Act 165: Federal Authority to Waive Maximum Out-of-Pocket or Actuarial Value Requirements

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Director of Health Care Reform

Agency of Administration

10/25/16

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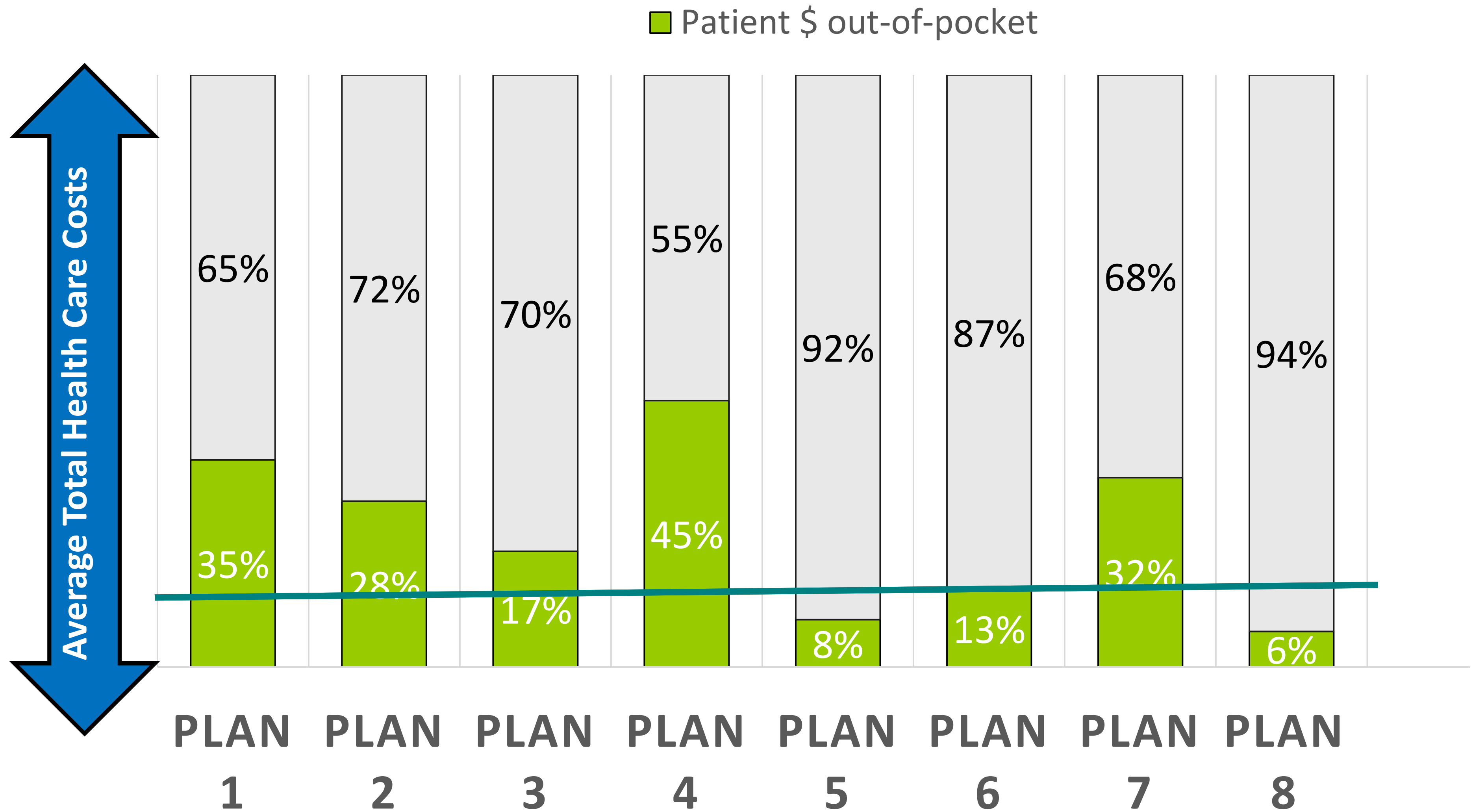
Act 165 Requirements

- Vermont's prescription drug limit conflicts with federal requirements for AV level and maximum medical out of pocket costs, jeopardizing bronze plans
- Options for legislature
  - 1332 Waiver
  - No bronze plans
  - Stakeholder group
  - Change inflation factor
  - Special fund
  - Review and reduce other pressures on AV and medical out-of-pocket maximum

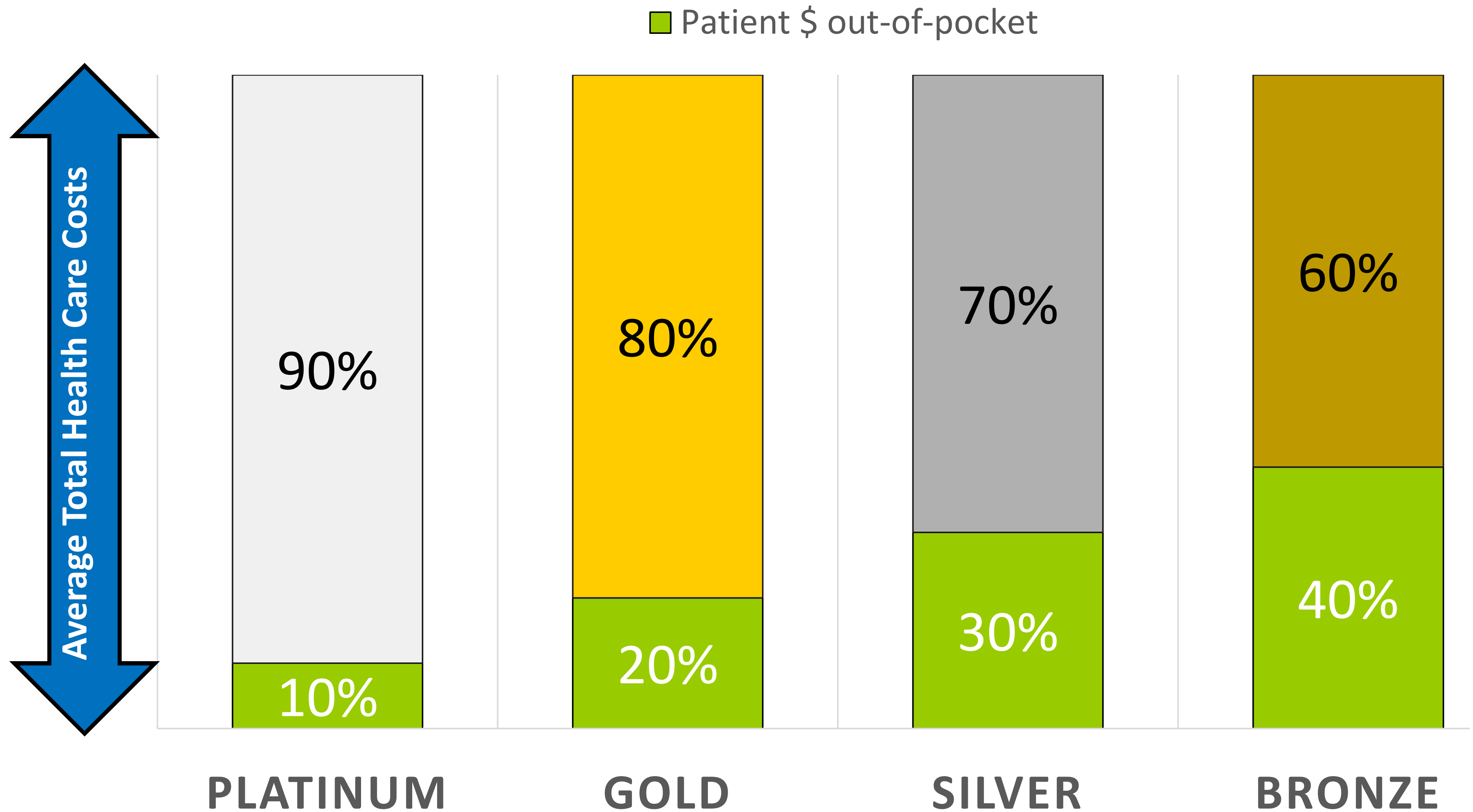
VT's prescription drug limit

- VT prescription drug limit is $1300
  - Tied to IRS rules for high deductible health plans
- VT Prescription drug limit applies to all insurance– large group, small group, individual
- Federal law places AV and medical maximum out of pocket on small group and individual plans
  - Regardless if on exchange or not

Prior to ACA, VT required prescription drug limit



Federal Actuarial Value Requirement

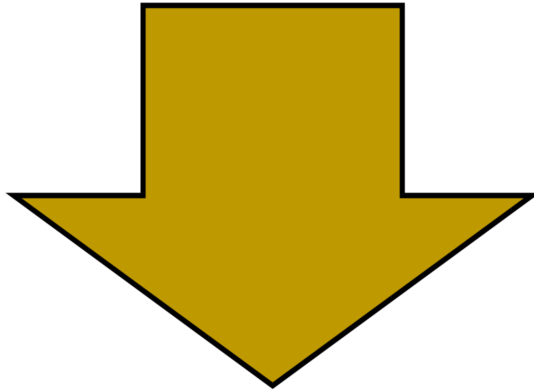


Federal Maximum Out-of-Pocket Requirement

Patient $ out-of-pocket

	PLATINUM	GOLD	SILVER	BRONZE
	90%	80%	70%	60%
Patient $ out-of-pocket	10%	20%	30%	40%

To maintain VT prescription limit within federal law, patients must pay more out of pocket



The plan must have the patient pay more out of pocket in other areas like co-pays and deductibles

When the plan has the patient paying less out of pocket for one thing, like prescription drugs…

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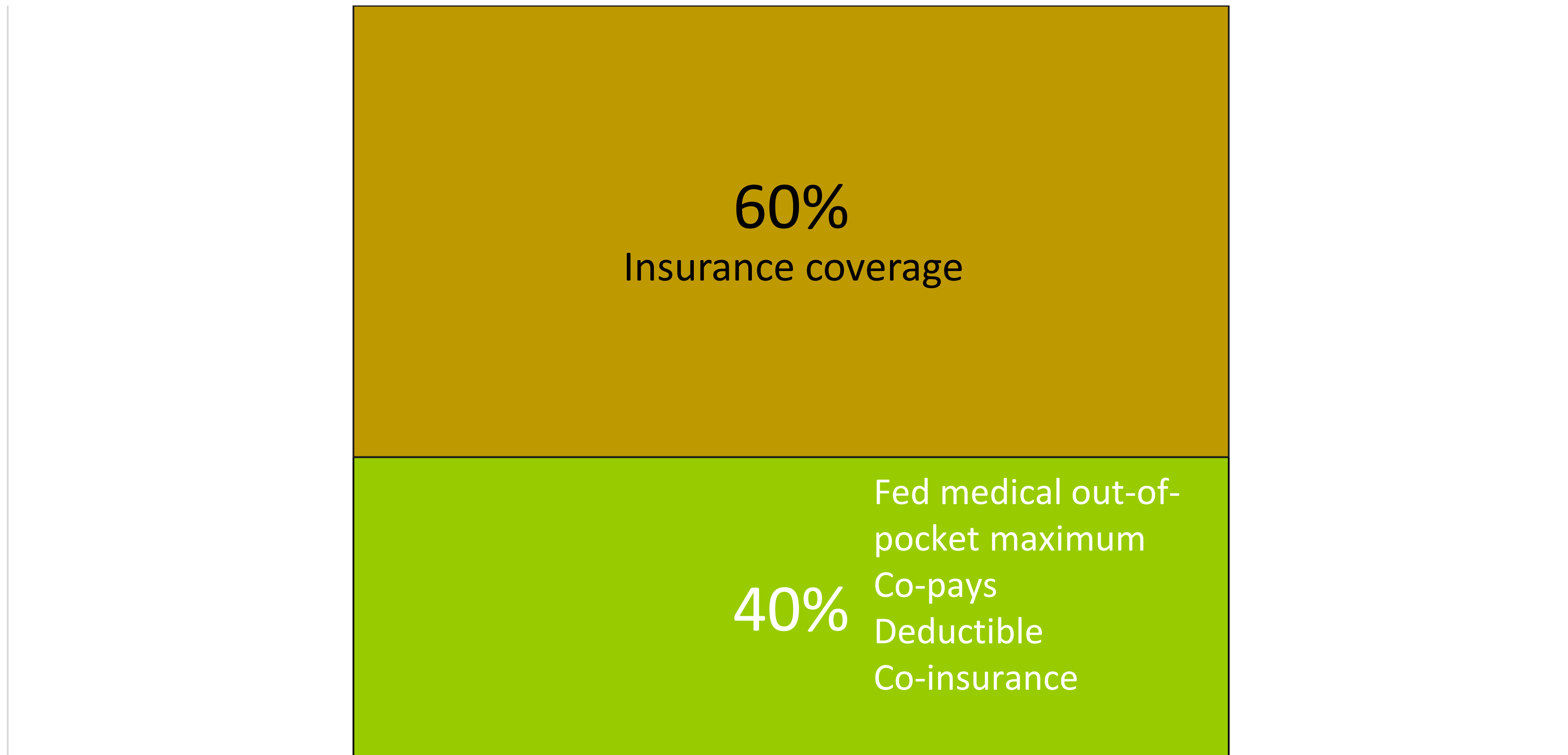
Bronze plan is running out of room to maintain federal AV level due to prescription drug limit



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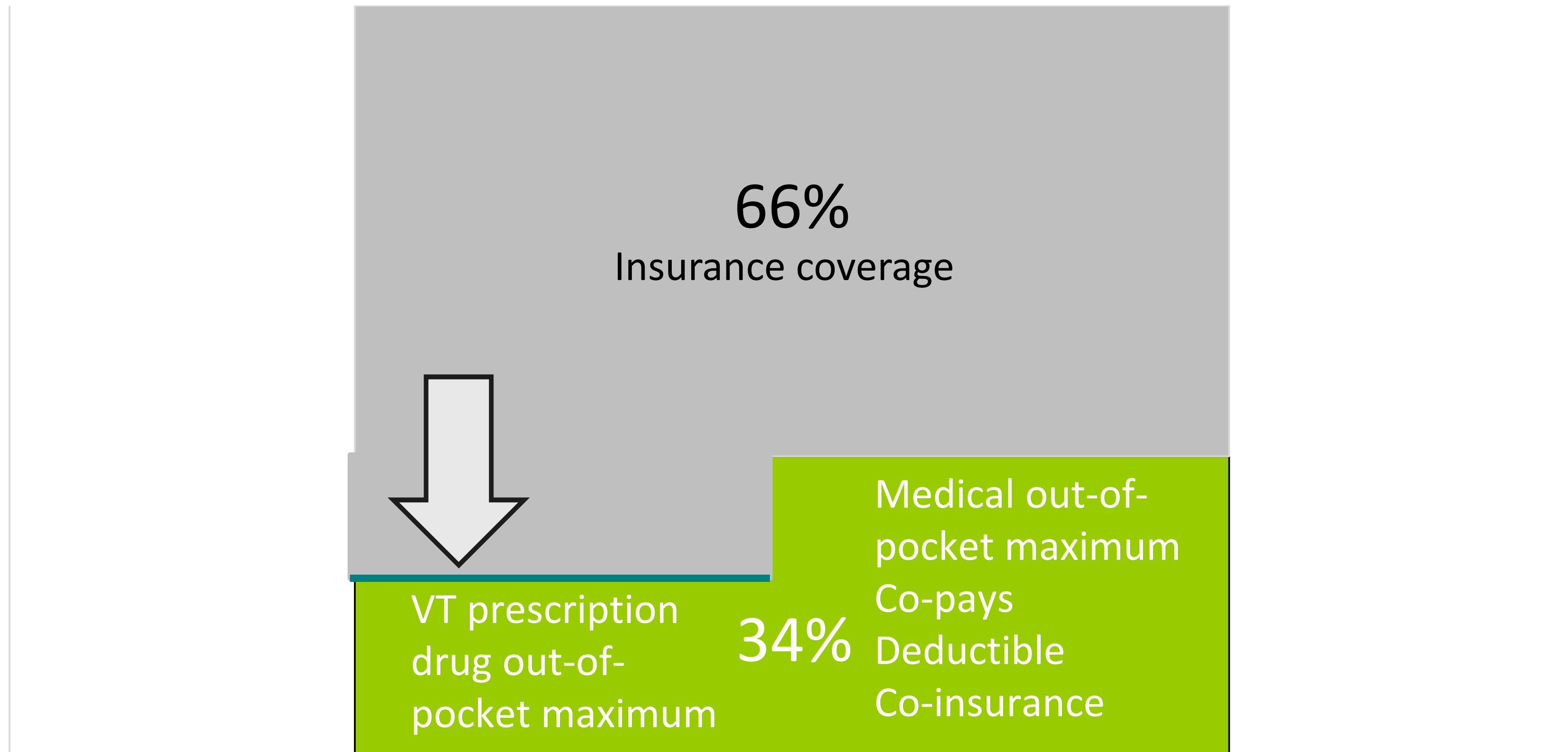
Bronze plan is running out of room to maintain federal AV level due to prescription drug limit



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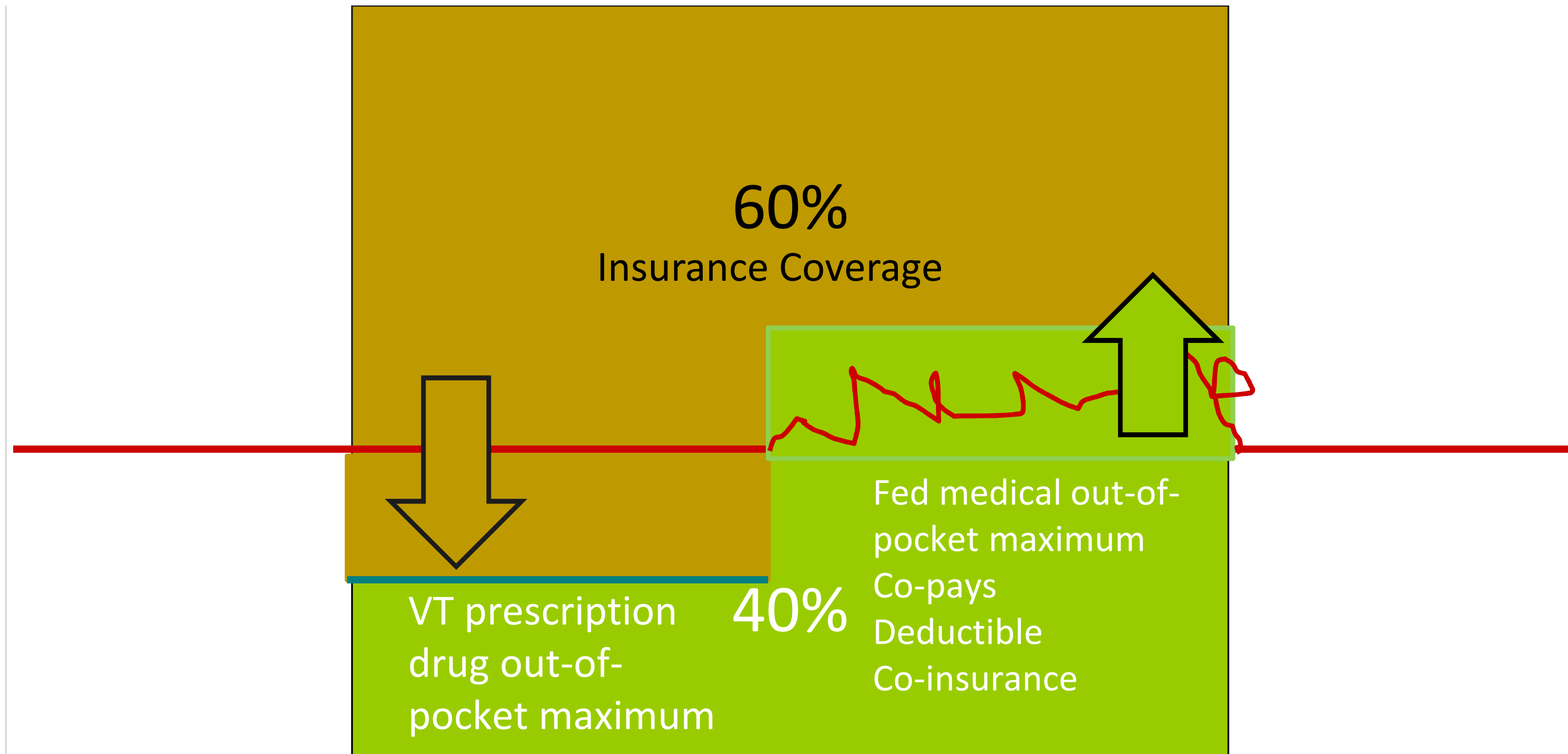
Increasing out of pocket costs may mean violating federal medical out-of-pocket maximum



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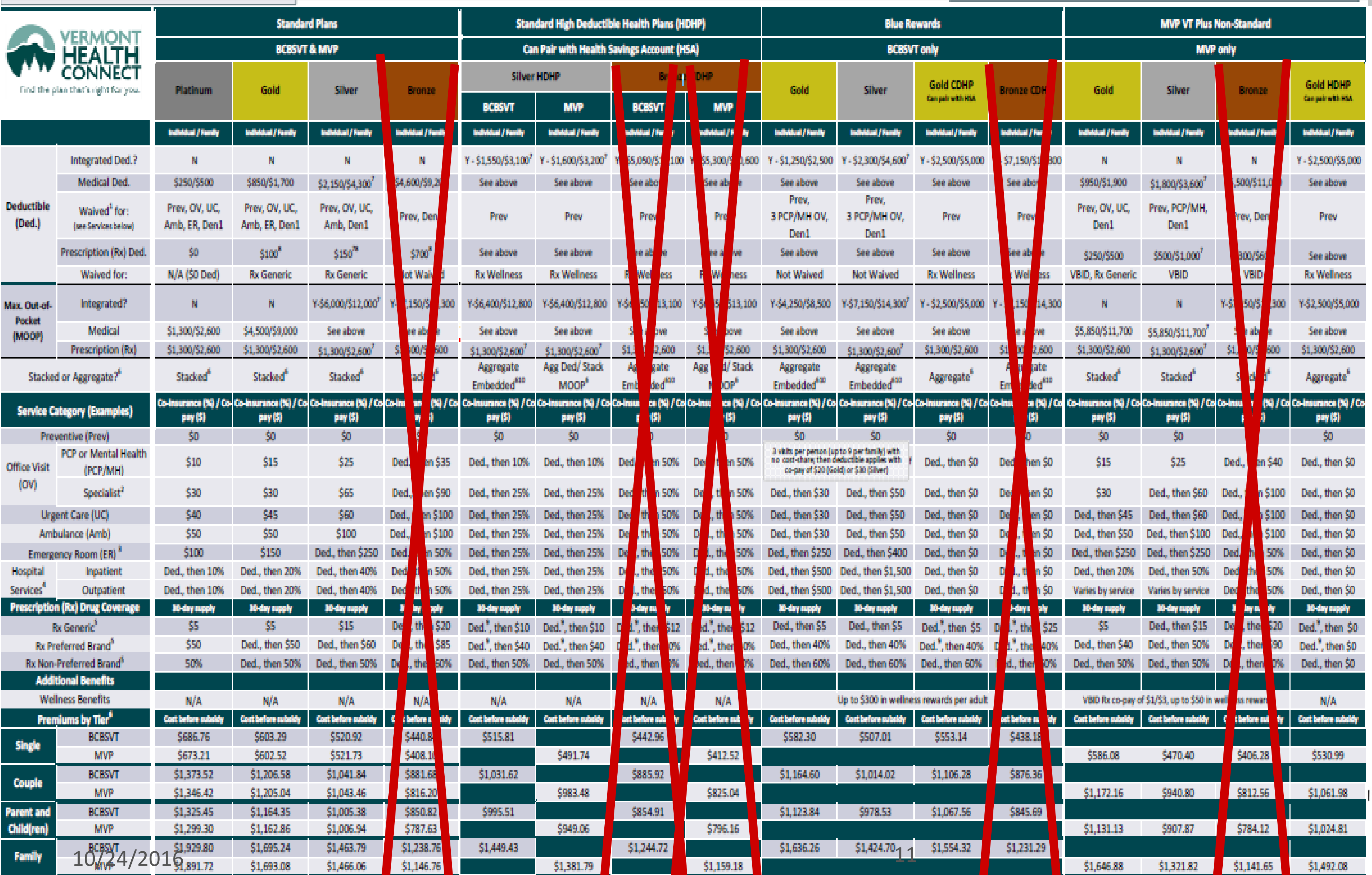
If bronze plans violate federal law, they cannot be legally offered to the public



VERMONT HEALTH CONNECT — Find the plan that's right for you.	Standard Plans				Standard High Deductible Health Plans (HDHP)				Blue Rewards				MVP VT Plus Non-Standard			
	BCBSVT & MVP				Can Pair with Health Savings Account (HSA)				BCBSVT only				MVP only			
	Platinum	Gold	Silver	Bronze	Silver HDHP		Bronze HDHP		Gold	Silver	Gold CDHP Can pair with HSA	Bronze CDH[illegible]	Gold	Silver	Bronze	Gold HDHP Can pair with HSA
					BCBSVT	MVP	BCBSVT	MVP								
	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family	Individual / Family
Deductible (Ded.): Integrated Ded.?	N	N	N	N	Y - $1,550/$3,100[7]	Y - $1,600/$3,200[7]	Y [illegible]$5,050/$1[illegible],100	Y [illegible]$5,300/$[illegible],600	Y - $1,250/$2,500	Y - $2,300/$4,600[7]	Y - $2,500/$5,000	[illegible]$7,150/$1[illegible]300	N	N	N	Y - $2,500/$5,000
Medical Ded.	$250/$500	$850/$1,700	$2,150/$4,300[7]	$4,600/$9,2[illegible]	See above	See above	See abo[illegible]	See ab[illegible]	See above	See above	See above	See abo[illegible]	$950/$1,900	$1,800/$3,600[7]	[illegible],500/$11,0[illegible]	See above
Waived[1] for: (see Services below)	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, ER, Den1	Prev, OV, UC, Amb, Den1	Prev, Den[illegible]	Prev	Prev	Prev[illegible]	Pre[illegible]	Prev, 3 PCP/MH OV, Den1	Prev, 3 PCP/MH OV, Den1	Prev	Prev[illegible]	Prev, OV, UC, Den1	Prev, PCP/MH, Den1	[illegible]rev, Den[illegible]	Prev
Prescription (Rx) Ded.	$0	$100[8]	$150[7,8]	$700[8]	See above	See above	[illegible]e ab[illegible]e	[illegible]e a[illegible]ve	See above	See above	See above	See ab[illegible]e	$250/$500	$500/$1,000[7]	[illegible]300/$6[illegible]	See above
Waived for:	N/A ($0 Ded)	Rx Generic	Rx Generic	[illegible]ot Wai[illegible]d	Rx Wellness	Rx Wellness	R[illegible] Wel[illegible]ess	R[illegible] We[illegible]ness	Not Waived	Not Waived	Rx Wellness	[illegible] Wel[illegible]ess	VBID, Rx Generic	VBID	VBID	Rx Wellness
Max. Out-of-Pocket (MOOP): Integrated?	N	N	Y-$6,000/$12,000[7]	Y-[illegible],150/$[illegible],300	Y-$6,400/$12,800	Y-$6,400/$12,800	Y-$6[illegible]50[illegible]13,100	Y-$[illegible]5[illegible]$13,100	Y-$4,250/$8,500	Y-$7,150/$14,300[7]	Y - $2,500/$5,000	Y - [illegible],150[illegible]14,300	N	N	Y-$[illegible]50/$[illegible],300	Y-$2,500/$5,000
Medical	$1,300/$2,600	$4,500/$9,000	See above	[illegible]e ab[illegible]e	See above	See above	S[illegible] [illegible]ove	S[illegible] [illegible]ove	See above	See above	See above	[illegible]e a[illegible]ve	$5,850/$11,700	$5,850/$11,700[7]	S[illegible] ab[illegible]e	See above
Prescription (Rx)	$1,300/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$[illegible]300/$[illegible]600	$1,300/$2,600[7]	$1,300/$2,600[7]	$1,[illegible]$2,600	$1,[illegible]/$2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,300/$2,600	$1[illegible]2,600	$1,300/$2,600	$1,300/$2,600[7]	$1,[illegible]/$[illegible]600	$1,300/$2,600
Stacked or Aggregate?[6]	Stacked[6]	Stacked[6]	Stacked[6]	[illegible]acked[6]	Aggregate Embedded[6,10]	Agg Ded/ Stack MOOP[6]	A[illegible]gate Emb[illegible]ded[6,10]	Agg [illegible]d/ Stack [illegible]OOP[6]	Aggregate Embedded[6,10]	Aggregate Embedded[6,10]	Aggregate[6]	A[illegible]gate Em[illegible]ded[6,10]	Stacked[6]	Stacked[6]	S[illegible]cked[6]	Aggregate[6]
Service Category (Examples)	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-In[illegible] (%) / Co[illegible]	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-Insu[illegible] (%) / Co[illegible]	Co-Ins[illegible] (%) / Co[illegible]	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-Ins[illegible] (%) / Co[illegible]	Co-Insurance (%) / Co-pay ($)	Co-Insurance (%) / Co-pay ($)	Co-Insu[illegible] (%) / Co[illegible]	Co-Insurance (%) / Co-pay ($)
Preventive (Prev)	$0	$0	$0	[illegible]	$0	$0	[illegible]0	[illegible]0	$0	$0	$0	[illegible]0	$0	$0		$0
Office Visit (OV): PCP or Mental Health (PCP/MH)	$10	$15	$25	Ded.[illegible]en $35	Ded., then 10%	Ded., then 10%	Ded.[illegible]en 50%	De[illegible] then 50%	3 visits per person (up to 9 per family) with no cost-share; then deductible applies with co-pay of $20 (Gold) or $30 (Silver)		Ded., then $0	Ded[illegible]hen $0	$15	$25	Ded., [illegible]n $40	Ded., then $0
Specialist[2]	$30	$30	$65	Ded.,[illegible]en $90	Ded., then 25%	Ded., then 25%	Ded[illegible]th[illegible]n 50%	De[illegible], th[illegible]n 50%	Ded., then $30	Ded., then $50	Ded., then $0	De[illegible]en $0	$30	Ded., then $60	Ded., [illegible]n $100	Ded., then $0
Urgent Care (UC)	$40	$45	$60	Ded., [illegible]n $100	Ded., then 25%	Ded., then 25%	De[illegible] th[illegible]n 50%	D[illegible], th[illegible] 50%	Ded., then $30	Ded., then $50	Ded., then $0	De[illegible]en $0	Ded., then $45	Ded., then $60	Ded., [illegible]n $100	Ded., then $0
Ambulance (Amb)	$50	$50	$100	Ded.,[illegible]n $100	Ded., then 25%	Ded., then 25%	De[illegible] th[illegible] 50%	D[illegible], th[illegible] 50%	Ded., then $30	Ded., then $50	Ded., then $0	De[illegible]en $0	Ded., then $50	Ded., then $100	Ded.,[illegible]n $100	Ded., then $0
Emergency Room (ER)[8]	$100	$150	Ded., then $250	Ded.[illegible]n 50%	Ded., then 25%	Ded., then 25%	De[illegible], the[illegible] 50%	D[illegible]., the[illegible] 50%	Ded., then $250	Ded., then $400	Ded., then $0	De[illegible]., t[illegible]en $0	Ded., then $250	Ded., then $250	Ded.[illegible]th[illegible] 50%	Ded., then $0
Hospital Services[4]: Inpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded[illegible]t[illegible]n 50%	Ded., then 25%	Ded., then 25%	D[illegible]., the[illegible] 50%	[illegible]d., the[illegible] 50%	Ded., then $500	Ded., then $1,500	Ded., then $0	D[illegible]d., t[illegible]n $0	Ded., then 20%	Ded., then 50%	Ded[illegible] th[illegible] 50%	Ded., then $0
Outpatient	Ded., then 10%	Ded., then 20%	Ded., then 40%	Ded[illegible]th[illegible]n 50%	Ded., then 25%	Ded., then 25%	D[illegible]., the[illegible] 50%	[illegible]d., the[illegible] 50%	Ded., then $500	Ded., then $1,500	Ded., then $0	D[illegible]d., th[illegible]n $0	Varies by service	Varies by service	Ded[illegible] the[illegible] 50%	Ded., then $0
Prescription (Rx) Drug Coverage	30-day supply	30-day supply	30-day supply	[illegible]-day [illegible]pply	30-day supply	30-day supply	[illegible]0-day su[illegible]y	30-day su[illegible]ly	30-day supply	30-day supply	30-day supply	[illegible]-day s[illegible]ply	30-day supply	30-day supply	[illegible]-day su[illegible]y	30-day supply
Rx Generic[5]	$5	$5	$15	De[illegible], th[illegible] $20	Ded.[9], then $10	Ded.[9], then $10	D[illegible]d.[9], then $12	[illegible]d.[9], the[illegible] $12	Ded., then $5	Ded., then $5	Ded.[9], then $5	D[illegible].[9], the[illegible] $25	$5	Ded., then $15	De[illegible], the[illegible] $20	Ded.[9], then $0
Rx Preferred Brand[5]	$50	Ded., then $50	Ded., then $60	De[illegible], th[illegible] $85	Ded.[9], then $40	Ded.[9], then $40	D[illegible]d.[9], then [illegible]0%	[illegible]d.[9], then [illegible]0%	Ded., then 40%	Ded., then 40%	Ded.[9], then 40%	D[illegible].[9], the[illegible] 40%	Ded., then $40	Ded., then 50%	De[illegible], then [illegible]90	Ded.[9], then $0
Rx Non-Preferred Brand[5]	50%	Ded., then 50%	Ded., then 50%	De[illegible], the[illegible] 50%	Ded., then 50%	Ded., then 50%	[illegible]d., then [illegible]%	[illegible]ed., then [illegible]%	Ded., then 60%	Ded., then 60%	Ded., then 60%	[illegible]d., then [illegible]0%	Ded., then 50%	Ded., then 50%	De[illegible], then [illegible]0%	Ded., then $0
Additional Benefits																
Wellness Benefits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Up to $300 in wellness rewards per adult				VBID Rx co-pay of $1/$3, up to $50 in wel[illegible]ss rewar[illegible]			N/A
Premiums by Tier[4]	Cost before subsidy	Cost before subsidy	Cost before subsidy	C[illegible] before s[illegible]sidy	Cost before subsidy	Cost before subsidy	[illegible]st before su[illegible]y	Cost before su[illegible]y	Cost before subsidy	Cost before subsidy	Cost before subsidy	[illegible]st before s[illegible]dy	Cost before subsidy	Cost before subsidy	C[illegible] before s[illegible]y	Cost before subsidy
Single: BCBSVT	$686.76	$603.29	$520.92	$440.8[illegible]	$515.81		$442.96		$582.30	$507.01	$553.14	$438.1[illegible]				
Single: MVP	$673.21	$602.52	$521.73	$408.1[illegible]		$491.74		$412.52					$586.08	$470.40	$406.28	$530.99
Couple: BCBSVT	$1,373.52	$1,206.58	$1,041.84	$881.6[illegible]	$1,031.62		$885.92		$1,164.60	$1,014.02	$1,106.28	$876.36				
Couple: MVP	$1,346.42	$1,205.04	$1,043.46	$816.20		$983.48		$825.04					$1,172.16	$940.80	$812.56	$1,061.98
Parent and Child(ren): BCBSVT	$1,325.45	$1,164.35	$1,005.38	$850.82	$995.51		$854.91		$1,123.84	$978.53	$1,067.56	$845.69				
Parent and Child(ren): MVP	$1,299.30	$1,162.86	$1,006.94	$787.63		$949.06		$796.16					$1,131.13	$907.87	$784.12	$1,024.81
Family: BCBSVT	$1,929.80	$1,695.24	$1,463.79	$1,238.76	$1,449.43		$1,244.72		$1,636.26	$1,424.70	$1,554.32	$1,231.29				
Family: MVP	$1,891.72	$1,693.08	$1,466.06	$1,146.76		$1,381.79		$1,159.18					$1,646.88	$1,321.82	$1,141.65	$1,492.08

BCBS Prescription drug data:
2.1% hit VT prescription drug limit

2015 Pharmacy Claims	Number of Subscribers	Total out of pocket for Rx	Total BCBSVT paid for Rx
Subscriber NOT reaching VT prescription drug limit	52,628	$8,080,630 = $154 annually per subscriber	$43,360,816 = $824 annually per subscriber
Subscriber reaching VT prescription drug limit	1,140	$1,430,200 = $1,255 annually per subscriber	$15,729,879 = $13,798 annually per subscriber
Total	53,768	$9,510,830 = $177 annually per subscriber	$59,090,695 = $1,099 annually per subscriber

MVP Prescription drug data: 1.9% hit VT prescription drug limit

	2015	% of 2015 Avg. Eligibility
Unique members who met individual VT prescription drug limit ($1300)	218	1.58%
Unique members who met family VT prescription drug limit ($2600)	64	0.46%
Unique families who met VT prescription drug limit ($2600)	47	0.57%
Total unique members who met prescription drug limit	264	1.91%

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Act 165 Requirements

- Vermont's prescription drug limit conflicts with federal requirements for AV level and/or maximum medical out of pocket costs, jeopardizing bronze plans
- Options for legislature
  - 1332 Waiver
  - No bronze plans
  - Stakeholder group
  - Change inflation factor
  - Special fund
  - Review and reduce other pressures on AV and medical out-of-pocket maximum

Option #1: 1332 Waiver

Current legislation enables VT to apply for waiver, but for federal approval, VT will need **further legislation** to address the following:

- Affordability
- Number of people covered
- Federal deficit neutrality

Option #1: 1332 Waiver

VT's prescription drug limit must meet 1332 Waiver "guardrails"

- coverage that is at least as comprehensive as would be provided absent the waiver
- coverage and cost sharing protections that keep care at least as affordable as would be provided absent the waiver
- coverage to at least a comparable number of residents as would be provided coverage absent the waiver
- will not increase the Federal deficit

Option #1: 1332 Waiver

- Affordability
  - Increased AV level increases premiums, unless VT makes up difference
  - Increase to maximum out-of-pocket is less affordable, unless VT makes up difference
- Number of people covered
  - Fewer people will be covered if plans are less affordable
- Federal deficit neutrality
  - Increased AV level increases federal subsidy in form of premium tax credit, unless VT makes up difference
  - Increase to maximum out-of-pocket creates increase in federal subsidy in form of cost sharing reduction, unless VT makes up the difference

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Option #2: No bronze plans

- At some point, bronze plans will not comply with federal law
- States are not required to offer bronze plans on the Exchange
- VT could have an Exchange with VT prescription drug limit in place and no bronze plans
- NOTE: eventually, this issue will affect silver and gold plans.
  - Federal law requires Exchanges to offer silver and gold plans

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Option #3: Stakeholder plan design

- A broad-based stakeholder group consisting of representatives from all VHC issuers (BCBSVT, MVP, NEDD), VLA, Vermont Cancer Society, AIDS advocates, VHC Outreach & Education, VHC navigator, DFR, GMCB is currently designing an alternative plan that does not have the prescription drug limit
- To date, stakeholders have expressed particular interest in Bronze plan designs emphasizing:
  - Driving care to medical office setting, instead of outpatient hospital with higher cost-share, through reduced-cost and/or pre-deductible primary care/MH/SA visits
  - Incentives to utilize generic Rx, also with flexibility around overall deductible
- Legislature provides guidance to stakeholder group to design plans that address prescription drug costs without violating federal law
  - These plans would replace VT prescription drug limit for small group and individual plans ONLY– limit would stay in place for large group

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Option #4: Change the inflation factor

- Right now, VT's prescription drug limit is tied to the minimum deductible for high-deductible health plans that qualify for HSAs.
  - This limit has not increased for 3 years, further exacerbating pressure on federal AV level and medical out-of-pocket maximum requirements
- Tie VT prescription drug limit to inflator more in line with health care costs
  - Examples: federal inflation factor for medical out-of-pocket maximum, percentage increase in second lowest cost silver plan, actuarial analysis of prescription drug increase year over year, etc.
- More analysis needed

Option #5: Special fund

- Do not have prescription drug limit in VHC plan designs, but provide special fund that can reimburse individuals who surpass the VT prescription drug limit
- Would likely require application process
- Would likely require additional admin and operations at DVHA
- Needs further analysis

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Option #6: Review and reduce other pressures on AV and medical out-of-pocket maximum

- Examine and adjust other Vermont cost-sharing requirements to give the prescription drug limit more room, to the extent VT covers more than what federal law requires:
  - early childhood developmental disease parity
  - victims of sexual assault
  - mental health parity
  - contraceptive coverage
  - mammograms
  - colorectal cancer screening
- Would need further analysis

Next steps

- Act 165 requirement to do a 1332 Waiver application by March 1st is premature
  - application will likely be rejected by the federal government due to affordability, persons covered, and federal deficit neutrality issues
  - New guidance from feds indicate that waiver is more time- and resource- intensive than previously thought
  - Recent federal proposed rules allow bronze plan AV levels to go up 5% to 65% for 2018 plan year, which buys time
- Recommendation: use session to examine stakeholder plan designs and determine next steps

Appendix: Provisions that can be waived with 1332 Waiver

- Part I of Subtitle D of Title I of the Affordable Care Act (relating to establishing qualified health plans (QHPs));

  Sec. 1302. Essential health benefits requirements

  - **1302(c): out of pocket maximum**
  - **1302(d): actuarial value**
- Part II of Subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health insurance marketplaces);
- Sections 36B of the Internal Revenue Code and 1402 of the ACA (relating to premium tax credits and cost-sharing reductions for plans offered within the marketplaces);
- Section 4980H of the Internal Revenue Code (relating to employer shared responsibility); and
- Section 5000A of the Internal Revenue Code (relating to individual shared responsibility).

Appendix: 1332 Waiver requirements

- The list of provisions the state seeks to waive, including the rationale for the specific requests;
- Data, assumptions, targets, and other information sufficient to determine that the proposed waiver will provide coverage that is at least as comprehensive as would be provided absent the waiver, will provide coverage and cost sharing protections that keep care at least as affordable as would be provided absent the waiver, will provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver, and will not increase the Federal deficit;
- Actuarial analyses and actuarial certifications to support State estimates that the waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement;
- A detailed 10-year budget plan that is deficit neutral to the Federal government;
- A detailed analysis of the impact of the waiver on health insurance coverage in the state;
- A description and copy of the enacted state legislation providing the state authority to implement the proposed waiver; and,
- A detailed plan as to how the state will implement the waiver, including a timeline.