III.

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

June 25, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight, HHS
HHH Building, Room 738 G
200 Independence Avenue, SW
Washington DC 20201

Re: Preliminary High Risk Pool Proposal

Dear Mr. Angoff:

Attached is a preliminary proposal for a potential way that Vermont could access the funding allocated to Vermont pursuant to the Patient Protection and Affordable Care Act Section 1101. Although we are committed to working with our federal partners to establish a successful program, we note that operational realities of such a program may ultimately result in a program which the state cannot support.

Vermont has been a leader in promoting health care access to its residents. In fact, many of the federal reforms being implemented will require the rest of the nation to abide by laws and practices which have long been in place in Vermont. However, because of our proactive approach to health care, we are struggling to develop a program under PPACA § 1101 which utilizes the available funding efficiently. As we note in our memo, we believe this funding could help many more Vermonters and provide far more relief if we could use it to enhance our current programs.

We look forward to your comments regarding the attached proposal. Please contact myself at (802) 828-2380 or Christine Oliver at (802) 828-2919 with any questions.

Sincerely,

Michael S. Bertrand
Commissioner

cc: Governor James H. Douglas

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MEMORANDUM

To: U.S. Department of Health and Human Services

From: Christine M. Oliver, Vermont Division of Health Care Administration
Deputy Commissioner

Date: June 25, 2010

Re: **Federally Funded High Risk Pool Proposal**

This memo outlines Vermont's preliminary proposal for accessing funding authorized pursuant to Section 1101 of the Patient Protection and Affordable Care Act of 2010. We do not believe this proposal utilizes the federal dollars for Vermonters in the most efficient or effective manner, however, after extensive conversations with officials in the Department of Health and Human Services, it seems to be the only approach that will be acceptable to the Federal Government.

Like several other states that have taken steps in recent decades to expand health care coverage to our citizens, we have found the development of this proposal to be a challenge. Our preference would have been to use these funds to enhance existing programs, which we believe would have benefited more Vermonters. With that, we note this is a preliminary proposal. As we work to finalize the specific details relating to this proposal, it is possible that unanticipated obstacles may result in the creation of a program which is not in the best interests of the state, in which case Vermont will not be able to sign a contract for this program.

CURRENT VERMONT INSURANCE MARKET

In Vermont, since 1992, health insurers in the small group and nongroup market have been required to guarantee acceptance of all insureds. 8 V.S.A. §§ 4080a and 4080b.[1]

[1] Vermont statutes are available on-line at http://www.leg.state.vt.us/statutes/statutes2.htm.

Thus, Vermont has no individuals that are denied insurance because of a health condition – the specific population targeted in PPACA § 1101. However, in both the small group and nongroup market, some preexisting condition exclusions are allowed.[2]

In 2005, the Vermont State Legislature and the Governor passed a law creating Catamount Health, a product designed to provide lower cost high quality health insurance to the uninsured. 8 V.S.A. § 4080f. Catamount Health is a public-private partnership. Vermont's two registered nongroup health insurers (Blue Cross Blue Shield of Vermont and MVP Health Insurance Company) enroll those eligible for Catamount. These carriers administer benefits and pay providers as with a traditional insurance plan.

Catamount premiums, however, are subsidized by the state, up to 300% of the federal poverty level. Premiums are subsidized with a combination of state and federal funds, in accordance with Vermont's Medicaid section 1115 waiver. The Vermont Medicaid Office, the Office of Vermont Health Access,[3] determines the level of premium subsidy to which an individual is entitled. After receiving premium assistance approval, the individual then enrolls in the Catamount insurance plan through the carrier of his or her choice. As income levels fluctuate, mechanisms are in place to move people between Catamount, Vermont Health Access Plan, and traditional Medicaid. This is intended to be as streamlined as possible.

Catamount benefits are largely dictated by the legislation which created the program and are generally considered high quality. Catamount carriers must provide coverage for "primary care, preventive care, chronic care, acute episodic care, and hospital services." 8 V.S.A. § 4080f(c). Cost-sharing is dictated by statute. Currently, Catamount health plans have a $250 deductible for an individual ($500/family) for in-network and $500 for out-of-network ($1,000 for a family).[4] Catamount provides for 20% co-insurance in-and out-of-network and a $10.00 office co-payment. Prescription drugs are provided without a deductible, but are subject to a co-pay ($10 for generic drugs, $30 for drugs on the preferred drug list, and $50 for nonpreferred drugs). As provided in statute, Catamount cost sharing is capped at $800 ($1,500 for a family) for in-network services and at $1,500 for out-of-network costs ($3,000 for a family). Prescription drug payments do not count toward out-of-pocket maximums. The actuarial value of the plan has been calculated at 83%.

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[2] Both small group and nongroup carries are allowed to impose preexisting condition exclusions up to 12 months. In the small group market, the "look back" period is limited to 6 months, in the nongroup period it is 12 months. Such exclusions are not allowed with evidence of sufficient continuous creditable coverage. See 8 V.S.A. §§ 4080a(g) and 4080b(g).

[3] Vermont's Office of Vermont Health Access will become the Department of Vermont Health Access effective July 1, 2010.

[4] Catamount deductibles and some cost-sharing are scheduled to be increased for policies renewing on or after October 1, 2010.

For preventive services all cost-sharing is waived. Additionally, all cost sharing is waived for chronic care if the insured individual is actively participating in a carrier's chronic care management program.[5] Although Catamount Health has a pre-existing condition exclusion, such exclusion,[6] is waived for chronic care if the individual is actively participating in the chronic care management program.

In order to facilitate affordability, the Catamount Health provider reimbursement is less than that typically provided by commercial insurers. By statute, Catamount Health insurers pay health care professionals 110% of Medicare reimbursement. Hospitals charges are calculated using a cost-to-charge ratio approved by the Health Care Administration Division adjusted for each hospital to ensure payments are at 110% of a hospital's actual cost to provide the service.

Catamount premium rates are filed for approval with the Health Care Administration Division and must be approved prior to implementation. "A rate shall be approved if it is sufficient not to threaten the financial safety and soundness of the insurer, reflects efficient and economical management, provides Catamount Health at the most reasonable price consistent with actuarial review, is not unfairly discriminatory, and" otherwise complies with the law. 8 V.S.A. § 4080f(g)(2). Currently, the full price cost of Catamount for an individual $442.25 for an individual. Subsidized premiums range from $60 to $208 for individual coverage per month.

In order to be eligible for Catamount Health, a person must be uninsured for twelve months or subject to one of the exceptions. There are numerous exceptions to the 12 month uninsured requirement, but exceptions include losing coverage due to loss of employment, a divorce, death or aging off a parent's plan. 8 V.S.A. § 4080f(a)(9). As of March 2010, Catamount Health had 11,488 enrollees.[7]

HIGH RISK POOL PROPOSAL

Ideally, Vermont would have chosen to use the federal funds allocated to Vermont to enhance existing programs. We believe this would have allowed the most people to benefit from the federal funding. However, current state legislation authorizing us to make the necessary changes to Catamount requires that such changes be budget neutral. Because HHS has interpreted the federal statute to prohibit the use of federal

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[5] In the Catamount program, chronic care management programs are mandated for certain conditions and must be approved by the state. Such programs must be consistent with Vermont's Blueprint for Health, a multi-faceted program currently focusing on medical homes, community health teams, wellness and prevention. See the 2009 Annual Report at: http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf

[6] By statute, pregnancy is not a pre-existing condition.

[7] Of these, only 1,733 pay full price, not subsidized premium. Please note that all children in Vermont under 300% of the poverty level are enrolled in Vermont's Dr. Dynasaur. As such, very few children are currently enrolled in Catamount.

dollars to fund any existing state assumed risk or risk assumed beyond that mandated by statute, there is no way to enhance the Catamount program without some negative impact on the state budget. Furthermore, we have concerns that trying to use the federal funding within existing programs, but only for individuals eligible for the high risk pool funding, may be prohibitively expensive from an administrative perspective.

As such, Vermont is proposing to create a separate pool of insureds comprised of "eligible individuals" as described below.

The state, in partnership with BCBSVT, [8] would create a risk pool which would be modeled on Catamount, but without the state subsidy. The coverage would be identical to Catamount, except that there would be no pre-existing condition exclusion. Provider networks and reimbursement would be the same as current Catamount. The premium charged for the product would be the Catamount full cost premium.[9] Catamount is a pure community rated product – there is no deviation in rates for age or any other factor.

In order to be eligible for the new program, individuals would have to be citizens of the U.S., would have to have been uninsured for at least six months, and would have to have a pre-existing condition.[10] There would be no allowance for exceptions to the uninsured requirement as there is in current Catamount. BCBSVT would manage eligibility determinations. Uninsured status would be established through self-certification.[11] Citizenship would be established as directed by HHS. The method of establishing a preexisting condition is yet to be determined, but would likely involve identifying such condition on the application.

It is expected the federal funding would cover all of the claims costs which were not supported by the premiums collected, as well as BCBSVT's administrative costs of administering the program. The program would include a mechanism whereby enrollment would be halted if it appeared that the $8,000,000 in federal funding was going to be exhausted before January 1, 2014. If the program ran out of funding, or appeared to be ready to run out of funding, enrollees would automatically be enrolled into the current nongroup market.

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[8] BCBSVT is a nonprofit medical service corporation

[9] As noted, the current Catamount individual premium is $442.25. Carriers are allowed to seek increases in of the premium on a quarterly basis, although an individual's premium rate is guaranteed for twelve months and does not change until renewal.

[10] We are still analyzing how best to define pre-existing condition.

[11] Catamount uninsured status is established through self-certification. However, both carriers check applicants against past insureds. BCBSVT has a sufficiently large market share, that such cross check is reasonably effective in ensuring that individuals have been uninsured. Cross checks have not revealed any significant fraud in this area.

Taking this approach is not ideal. Not being able to leverage the $8,000,000 in our current programs and the Catamount risk pool means that far less people will benefit from the federal dollars. However, because the federal funds under current statutory interpretation appear to be unavailable for any currently assumed state risk or risk beyond the federally defined "eligible individual," attempting to leverage our current programs would result in a negative impact on the state budget, is not permitted under current state law, and is contrary to Vermont's interests especially in these difficult economic times. In addition, we are uncertain whether there is a viable target population for this program. Furthermore, it is unclear how this program will impact current risk pools. It is possible the amount of money allocated to Vermont will not be sufficient to cover the target population, particularly since we cannot pool the risk with better risk to offset high cost individuals.

Finally, there are elements of unfairness associated with the introduction of this product. For example, those individuals who have elected to purchase Catamount, but are subject to the pre-existing condition limitation, will not have access to this federally subsidized coverage.

Notwithstanding its limitations, Vermont intends to proceed with a high risk pool application in accordance with the conceptual proposal outlined above, and subject to Vermont's acceptance and execution of the terms of a contract.

Act 156 of 2010

Sec. E.230 FEDERAL HEALTH CARE GRANT FUNDING TO SUPPORT CATAMOUNT HEALTH

(a) It is the intent of the general assembly that the state maximize federal funding opportunities to expand access to health care coverage for uninsured and underinsured Vermonters. The general assembly is aware of upcoming federal funding opportunities related to the creation of a high-risk pool and supports using the Catamount Health program, to the extent practicable, to leverage applicable federal funds while keeping eligibility standards consistent across all of the state's health care programs.

(b) The commissioner of banking, insurance, securities, and health care administration shall notify the members of the joint fiscal committee by telephone and provide the members with a copy of the application by electronic mail prior to applying for federal funding under the high-risk health insurance pool program authorized by Section 1101 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, for the purpose of supporting the Catamount Health program or the market security trust provided for in 8 V.S.A. § 4062d. If feasible given the federal time lines, the commissioner shall make reasonable efforts to provide notice, a copy of the application, and an opportunity for the members to respond at least 3 business days prior to the application deadline.

(c)(1) Notwithstanding 32 V.S.A. § 5, and with the approval of the secretary of administration, the commissioner of banking, insurance, securities, and health care administration shall request approval from the joint fiscal committee to accept federal funding under the high-risk health insurance pool program authorized by Section 1101 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, for the purpose of supporting the Catamount Health program or the market security trust provided for in 8 V.S.A. § 4062d.

(2) The commissioner of banking, insurance, securities, and health care administration shall provide the joint fiscal committee with information on whether the proposal is budget neutral or financially beneficial to the state, as determined by the commissioner in consultation with the commissioner of the department of Vermont health access. If the grant meets the criteria under this subsection and notwithstanding 32 V.S.A. § 5, the commissioner may accept the grant after approval by a majority of voting members of the joint fiscal committee.

(d) Upon approval by the joint fiscal committee as part of the review under subsection (c) of this section or at a later meeting and notwithstanding 8 V.S.A. § 4080f (Catamount Health), 33 V.S.A. § 1973 (Vermont health access program), 33 V.S.A. § 1974 (employer-sponsored insurance assistance program) and 33 V.S.A. Chapter 19, Subchapter 3A (Catamount Health assistance program), the commissioner of banking, insurance, securities, and health care administration and the secretary of human services may waive the statutory requirements establishing the 12-month uninsured requirement and the pre-existing condition exclusion provisions if necessary to permit the state to accept grant funds under the federal high-risk pool program. The request to waive the statutory requirements shall specify a time period ending no later than June 30, 2011.