Exchange to enroll in Medicaid. The Exchange will also integrate the small group and association markets and could additionally integrate the individual market as well. Municipal employees are currently in the small group market, so their coverage would also be integrated in the Exchange. See the Act 48 Integration Plan on the Exchange for more information on each of these groups and how they will be integrated into the system. The remainder of this section addresses groups that may not be able to be integrated into the Exchange and may be integrated once Vermont implements Green Mountain Care.

The three payers who may not be able to be integrated into the Exchange are Medicare, state employees, and school employees. An explanation of the challenges with integrating each group, and how these groups could be integrated into Green Mountain Care, follows.

Medicare

Medicare is a federal program, paid for with all federal funds and administered entirely by the federal government. 33 V.S.A. 1824 provides that the agency of human services shall collect information to determine if an individual is eligible for Medicare in order to ensure that federal funds are utilized before state funds. Act 48 specifically provides that Green Mountain Care will not alter anyone's Medicare benefits under Medicare. If an individual is enrolled in Medicare, he or she need not apply for or enroll in Green Mountain Care if he or she does not wish to. Act 48 allows the individual the choice to have Green Mountain Care as a secondary insurance, but does not require it. The cost of these provisions will be looked at as part of the financing study due in January 2013.

For individuals who wish to enroll in Green Mountain Care, the program could pay for an individual's Medicare premiums, including potentially supplemental coverage, as one way to ensure coordination between the programs. This is currently done with

individuals who are eligible for both Medicaid and Medicare at certain income levels. Medicaid pays for the individuals' Medicare premium and acts as the secondary insurer.

In addition, Act 48 allows for Green Mountain Care to bid to act as the administrator of payments for Medicare, which will provide for administrative simplification.

State Employees
The state currently provides health coverage to its employees by self-funding the coverage. In other words, the state does not purchase insurance from an insurance company. A third-party administrator is typically used for the administration of the three coverage options currently available to state employees. The parameters of coverage are negotiated as part of the union contract with the Vermont State Employees Union. If the state were to purchase insurance, it would purchase in the large group, given the number of state employees. As stated in the Integration Plan for the Exchange, the Affordable Care Act does not allow large group employers to participate in the Exchange until 2017. Because of this federal requirement, state employees are likely to move directly from self-funded insurance to Green Mountain Care, when the state is able to receive a waiver from the Exchange. The VSEA has publically stated its support for participating in Green Mountain Care and is actively participating in discussions with the administration to determine ways to simplify existing administration, such as through the use of the Exchange web portal for enrollment into the state employee health benefit plans.

Education Employees
Employees of schools are currently provided insurance through the Vermont Education Health Initiative (VEHI). VEHI has traditionally been regulated as an "association" exempt from the small group market. Accordingly, school employees are fully discussed in the Integration Report for the Exchange. Currently, VEHI plans have "grandfathered status." Grandfathered plans do not have to comply with the Affordable Care Act. Once the plans no longer meet the legal requirements for grandfathered plans, school districts would purchase insurance in the appropriate market, depending on size and the definition of small group chosen by the general assembly. So, districts that meet the definition of small group would purchase in the small group market. Districts that meet the definition of large group would purchase in the large group market.

Please see the Integration Report for the Exchange for a detailed explanation.

Recommendation:
The agency of human services and the director of health care reform will continue to research and study the integration of the populations in preparation for Green Mountain Care.

2. What is the potential for purchasing prescription drugs in Green Mountain Care through Medicaid, the 340B drug-pricing program, or another bulk purchasing mechanism?

Sec. 8 of Act 48 requests information on "the potential for purchasing prescription drugs in GMC through Medicaid, the 340B drug pricing program or another bulk purchasing mechanism." This section provides a brief discussion of bulk purchasing and a more in depth discussion of the 340B drug pricing program.

Bulk Purchasing

For outpatient drugs included in most drug benefit programs, pharmacies typically purchase drugs from wholesalers or direct from manufacturers who deliver or drop-ship directly to the pharmacy. Some chain pharmacies have medications delivered or drop-shipped to a central depot which then distributes to their individual pharmacies. Insurers, public or private, are therefore not direct purchasers of drugs nor would this be practical in terms of the efficient delivery of medication to pharmacies and patients.

However, insurers and Medicaid can and do negotiate rebates and discounts which lower the cost of drugs to the payer and their insured. The consolidation of lives under a single payer system will potentially allow the State to leverage the larger population to negotiate additional or larger discounts and rebates for categories of drugs included in Vermont's GMC benefit. Participation in a bulk purchasing pool as a mechanism for negotiating rebates and discounts could be done when the state moves to a single formulary, which will be more fully discussed in a separate report. Please see that report for more information on this topic.

340B pricing

A *Report on Expanding 340B* was published January 1, 2005, and its principal recommendation was that the best way to expand 340B was to expand FQHCs. Vermont has made substantial progress in expanding 340B availability since 2005, including applying for and receiving federal approval that enables the statewide 340B network infrastructure to be operated by five of the state's FQHCs.

In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA. As of October 1, 2011, all but two Vermont hospitals and some of their owned practices are eligible for participation in 340B as covered entities.

In 2011 DVHA applied for, and on January 10, 2012 received, federal approval for a Medicaid pricing 340B methodology. Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont's innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program.

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

The fundamental limiting factor preventing "340B for everyone" is that only federally designated Covered Entities are eligible to purchase at 340B pricing and only patients of record of those Covered Entities may have prescriptions filled by a 340B pharmacy. Green Mountain Care is not a federally designated covered entity, so the program cannot directly purchase drugs under the program. The only mechanism for all Vermonters to have drugs at the 340B price is for care and scripts to be provided through a covered entity.

The definition of "covered entities" include:

- Certain nonprofit disproportionate share hospitals (DSH), critical access hospitals (CAH), and sole community hospitals owned by or under contract with state or local government, as well as certain physician practices owned by those hospitals, including Rural Health Clinics
- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- State operated AIDS drug assistance programs (ADAPs)
- The Ryan White CARE Act Title 1, Title 11, and Title III programs
- Tuberculosis clinics
- Black lung clinics
- Family planning clinics
- Sexually transmitted disease clinics
- Hemophilia treatment centers
- Public housing primary care clinics
- Homeless clinics
- Urban Indian clinics
- Native Hawaiian health centers

In Vermont, the following entities participate in 340B, although not all of the following yet participate in Medicaid's 340B initiative:

- The Vermont Department of Health, for the AIDS Medication Assistance Program, STD drugs programs, and the TB program, all of which are specifically allowed under federal law.
- Planned Parenthood of Northern New England's Vermont clinics
- All of Vermont's FQHCs, operating 41 health center sites statewide
- Central Vermont Medical Center
- Copley Hospital
- Fletcher Allen Health Care

- Gifford Hospital
- Grace Cottage Hospital
- North Country Hospital
- Northern Vermont Regional Medical Center
- Porter Hospital
- Rutland Regional Medical Center
- Springfield Hospital

In order for the state to access 340B pharmacy pricing for all prescriptions, there would need to be a reorganization of the primary care delivery system to become the types of participants allowed under federal law.

Recommendation:
Prescription drug coverage for Green Mountain Care should strive to contain costs through multiple, proven methods, such as promoting the use of generic drugs, using a drug formulary to negotiate discounts and rebates, and encouraging entities who have access to 340B pricing to participate in the program.

3. How to allow employers and individuals to purchase supplemental health services from Green Mountain care and/or allowing private insurers to provide supplemental insurance plans.

This section of the report will define supplemental health policies and services, discuss the role of supplemental health services and insurance in countries with universal healthcare coverage, and provide recommendations for future legislative consideration.

Description of supplemental insurance
Supplemental health insurance policies are typically designed to add on more comprehensive health coverage. They "wrap around" and complement basic health insurance.[1] Perhaps the most common type of supplemental policy is a Medicare supplemental policy known as "Medigap" for persons with Medicare. A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare coverage and helps pay some of the health care costs that Original Medicare does not cover.[2] For example, a hospital indemnity policy is a supplemental policy that pays cash benefits for each day a person is in the hospital. Another example is supplemental prescription drug coverage similar to what Vermont provides for certain seniors and individuals with disabilities with Medicare coverage. Medicare Part D, the drug coverage under Medicare, has a "donut hole." The "donut hole" provides coverage up to a certain amount, and then stops covering drugs until the out-of-pocket costs add up to a higher amount. In Vermont's VPharm program, the state provides supplement coverage for the "donut hole".

[1] Insurance Basics. Supplemental Policies. www.healthcare.gov
[2] Your Medicare Coverage Choices. http://www.medicare.gov/navigation/medicare-basics/coverage-choices.aspx

While supplemental policies can fill in gaps in coverage, they can also lead some consumers to pay for more protection than is necessary. Some consumers are "over-insured" and are paying for coverage they are unlikely to use. Supplemental insurance offerings should be tailored to complement comprehensive health coverage and to offer coverage for services that are beyond the scope of the comprehensive plan, but are not duplicative or unnecessary.

For instance, if a comprehensive insurance plan does not cover vision services, a supplemental insurance offering designed to provide coverage for these services may have a legitimate role in the supplemental insurance market. However, if the comprehensive insurance plan includes coverage for annual eye exams and corrective lenses, a supplemental policy for vision services may not be of use to many individuals.

Supplemental Health Policies and Services in Countries with Universal Healthcare Coverage

Many countries with universal health care coverage allow for a supplemental insurance market: Australia, Canada, Denmark, England, Estonia, France, Germany, Italy, Netherlands, New Zealand, Norway, Sweden, Switzerland, and Taiwan. However, in many cases supplemental insurance cannot be duplicative with regard to the health services that are covered by the country's health care system. Many times, the size of the supplemental insurance market correlates with the breadth or comprehensiveness of the publicly offered benefit package. For example, Sweden offers very comprehensive health benefits through its health care system. As a result, supplemental insurance accounts for less than 1 percent of total health expenditure in that country. Conversely, in Canada the federal government offers universal coverage for physician and hospital services only thus, two-thirds of Canadians have supplemental insurance to cover vision, dental, and prescription drugs. Supplemental insurance accounts for 15 percent of total health expenditure in Canada.[3]

It is important to note that all of the countries with universal coverage that we reviewed had a supplemental market available.

[3] Koppel, Agris; Kahur, Kristiina; Habicht, Triin; Saar, Pille; Habicht, Jarno; Van Ginneken, Ewout. *Estonia Health System Review*. Health Systems in Transition Vol. 10 No. 1 2008.

Squires, David. *International Profiles of Health Care Systems*. The Commonwealth Fund. June 2010.

Yu, Suchuan and Alexander Lin. Private Insurance in Taiwan. *Health Affairs*. Vol. 28 No 6. 1862-1863. 2009.

Table 1. Supplemental Health Insurance in Countries with Universal Health Care Coverage

Country	Basic Health Coverage	Supplemental Insurance	Description of Supplemental Insurance
Australia	Australian Medicare provides free or subsidized access to most medical and some optometry services and prescription drugs.	✓	• Tax breaks and subsidies for supplemental insurance encourage its use. • Provides greater choice and additional services such as dental, podiatry, and complementary and alternative medicine (CAM).
Canada	Canadian Medicare provides universal coverage for physician and hospital services. Provincial and territorial governments provide varying levels of additional insurance for prescription drug, dental, vision, home care, and ambulance services.	✓	• Two-thirds of the population has private supplemental insurance. • Employment-based group plans are the source of much of the supplemental coverage. • Duplicative private insurance for publicly funded physician and hospital services is not available.
Denmark	Provides coverage of all primary and hospital services based on medical assessment of need.	✓	• Private insurance is common in the Danish health system. • Used to cover copayments in the statutory system and services that are not fully covered by the state. • Tax deductions encourage use of private insurance.
England	The National Health Services (NHS) provides preventive services, inpatient and outpatient hospital services, specialist care, general practitioner services, inpatient and outpatient drugs, dental care, mental health care, learning disabilities, and	✓	• Supplementary private insurance offered by for-profit and not-for-profit insurers. • Private insurance is used to offer faster access to elective surgery, more comfort and privacy. • In 2006, just 1 percent of total health expenditure was from private insurance.

	rehabilitation.		
Country	Basic Health Coverage	Supplemental Insurance	Description of Supplemental Insurance
Estonia	Provides universal health coverage and comprehensive benefits	✓	• Allows supplemental insurance to cover services that are not provided for publicly. • Known as Voluntary Health Insurance (VHI). Most VHI is purchased as insurance for travelers. • VHI has not been a big component of health spending in Estonia and there are no tax credits available for its purchase.
France	Universal Coverage. The public health insurance scheme covers hospital care, ambulatory care, and prescription drugs. It provides minimal coverage of outpatient eye and dental care. Preventive services (immunizations) are covered to a certain extent, usually for defined target populations.	✓	• Complementary private health insurance can be purchased to provide reimbursement for statutory cost-sharing. • Covers only those services that are also covered by the public health insurance scheme. • For-profit commercial insurers offer coverage for services not included in the public benefits package, such as psychotherapy or acupuncture.
Germany	Health insurance is mandatory for all citizens. Statutory Health Insurance (SHI) covers 85% of the population.	✓	• Private health insurance has complementary and supplementary role. • Adds certain minor benefits to the SHI coverage. • Provides access to better amenities such as single/double hospital rooms, and covering some copayments, especially for dental care.

Country	Basic Health Coverage	Supplemental Insurance	Description of Supplemental Insurance

Italy	The public health system (Servizio Sanitario Nazionale, or SSN) covers all citizens and legal foreign residents.	✓	• Approximately 15 percent of the population has some form of private insurance. • Covers cost-sharing requirements, services excluded under the SSN, and wider choice of public and private providers.
Netherlands	All residents and those paying income tax in the Netherlands are required to purchase health insurance coverage.	✓	• Substitutive private health insurance was abolished in 2006. • Most people purchase a mixtureof complementary and supplementary private health insurance from the same health insurers who provide statutory coverage.
New Zealand	All residents have access to broad range of health and disability services funded primarily by the government.	✓	• Private insurance is used to cover cost-sharing, elective surgery in private hospitals, and some specialist outpatient consultations. • Less than 6% of total health care expenditures come from supplementary insurance.

Country	Basic Health Coverage	Supplemental Insurance	Description of Supplemental Insurance
Norway	Universal Coverage	✓	• Private insurance plays a very limited role. • Offers shorter waiting times for publicly covered services, but few people choose to enroll. • Private coverage is typically offered through employers.
Sweden	Universal coverage offers a broad range of services.	✓	• Provides faster access to care and care that is in the private sector. • Accounts for less than 1

			percent of total health expenditure.
Switzerland	Covers most GP and specialist services, a list of pharmaceuticals, and some preventive measures.	✓	• Can be purchased for wider coverage and more options than basic health coverage. • Regulated but can refuse applicants based on health information. • Illegal to base private insurance enrollment decisions on the health information obtained from basic health coverage records.
Taiwan	National Health Insurance (NHI) offers comprehensive coverage of preventive, inpatient, outpatient, prescription drug and dental services.	✓	• Private supplemental insurance is available purportedly as indemnity insurance, yet a large portion of health spending is for private insurance.

Sources:
Koppel, Agris; Kahur, Kristiina; Habicht, Triin; Saar, Pille; Habicht, Jarno; Van Ginneken, Ewout. *Estonia Health System Review*. Health Systems in Transition Vol. 10 No. 1 2008.

Squires, David. *International Profiles of Health Care Systems*. The Commonwealth Fund. June 2010.

Yu, Suchuan and Alexander Lin. Private Insurance in Taiwan. *Health Affairs*. Vol. 28 No 6. 1862-1863. 2009.

Many countries that offer universal health care coverage also permit some form of supplemental insurance. The level of supplemental insurance typically corresponds with the degree of all-inclusivity in the public health care coverage. If public health care coverage is very basic, there is a stronger likelihood that there will be a larger presence of supplemental insurance.

Because the supplemental market varies based on the coverage provided, it is premature to design the contours of the supplemental market until the benefits for Green Mountain Care have been decided upon. While Act 48 sets forth several parameters on the benefits package, the final package will be decided upon by the Green Mountain Care Board. A draft timeline for the development of a draft package or packages is included in Appendix A.

Recommendations:

- Given the prevalence of supplemental markets in single-payer countries throughout the world, Vermont should provide for a supplemental market.
- The design of the supplemental market should follow the design of the Green Mountain Care benefit package.

4. How to enable parents to make coverage under Green Mountain Care available to young adults up to age 26 who would not otherwise be eligible for coverage under the program, including a recommendation on the amount and mechanism for collecting a financial contribution for such coverage and information on the difference in costs to the system between allowing all adult children up to age 26 to be eligible and limiting eligibility to adult children attending a college or university.

This section of the report focuses on how to enable parents to make coverage under Green Mountain care available to young adults up to age 26, who would not otherwise be eligible for coverage under the program because they are living out-of-state. The amount and mechanism for collecting a financial contribution for such coverage is discussed and information on the difference in costs to the system between allowing all adult children up to age 26 to be eligible and limiting eligibility to adult children attending a college or university. This section of the report will:

- Outline the current insurance requirement under the Federal Affordable Care Act to allow young adults up to the age of 26 to remain insured on their parents' health coverage plan.
- Outline current methods for extending health insurance coverage out-of-state
- Provide a broad overview of how out-of-state coverage for young adults works today.
- Discuss the increase in cost to insurers for providing coverage for adult children up to age 26.
- Address the differences in cost to the system between extending eligibility for out-of-state insurance coverage to all adult children or only those attending college or university.
- Provide Recommendations

The Affordable Care Act Insurance Requirement
Section 2714 of the Affordable Care Act of 2010 states that:

> *In General.—a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.*

Health plans that do not offer dependent coverage are not subject to this policy change. However, most insurers and employer-sponsored health plans do offer dependent coverage, commonly known as a family plan. This requirement only applies to health insurers, not to a state-sponsored health plan available to all Vermonters, however it is important to note that this will have become the status quo and common expectation when Vermont is able to implement Green Mountain Care. As such, it is important to consider whether to continue the availability of this option.

Current methods for extending health insurance coverage out-of-state
For members of most Health Maintenance Organization (HMO) plans, access to out-of-state coverage is limited to emergency care and does not include routine care. Even if a young adult covered by the plan is living out-of-state while attending college or university, he or she cannot receive routine healthcare. Riders are available for college students to have access to selective routine care. Persons who live out-of-state seasonally also are limited to emergency health services if they have health insurance coverage through an HMO type plan.

There are two methods that are currently used by Vermont insurers to provide out of state coverage: leased networks and national networks. Both Cigna and Blue Cross Blue Shield of Vermont have national networks. Cigna has a national network because it is a national carrier doing business in most states. Blue Cross Blue Shield of Vermont has a national network through the BlueCard, described below. Green Mountain Care could offer out-of-state coverage through one of these systems. Each is described in more detail in the next sections.

Leased Networks
In general, one insurance company may allow another insurance company access to its Preferred Provider Organization (PPO) network through a lease; this is called a leased network. A leased network is the simplest way for an insurance company in one state to extend coverage to customers who are living in another state where the providers are a part of a local insurance company's network or PPO. This mechanism is currently used by MVP for their products offering out-of-state services to their members. Vermont could similarly lease a network both for the coverage of young adults as well as any Vermonter in need of care out of state while on vacation or because of a health condition needing sub-specialty care unavailable in-state.

The BlueCard
The BlueCard program, as defined by Blue Cross and Blue Shield of Vermont, is a collection of programs and policies that enable Blue members to receive healthcare services across the nation and around the world. Members of PPO plans have access to the entire BlueCard network. Members include:

- Vermonters who travel out of a state and out of country (including snowbirds)
- Out of state residents who are employed by Vermont employers
- Children and other dependents (including young adults up to age 26)
- Other Blue Plan members accessing services in Vermont

Vermonters with Blue Cross and Blue Shield coverage from a PPO can access emergency and routine care outside the state through the BlueCard network. The BlueCard network allows members access to medical care in at least 99 percent of the urban and suburban United States and 87 percent of the rural United States population has access to a Blue provider within five to twenty miles of their residence.

The BlueCard Worldwide program provides members living or travelling overseas with access to an international network of doctors and hospitals in more than 200 countries and territories. [4]

In addition, Medicaid contracts with out-of-state coverage in certain circumstances:

(b) According to Title 42-CFR 431.52, Payments for services furnished out of State, a State plan must provide that the State will pay for Services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency

(2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence

(3) The state determines on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State.

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

(c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.[i]

Vermont's current Green Mountain Care Provider Manual specifies that in order for providers to participate in and receive reimbursement from Vermont Medicaid Programs, that the provider must first be enrolled. Providers may be enrolled as Vermont Medicaid providers, contingent upon at least one service that they provide being recognized in the Vermont Medicaid State Plan. Out of state providers, with the exception of those that are recognized along the border, are granted a special status in Medicaid. Out of state providers may see a Vermont Medicaid beneficiary in an emergency or urgent situation, or may be given prior approval for out of state services. However, currently no prior approval is required for outpatient services obtained at out-of-state non-border providers.[ii]

Out-of-state coverage for young adults today

[4] Goddard, Kevin. *World Wide Care. Accessing Care Out of State and Out of Country Through BlueCard.* Power Point Presentation.

The Massachusetts based advocacy group Young Invincibles, is a national organization that represents the interests of 18-34 year olds. The group's aim is to ensure that young people's perspective is heard in the debate over health care reform. The group uses policy research and analysis to educate and inform young people about their health care rights. According to the Young Invincibles it does not matter what state a young person or their parents live in terms of extending health insurance coverage to young adults. However, while it is possible to be covered by a parent's plan while out-of-state, this coverage is many times not practical. If a plan has a limited provider network, the coverage for a dependent out-of-state could be limited to emergency care, if the provider network does not include providers out-of-state. For some young adults who enjoy coverage on their parent's plan, it can be inconvenient to receive routine care even while in the same state as their parents due to some plans' limited geographic area of coverage.

Health plans must provide all qualified young adults with the same benefit package that is available to younger dependents, meaning the benefits 16 year-old dependents receive must be the same as the benefits a 26 year-old dependent enjoys. However, as stated above, different plans provide different types of coverage to plan members who are out-of-state.

Increase in Cost to Insurers for Providing Coverage to Adult Children up to Age 26
In the survey, The Current Vermont Health Insurance Market, submitted to the State of Vermont by Bailit Health Purchasing, Vermont's three major health insurers, Blue Cross and Blue Shield of Vermont, CIGNA, and MVP reported that the premium impact of the ACA-required changes that have been implemented have been insubstantial. For dependent coverage up to age 26, insurers estimate a range of 1-2 or 3% increase in premium as a result of the new federal requirement.[5]

The White House's fact sheet on young adults and the Affordable Care Act reports as little as a 0.7% increase in family premiums due to the expansion of dependent coverage to young adults up to the age of 26.[6]

The Young Invincibles report an increase of 0.7%-1% in average family premiums due to the expansion of coverage for young adults on their parents' plans.[7]

Differences in Cost to the System Between Expanding Eligibility to All Young Adults Versus Only Those Attending College and University
Green Mountain Care can structure its out-of-state coverage for all dependents to be minimal or comprehensive as is currently the case with private insurance. As was stated previously, HMO type plans often cover only emergency care for beneficiaries who are out-of-state, while PPO plans may lease out-of-state networks or have their own networks

[5] Bailit Health Purchasing. *The Current Vermont Health Insurance Market*. May 20, 2011. 14.
[6] Young Adults and the Affordable Care Act. Available at: http://www.whitehouse.gov/sites/default/files/rss_viewer/fact_sheet_young_adults_may10.pdf
[7] Young Invincibles. Dependent Coverage Frequently Asked Questions. Available at: http://www.younginvincibles.org/HealthCare/dependentCoverageFAQs.html

that allow for the provision of routine coverage for beneficiaries out-of-state. HMO type plans often allow customers to purchase a rider for routine out-of-state coverage for college students and this may be a possibility for Green Mountain Care as well.

In terms of the difference in cost to the system for covering all young adults living out-of-state versus only those attending college or university, the cost is likely a fraction of the already low impact on premiums that expanding coverage to all young adults has had on the three insurance carriers currently doing business in Vermont. Determining an exact dollar amount is not possible until the parameters of the out-of-state coverage are determined as part of the benefit package.

Recommendations:
Out-of-state coverage for young adults under Green Mountain Care should be provided using similar parameters as under current law, however, the exact benefit structure should be determined as part of the benefit determination. There are two mechanisms for providing this type of coverage. Because the administrative structure of Green Mountain Care is required to be put out to bid, neither should be eliminated at this time.

5. A determination of whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care, and if so, what is the impact, if any, on the state's bond rating.

This section of the report addresses the question of whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care, and if so, how to accomplish such implementation; and the impact, if any, on the state's bond rating.

This section will:

1. Define reserves, surplus, and reinsurance.
2. Discuss how the Vermont employee health plan currently manages risk.
3. Examine the necessity of providing a financial reserve or reinsurance for federally funded populations.
4. Consider the methods other countries with universal coverage employ for risk management.
    a. The Estonian Health Insurance Fund and Reserves
5. Discussion of factors for Green Mountain Care
6. Assess the impact that a reinsurance or financial reserve program for Green Mountain Care will have on the state's bond rating.

Definitions

Reserves
Although the term is frequently used to describe excess or extra funds, in insurance reporting reserves actually refers to the actuarially estimated amount that should be held as a liability to cover:

1. Known or reported incurred losses, not yet paid
2. Unknown/unreported incurred losses expected to emerge after the financial year-end
3. The company's cost to pay the above amounts (administrative)

Surplus

In general parlance, the term "reserves" has sometimes been used to describe the net worth (excess of assets over liabilities) or "surplus" of a company. Reserves and Surplus are entirely different. Surplus is the Statutory Accounting term that refers to the net worth of a company (Assets less Liabilities). As such, a Company with $100 in Investments and $75 in Reserves (claims liabilities) will have a Surplus of $25.

ABC Insurance Company

Investments:	$100
Reserves	(75)
Surplus	$ 25

The remaining discussion focuses on the need for surplus for any underwriting entity.

Why Insurance Companies Need Surplus

In a perfectly predictable world, investment returns would be positive with no risk of loss and reserve estimates would be 100% accurate. In the above example, there would be no need for the $25 Surplus, because the investments would never lose their value, and the actuary's $75 reserve estimate would be spot on, with no chance that it was understated. However, we know that neither is true, and that is why insurers and regulators agree on the need for Surplus. Surplus provides a cushion for investment losses or inadequate reserves.

There are many ways of measuring surplus in an entity. A simple way is to express it as a percent of the annual premium of the company, called Surplus as a Percent of Revenue (SAPOR). An example of the use of SAPOR as a regulatory tool exists in 8 V.S.A. §4513, which permits a health insurer to add a 2% profit margin into premiums charged until such time their SAPOR reaches 8%. SAPOR is very simple to compute and understand, but lacks sophistication and utility. For instance, a company that writes dental insurance with a $1,000 per member annual benefit cap and a very conservative investment portfolio may have what a regulator considers a very adequate Surplus level at 5% SAPOR. In contrast 5% SAPOR would likely be viewed as inadequate for a life insurance company that invests very aggressively. The risk profile of the insurance sold and the investment portfolio is not considered in a SAPOR calculation. As such, SAPOR is not a very good measure when it comes to comparing surplus levels across the industry.

Risk Based Capital (RBC) is the standard adopted by the National Association of Insurance Commissioners (NAIC) and enforced by law or regulation in all 50 states. It is a very sophisticated way to incorporate the risk in the assets, liabilities and underwriting practices of the company in order to determine the baseline capital for each entity, called

the ACL. The level of RBC is expressed as a percentage of the ACL. If the ACL of the insurance company in the above example was determined to be $10, the RBC ratio would be $25/$10 or 250%. Most states begin an escalating path of regulatory authority over a company when the RBC ratio falls under 200% (see Insurance Reg. 97-2). Most "A" rated companies will have an RBC well over 400%, many over 1,000%. Financial Strength Ratings, issued by rating agencies such as AM Best or S&P are used to rate companies.

Reinsurance

Surplus is used as a backstop or to mitigate the financial impact to the insurer of investment, underwriting and reserving risk. Another tool that addresses underwriting and reserving risk (but not investment risk) is Reinsurance. Simply put, reinsurance is insurance sold to insurance companies. The reinsurance market is incredibly dynamic and customized. There are generally no "off the shelf" products, as there are in consumer oriented insurance. In other words, the coverage and premiums in a reinsurance contract are customized for each insurance company customer. In the health industry, reinsurance can typically be found as either Aggregate or Specific Stop-loss Coverage. A health insurer can purchase Aggregate Stop-loss reinsurance coverage that states that its aggregate losses for the entire company will not exceed $10 million dollars in any given year. Using the example above, the ABC Insurance Company may choose to purchase an aggregate reinsurance contract that pays 100% of claims over $85, since its claim Reserves are $75 and it only has $25 in surplus. This would help protect the company against having made an inadequate actuarial estimate of claims reserves. Again, these contracts are highly customizable, so to save in premium costs, ABC may later choose to purchase coverage that only covers 50% of claims over the $85 per year.

Specific Stop-loss coverage is based on a cap per policyholder. This contract may state that the reinsurer will cover all costs over $10,000 per member per year. This protects the insurance company from a handful of high cost patients causing financial harm to the company. However, if all of the health insurer's customers make claims of $9,999, there would be no reinsurance coverage and the company could find itself in financial trouble (assuming for example that the Reserve was set using an estimate of $1,500 per member per year in claims). Companies have the option of purchasing both specific and aggregate reinsurance.

The Relationship Between Reinsurance, Reserves and Surplus

The relation of reinsurance to the need for Reserves and Surplus is important. Reinsurance provides "Surplus relief", in that reinsurance coverage lessens the amount of earned premiums a company reports. If ABC Company sold $100 in insurance in 20XX, and purchased an aggregate reinsurance contract for $15 dollars to provide certain protection on that $100 of business, the actual premium presented in the financial statement would be $85. This lower premium amount would be incorporated into the RBC calculation when determining that baseline ACL. The claims Reserves of the company would also be reduced by a similar amount (somewhat less than $15). It is important to note that there would still be a requirement for Surplus in the entity, even if the company's operations were 100% reinsured from the first dollar up. There is always

asset risk and risk of non-performance of the reinsurance contract that needs to be mitigated by Surplus, and the RBC calculation takes that into account. In conclusion, while reinsurance can dramatically reduce the need for Surplus in an entity, it is not a 1 for 1 substitute for surplus.

The Vermont State Employee Health Plan
The State Employee's Health Plan is a self-insured arrangement whereby the underwriting risk of the group is borne by the State of Vermont. When a group (or insurance company) materially exceeds its total expected or budgeted losses it is generally due to either Severity (dollar amount of a single claim or claimant) or Frequency (total number of claims); or frequently a combination of both. Even a few severe claimants can affect the total expected losses of a large group, this is "severity". Conversely, even if there are no individual severity outliers, if the actual number of claims exceeds the norm, that can cause the total expected losses to be exceeded, that is "frequency".

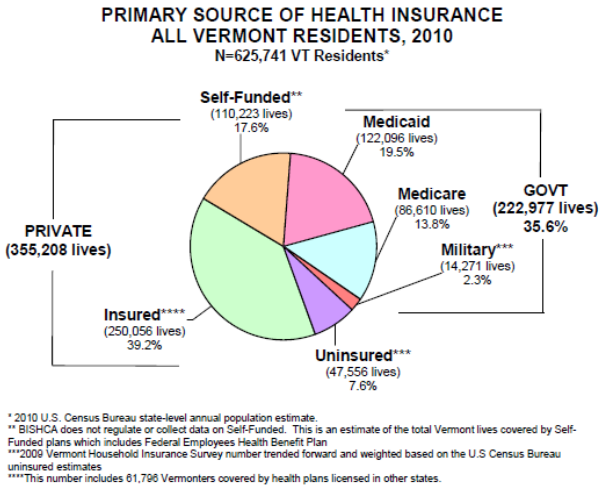
There are generally two types of stop loss coverage available to large groups to address each driver: Specific and Aggregate. Specific stop loss coverage protects the group against severity by transferring the risk of individual losses in excess of a specified amount. Aggregate stop loss coverage protects the group from frequency, and a combination of frequency and severity by capping the total losses for the whole group. An example of aggregate stop loss coverage would be to have an insurer bear the risk of all costs that exceed 130% of expected losses. An example of specific stop loss can be seen in the State's self-insured plan. The State makes use of specific stop-loss coverage for medical claims arising from one individual that exceed a specified dollar amount. For the most recent fiscal year-end, that dollar amount was approximately $400,000 (the amount went from $385K to $410K mid-year). For general information (this would vary widely by the population and experience of a group) it may be useful to know that the cost of this level of specific coverage was $963,555, relative to actual losses during the coverage period of $92.8 million. This equates to about 1.1% of claims. This coverage did not apply to pharmaceutical or behavioral claims, just inpatient, outpatient, and physician claims. .

Providing reinsurance or a financial reserve for federally funded populations
In 2010 the Department of Banking, Insurance, Securities, and Health Care Administration reported that a total of 35.6 percent of the population was covered by government funded health care programs: Medicaid, Medicare, and Military health care programs. Private health insurance (including municipal employees and school employees) provided coverage for 39.2 percent of Vermont's population. Self-funded health insurance plans (including state employees) cover 17.6 percent of the population and 7.6 percent of Vermonters are uninsured.

Currently, Medicaid and Medicare have no form of reinsurance in place to manage the risk of insuring Medicaid or Medicare beneficiaries. Both of these programs, however, have large populations covered, which provides for stability in costs. Medicaid has some reserves provided for through the general fund reserve, although this reserve is not

limited to covering just Medicaid. Medicare does not have a reserve provided for, but the state is not a risk for Medicare coverage, because it is 100% federally funded. In determining whether a reserve should be provided, it would not be logical for the state to provide a reserve for a federally funded population, because the state is not at risk for the costs of that population. Regardless of whether a reserve is provided for a particular population, it is important for ensure that appropriate cost-containment mechanisms are in place for the entire system to ensure that health care costs are sustainable.

Table 2.



Methods Other Countries Use to Manage Risk

Most universal health systems in Europe are tax-funded and do not have a reinsurance or financial reserve mechanism to manage risk for the entire health system. However, there are some examples of risk management in other countries with universal health coverage and Estonia provides a rare example of a financial reserve system for an entire health care system.

- In Germany, private health insurers are required to set aside "aging reserves" from insurance premiums to enable premiums to grow more slowly as people age and these reserves can be transferred if the insured person changes to another private insurer.[8]

- Estonia's single payer system was established in the early 1990s and the Estonian Health Insurance Fund was established in 2001. Over 95% of the population is entitled to EHIF benefits. The healthcare system is financed in large part through an earmarked tax on wages or social tax. Other funding from the central government contributes one tenth of funding and

[8] Squires, David. *International Profiles of Health Care Systems.* The Commonwealth Fund (2010).

private sources contribute just under one quarter of funding. While the population of Estonia, 1.340 million, is larger than Vermont's, it is closer in population size to the Green Mountain State than many other countries with universal health care systems. The area of Estonia is smaller than both Vermont and New Hampshire combined.[9]

Reserves in Estonia

The Estonian Health Insurance Fund (EHIF) is an independent and autonomous agency that is responsible for pooling funds and purchasing health services on behalf of its members. The budget of the EHIF is dependent upon the national budget and cannot be approved until the national budget has been passed.[10]

Three kinds of reserves are regulated by the Estonian Health Insurance Fund:

- Risk Reserve
- Legal Reserve
- Retained Earnings

The legal reserve is a part of the Government of Estonia's budget.[11]

The risk reserve of the health insurance fund is formed from the budgetary funds of the health insurance fund in order to minimize the risks that arise for the health insurance system. The size of the risk reserve is 2 percent of the health insurance budget of the health insurance fund. The funds of the risk reserve are issued based on a decision of the health insurance fund supervisory board. In 2010, 27 million kroons were used from the risk reserve to cover the costs related to vaccinations for HIN1.[12]

The legal reserve of the health insurance fund is a reserve formed for the reduction of risk caused by macro-economic changes to the health insurance system. The legal reserve is set at 6 percent of the budget (reduced from 8 percent). Every year, at least one-fiftieth of the total budget of the health insurance fund and revenue from the social tax is transferred to the legal reserve, until the amount of the legal reserve reaches the amount specified in the Estonian Health Insurance Fund Act. The legal reserve can only be used as an exception by an order of the Government of the Republic on the proposal of the Minister of Social Affairs. Prior to submitting a proposal to the Government of the Republic, the Minister of Social Affairs shall hear the opinion of the supervisory board of the health insurance fund. When Estonia was preparing for entry into the Eurozone, the Minister of

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[9] Thomson, Sarah; Võrk, Andres; Habicht,Triin; Rooväli, Liis; and Tamás Evetovits. Responding to the challenge of financial sustainability in Estonia's health system. Estonian Health Insurance Fund. World Health Organization. 2010.
and Jarno Habicht

[10] Habicht T. (2008). "Governing a single-payer mandatory health insurance system: the case from Estonia". Chapter in Sawedoff WD and Gottret P eds. Governing mandatory health insurance Learning from experience. Washington, DC: World Bank.

[11] Estonian Health Insurance Fund Annual Report 2010. 70. Available At: http://www.haigekassa.ee/uploads/userfiles/Eesti_Haigekassa_majandusaasta_aruanne_2010_eng.pdf

[12] Ibid.

Finance refused to deplete the reserve with health related spending. [13]

Estonia also has a retained earnings[14] reserve is administered by the State Fund and is used to cover deficit between revenue and expenses. This fund may be used in the amount of up to 30 percent in one financial year and is in place to ensure smooth daily cash flows. As of December 31, 2010, the Health Insurance Fund had 2.4 billion kroons in retained earnings.[15][16]

Discussion
The need by private companies for Surplus and Reinsurance is clear. If the investment portfolio drops 30% in one year, or the actuarial estimate (Reserves) are severely understated, the company will immediately find itself in a position where its liabilities exceed its assets and creditors will come calling as the company is unable to pay bills, and policyholder claims. This happens because in that financial situation, it is very difficult if not impossible for that company to access additional money. A dramatic increase in premiums would likely result in cancellations. A lender would be dubious, and the capital markets would hesitate to invest at a reasonable cost of capital in a company on that trajectory.

The above environment is, of course, entirely different when the insurance company is actually a government entity with taxing authority. The risk of insolvency really becomes supplanted with political risk. If the ABC Insurance was actually a government funded health plan and the premiums (or tax revenue source) and reserves were materially inadequate, the money to fill the hole would have to come from somewhere, and if the hole was big enough, it is of course possible that the necessary tax increase would be politically impossible. Reinsurance and perhaps provider risk-sharing could prove useful as a way to improve predictability of costs and to lessen the possibility and magnitude of inadequate premiums and reserving; however those mechanisms come at a cost in the front-end. Building a Surplus or rainy day fund would also provide a pool of funds to mitigate inevitable cost fluctuations.

Impact of reinsurance or financial reserves on the state's bond rating
According to staff at the Treasurer's Office, the impact on the state's bond rating must be examined for the program as a whole and it is difficult to do so for particular components independently. As such, it would be more appropriate to explore the potential impacts of Green Mountain Care on the State's bond ratings after the state has specific information on:

1. estimated program costs and required annual expenditures,

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[13] Ibid.
[14] Retained Earnings is a term used in some forms of accounting that is exactly the same as Surplus as defined above, it is where any year's excess is stored and as described here (and in the surplus section) can be used to absorb losses in bad years)
[15] Ibid.
[16] Habicht T. (2008). "Governing a single-payer mandatory health insurance system: the case from Estonia". Chapter in Sawedoff WD and Gottret P eds. Governing mandatory health insurance Learning from experience. Washington, DC: World Bank.

2. potential revenue sources,
3. risks to/possible variances around these estimates,
4. potential additional reserves, and whether the State's existing budgetary reserves would be impacted,
5. any resulting reductions to the State's other post-employment benefit ("OPEB," i.e., retired State and Teacher healthcare) liabilities,
6. expected economic positives/negatives, e.g., higher taxes, greater labor mobility, lower employer costs, etc.,
7. the amount of federal financial participation in GMC? and
8. any other material impacts to the State's budget and financial outlook.

For background, the ratings criteria for U.S. states from the three major rating agencies – Moody's, Standard & Poor's and Fitch are included in the Appendix.

In addition, the state's latest annual Capital Debt Affordability Advisory Committee (CDAAC) Report contains more information about Vermont's bond rating, which is currently AAA from two of the three agencies and AA+ from the third:

http://www.vermonttreasurer.gov/debt-management/capital-debt-affordability

The staff also indicated that if Green Mountain Care meaningfully reduces or eliminates the State's OPEB liabilities described above, that could have a beneficial impact on Vermont's credit standing. Because of the complicated nature of bond rating, it is recommended that this analysis be done at a later time as it is premature now.

Conclusion

Over the course of the summer and fall, we have done extensive research into how other payers and other countries address the issues raised by the general assembly. For some policy questions, such as how to provide out-of-state coverage, the choices and answers are clear. For other questions, such as the exact coverage parameters of a supplement market, the answers are premature and require other studies to be completed prior to finalizing the answers. The administration will continue to research other countries' models, develop information and operational details, and refine recommendations that are needed to implement Green Mountain Care.

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[i] Electronic Code of Federal Regulations e-CFR. Title 42: Public Health. 431.52 Payments for Services Furnished Out of State. http://ecfr.gpoaccess.gov.

[ii] Department of Vermont Health Access. Green Mountain Care Provider Manual. 8/2/2011. 19-20