Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System

Report Appendices

Submitted by Governor Peter Shumlin to the Vermont State Legislature December 30, 2014

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Appendix A-1: 5-Year Comparison of Vermont Populations under ACA and GMC

	2017		2018		2019		2020		2021	
	ACA	GMC	ACA	GMC	ACA	GMC	ACA	GMC	ACA	GMC
Non-group Insurance	49,000	-	51,000	-	50,000	-	49,000	-	49,000	-
Medicaid Primary	141,000	-	142,000	-	141,000	-	141,000	-	140,000	-
Employer Sponsored Insurance	296,000	31,000	289,000	15,000	287,000	2,000	286,000	2,000	283,000	2,000
Private ESI	216,000	31,000	212,000	15,000	211,000	2,000	210,000	2,000	208,000	2,000
State ESI	26,000	-	26,000	-	26,000	-	25,000	-	25,000	-
Local ESI	14,000	-	14,000	-	13,000	-	13,000	-	13,000	-
Muni ESI	40,000	-	38,000	-	37,000	-	37,000	-	37,000	-
Federal Government Employee Insurance	10,000	-	10,000	-	10,000	-	10,000	-	10,000	-
Uninsured	17,000	-	18,000	-	18,000	-	18,000	-	18,000	-
Medicare	140,000	140,000	144,000	144,000	148,000	148,000	152,000	152,000	156,000	156,000
Individuals Supplementing Medicare	36,000	36,000	37,000	37,000	38,000	38,000	39,000	39,000	41,000	41,000
Medicaid/GMC Medicare Supplementation	37,000	37,000	37,000	37,000	38,000	38,000	39,000	39,000	40,000	40,000
Employer Medicare Supplementation	22,000	22,000	23,000	23,000	24,000	24,000	25,000	25,000	25,000	25,000
Military Insurance	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
GMC Enrollment	-	519,000	-	533,000	-	544,000	-	542,000	-	538,000
Population of Commuters in on GMC	61,000	61,000	64,000	64,000	66,000	66,000	66,000	66,000	65,000	65,000

Appendix A-2: Coverage for Vermont Populations under GMC

Description	Primary Coverage	Secondary Coverage	Contribution to GMC	Considerations
Medicare:				
Seniors (over age 65)	Medicare	Vermont's Current Medicare wrap programs, such as VPharm, QMB, and SLMB would stay the same.	None	Medicare Supplemental Insurance would remain available.
Individuals with disabilities (over 24 months)	Medicare	Vermont's Current Medicare wrap programs, such as VPharm, QMB, and SLMB would stay the same.	None	Medicare Supplemental Insurance would remain available.
Military:				
Active duty military[1]	TRICARE	None while on TRICARE	None while on TRICARE	GMC coverage is suspended. GMC would be available as soon as the individual drops or is no longer eligible for coverage. Individuals who are eligible for enhanced benefits from Medicaid would maintain enhanced benefits through GMC.

[1] In order for TRICARE to be primary coverage, a state statutory change is needed. This is because, under federal law, TRICARE is always secondary, except to Medicaid.

Description	Primary Coverage	Secondary Coverage	Contribution to GMC	Considerations
National Guard	TRICARE, while on active duty	None while on TRICARE	None while on TRICARE	Vermonters with the Guard would have GMC coverage while not on active duty & can suspend that coverage during the time period they are on active duty.
Veterans	VA insurance, if applicable	None while using VA insurance	None while using VA insurance	Insurance provisions expire in August 2017 or sooner.[2] Veterans may use the VA Hospital for services as well, but are not required to under GMC.
Public employees:				
Federal employees taking federal insurance (FEHB)	Federal employee insurance	GMC	Full contribution	
State employees	GMC	Depends on bargaining agreement	Full contribution	
Public education employees	GMC	Depends on bargaining agreement	Full contribution	
Municipal employees	GMC	Depends on bargaining agreement	Full contribution	
Employees in the private sector:				
Employees not taking private employer sponsored insurance (ESI)	GMC	N/A	Full contribution	

[2] Veterans Access, Choice, and Accountability Act of 2014 § 101(p) states that the Veteran's Choice program will end after amounts in Veteran's Choice Fund are exhausted or after three years from enactment, whichever is first. The bill was enacted on August 7, 2014.

Description	Primary Coverage	Secondary Coverage	Contribution to GMC	Considerations
Employees taking private employer sponsored insurance (ESI)	ESI	GMC	Full contribution	
Non-residents working for a Vermont employer	GMC, ESI, or Exchange coverage from state of residence	N/A	Optional contribution	Non-residents working for a Vermont employer may purchase GMC coverage.
Retirees:				
Retiree not on Medicare with no other coverage	GMC	N/A	Full contribution	
Retiree not on Medicare with private employer coverage	Employer retiree coverage	N/A	No contribution	GMC creates a ten year window where non-Medicare retirees with employer coverage are exempt from GMC coverage and taxes.
Retiree on Medicare	Medicare or retiree plan	Medicare supplemental or retiree plan	No contribution	
Resident state or education employee retiree	GMC if not on Medicare, otherwise, Medicare	Depends on bargaining agreement, but retirees on Medicare will have state retiree plan	Full contribution to GMC if not on Medicare, otherwise no contribution	

Description	Primary Coverage	Secondary Coverage	Contribution to GMC	Considerations
Non-resident state or education employee retiree	State retiree plan if not on Medicare, otherwise, Medicare	If on Medicare, state retiree plan	No contribution to GMC	

Appendix A-3. Legislative Council Memorandum on Residency

MEMORANDUM

To: Senate Health & Welfare Committee

From: Robin Lunge, Bill Russell

Date: April 6, 2006

Subject: Durational Residency Requirements for Health Care Coverage

The U.S. Supreme Court has imposed strict constitutional limits on the imposition of residency requirements as a condition for receipt of state benefits. In short, a state may establish residency requirements to insure that benefits of state citizenship inure only to citizens of the state. However, *durational residency requirements* – those that require a period of residency in the state prior to receipt of benefits – are extremely problematical and probably prohibited.[1]

The Court's decisions are based on a constitutional "right to travel" protected by both the Equal Protection Clause of the 14th Amendment and the Privileges or Immunities Clause of that amendment.[2]

Equal Protection Cases

In the earlier cases decided in the 1970s, the Court's holding was based on the Equal Protection Clause. In those cases, the court found that the right to travel was such a fundamental right that it would apply a "strict scrutiny" analysis to balance the purported governmental justification underlying any state residency requirement with the burden of that right. Significantly, based on that analysis, the Court struck down an Arizona statute which required one year of residency within the county as a condition of eligibility for non-emergency medical care at public expense. The Court held that restricting medical care for indigents from other states severely burdened the right to travel under the Equal Protection Clause.[3]

However, in some of the Court's Equal Protection Clause decisions in the decade of the 1970s, a durational residency requirement was upheld because the right to travel was

[1] Durational requirements would include any restrictions in coverage of pre-existing conditions and requirements for "credible coverage" (defined in ERISA and HIPAA) which apply only to recent residents of Vermont.

[2] Although the word "travel" is found nowhere in the text of the Constitution, the Court found that the "right to travel from one state to another is firmly embedded in our jurisprudence." In fact, "the right is so important that it is a virtually unconditional personal right, guaranteed by the constitution to us all." *Saenz v. Roe,* 526 U.S. 489, 498 (1999)

[3] *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974).

apparently not sufficiently burdened by those requirements. These decisions are not easily reconcilable. They include upholding durational residency requirements for the following:

In-state college tuition rates. "The state can establish such reasonable criteria for in-state status as to make virtually certain that students who are not in fact bona fide residents of the state, but have come there solely for educational purposes, cannot take advantage of the in-state rates."[4]

Divorce. The Court upheld a one-year residency requirement for the ability to obtain a divorce in state courts.[5]

Voting in political party primaries. The Court upheld political party registration restrictions that amounted to a durational residency requirement for voting in primary elections.[6]

Privileges or Immunities Cases

However, whatever possibility that may have existed for sustaining some durational residency requirements under the 14th Amendment's Equal Protection Clause (above) seems to have been foreclosed by the Court's more recent rulings under the Privileges or Immunities Clause.

The controlling decision is *Saenz v. Roe*, 526 US 489 (1999), in which the U.S. Supreme Court struck down a California statute imposing durational residency requirements by limiting welfare benefits in a recipient's first year of residency to the amount of benefits that the recipient would have received from the state of former residence. In this decision, the Court asserted and expanded upon the "right to travel." It includes "for those travelers who elect to become permanent residents, the right to be treated like other citizens of that state."[7] It is therefore constitutionally impermissible for a state to establish two classes of benefits for new and older residents. Newly arrived citizens have the same right to enjoy the "privileges or immunities" as other citizens of the same state. This "citizenship clause" does not allow for degrees of citizenship based on length of residence.[8]

In short, "it appears that the Court's invocation of the Privileges or Immunities Clause prohibits durational residency requirements in every context."[9] In dissent, Chief Justice Rehnquist eschewed this rationale based on creating a "conflated" right to travel. The

[4] *Vlandis v. Kline*, 412 U.S. 441(1973).
[5] *Sosna v. Iowa*, 419 U.S. 393 (1975).
[6] *Rosario v. Rockefeller*, 410 U.S. 752 (1973).
[7] *Saenz v. Roe*, 526 US 489, 500 (1999)
[8] Id. at 504.
[9] Id. at 514-516, (Rehnquist, C.J, dissenting) (stating that virtually all classifications of citizenship based on the length of state residency will violate the Privileges and Immunities Clause of the 14th Amendment).

right, he asserted, is properly defined as the right of a person to become a citizen of another state. There is no infringement on travel.

Chief Justice Rehnquist also stresses the irreconcilability of the Court's durational residency decisions. "If states can require individuals to reside in-state for a year before exercising the right to educational benefits, the right to terminate a marriage, or the right to vote in primary elections, then states may surely do the same for welfare benefits . . . he durational residency requirement challenged here is a permissible exercise of the state's power to assure that services provided for its residents are enjoyed only by residents."[10]

A "Wait and See" Approach

In California, Senate Bill 840 would provide comprehensive universal health care to all Californians, including undocumented residents, using a single-payer publicly financed mechanism. Included in the bill is the provision which, after two years of plan implementation, would give the commissioner the discretion to impose a waiting period on eligibility if the commissioner determines that "large numbers of people are emigrating to the state for the purpose of obtaining health care through the California Health Insurance System." (SB 840 §140200(c)(10)(G)). Additionally, the bill specifies that any implementation of a waiting period must be done on a statewide basis. (SB 840 §140204(d)).

Conclusion

Durational residency requirements in state legislation (those that distinguish among residents of a state based on length of residency) are difficult to support for at least two reasons.

First, if federal funds (such as Medicaid) are involved, federal requirements usually prohibit different classes of eligibility based on length of residence in the state.

Second, the U.S. Supreme Court has held that a citizen's "right to travel", protected by the 14th Amendment, is infringed by denying newly arrived residents the same benefits a state provides to longer term residents. Like any constitutional right, this right to travel is not absolute. Some infringement may be permissible, but only by a showing of an extremely compelling state interest.[11]

Applying these considerations to the health care legislation proposed last year:

We recommended no durational residency requirement for pharmaceutical programs in H.516. These programs intermingle federal funds. Also, while VT has provided

[10] Id. at 520 – but this of course is in dissent.

[11] In the most recent controlling decision, *Saenez v. Roe*, 526 US 489 (1996), California was unable to show that the fiscal savings to the state gained through a differential in welfare benefits paid to short term residents was not enough of a compelling state interest to justify infringing the right to travel.

generally better pharmaceutical benefits than most other states, there is little evidence that this has caused a migration into the state causing a significant enough fiscal impact to the state to justify infringing the right to travel. These programs would use Medicaid funds for their support.

We recommended a reasonable durational residency requirement for the House-passed universal access health care program in H.524. This program would be state funded; Medicaid would be separate. And, what is at stake is more than a minor impact on the state's finances; arguably there is a compelling state interest. The health care system, every citizen's medical care, the state's entire budget, and the state's economy as a whole may be impacted sufficiently to justify some infringement on the constitutional right to travel.

Appendix B-1: Detailed Information on Benefit Design

What are the benefits?

Benefits consist of three main components:

- Covered services
  - What services are paid for in whole or in part?
- Cost-sharing
  - How much does an individual pay out of pocket when they get services?
  - Do individuals pay out of pocket through co-pays, deductibles, or co-insurance?
- Network of health care providers
  - Are there restrictions on the specific providers an individual can use?

In creating benefit plan designs, we worked with consultants, including actuaries at Wakely Consulting Group, and reviewed the following information:

- health economic studies on impacts of cost-sharing,
- the current plans offered through Vermont Health Connect,
- the state employee plans,
- the plans offered to education employees through VEHI,
- anecdotal information from members of the public who were dissatisfied with the VHC plan choices, and
- public input provided in the benefits listening sessions conducted in 2012.[1]

In addition, we consulted with the Governor's Consumer Advisory Group on an on-going basis as plan designs were being developed. We also provided periodic updates to and sought input from the Governor's Business Advisory Group.

We used the following principles to focus our efforts throughout the benefit design process:

- Federal and state requirements for benefits
- Equity
- Administrative cost & complexity
- Options fit together, easy to explain
- Individual out of pocket cost (average & max)
- Medical cost & utilization
- Change from current/expected
- Federal & state tax implications

After applying the above principles to the research and various benefit designs, we concluded that GMC should provide Vermonters with coverage of the essential health

[1] A summary of the public input is available here: http://hcr.vermont.gov/public_engagement/benefits

benefits under the ACA at a 94 percent actuarial value (AV), a cost-sharing level similar to the Vermont state employee plan. The following discussion will break down each component of benefit design and explain how we made our determination of offering coverage of the essential health benefits at a 94 percent AV.

Overview of Legal Requirements for All Benefit Components

Federal law through the Affordable Care Act (ACA) and state law through Act 48 place certain legal parameters on the GMC benefit design. Under the ACA, the GMC benefit design's coverage must be as comprehensive and affordable or more comprehensive and affordable as the plans currently offered through Vermont Health Connect.[2]

Under Act 48, the GMC benefit design's coverage must be as comprehensive as Vermont's Catamount Health plan and at least as affordable as an 80 percent AV, which is the same as a gold plan on Vermont Health Connect.[3] Act 48 also requires that individuals with low incomes and children with family income under three times poverty will receive the covered services currently provided by Dr. Dynasaur[4] and Medicaid as of January 1, 2014.[5] This ensures that low and middle-income Vermonters will not be worse off under GMC than they are today. This means that GMC as one health care program would actually encompass two different plans: a plan for Vermonters who are eligible for Medicaid funding with the enhanced benefits that are offered today and the GMC plan for those that are not eligible for Medicaid funding. Because the Medicaid benefit was already determined as the same benefit offered as of January 1, 2014 through Act 48, we focused on the GMC benefit plan that would be offered to Vermonters who are not eligible for Medicaid funding.

Covered Services: Background

In order to get a waiver from the federal government under the ACA, GMC must cover all of the essential health benefits required by the ACA. The ACA requires the following 10 benefits to be covered:

- Ambulatory patient services (outpatient care without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Pregnancy, maternity, and newborn care (care before and after a baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs

[2] ACA § 1332.
[3] 33 V.S.A. § 1822 & 1825.
[4] Includes early periodic screening, diagnosis and treatment (EPSDT).
[5] 33 VSA 1825(b)

- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric dental and vision services

Currently, individuals and small businesses purchasing a Vermont Health Connect plan have an essential health benefit package, which was based on a benchmark plan. The benchmark plan was chosen from the most commonly purchased plans in 2012, so it includes Vermont's legally required insurance benefits. In Vermont, the Green Mountain Care Board (GMCB) chose a benchmark plan offered by Blue Cross Blue Shield of Vermont. This plan was then supplemented to ensure that the plan met the 10 required benefits described above. [6]

Table B-1.1., below, shows the differences between the covered services provided by plans in Vermont Health Connect to the individual and small group market versus covered services in plans for state employees and education employees. The fact that the figure shows only a few services with variations in coverage illustrates how similar covered services are across plans today.

Table B-1.1

	Essential Health Benefit	State Employee and Retirees		VEHI Education Employees and Retirees	
		SelectCare	Total Choice	300 Ded	VHP
Chiropractic	Limit 12 visits then prior approval required	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Prior approval required after 12th visit	Prior approval required after 12th visit
Infertility	Not covered	Up to $50,000 lifetime max	Up to $50,000 lifetime max	Not covered	Not covered
Fertility Drugs	Covered	Covered	Covered	Covered	Covered
Bariatric Surgery	Covered	Covered, medical necessity	Covered, medical necessity	With prior approval	With prior approval

[6] The details of this plan are provided in Appendix B-3.

	Essential Health Benefit	State Employee and Retirees		VEHI Education Employees and Retirees	
Routine Eye Exams	1/year for children	$100/2 years	$100/2 years	Not covered	1/year

Expansion of Covered Services
As required by Act 48, we determined cost estimates for additional covered services, specifically, adult dental, adult vision, hearing, and long-term care.

Adult Dental
Three scenarios were considered for adult dental coverage. In the first option, GMC only covers dental tiers I and II (preventive and restorative services) at 100% and 80% coverage respectively. In the second option, GMC covers dental tiers I, II, and III (preventive, restorative and major services) at 100%, 80% and 50% coverage respectively. Scenarios 1 and 2 reflect typical private dental insurance. The last scenario is the Vermont state employee plan.[7] Medicaid covers dental up to a $510 benefit maximum with $3.00 co-pay per visit. Only the *additional* costs of expanding the benefit are included here. Any GMC wrap of Medicaid assumes the co-insurance would not apply to Medicaid-eligible individuals but that the annual maximum, where applicable, would apply. For example, under the Vermont state employee plan scenario, Medicaid's $510 benefit maximum would be increased to $1,000 benefit maximum, providing increased coverage. Due to the unique nature of this coverage, our actuaries used a conservative estimate of administrative expenses at 7 percent.

The following tables show the total annual cost by scenario. Each table shows the additional PMPM and cost of dental coverage for all adults in GMC, except for non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage.[8]

[7] Additional benefits details for the Vermont state employee plan can be found at: http://humanresources.vermont.gov/salary/benefits/dental
[8] These cost analyses were developed prior to the Governor's final decisions and announcement not to pursue financing for GMC. These scenarios have not been updated to reflect the preferred population assumptions in the financing plan due to the cost of actuarial services. Including the additional populations would further increase the costs of providing these services.

Table B-1.2: Additional Cost of Alternative Adult Dental Scenarios ($ Millions)[9]

Dental Benefit Applies to Adults Only[10]	Scenario 1	Scenario 2	Vermont state employee plan
Coverage Levels			
Tier I - Preventive	100%	100%	100%
Tier II - Basic Restorative	80%	80%	80%
Tier III - Major Restorative	Not Covered	50%	50%
Deductible	Not Applicable	Not Applicable	$25 Deductible All Tiers
Annual Benefit Maximums	Not Applicable	Not Applicable	$1,000 Annual Max
Estimated Cost Impact (includes Administrative Costs)			
Commercial			
"Premium" PMPM	$34.85	$41.40	$29.86
Estimated GMC Adults	259,150	259,150	259,150
Total Cost	$108,400,000	$128,700,000	$92,900,000
Medicaid			
"Premium" PMPM	$8.81	$11.80	$7.77
Estimated GMC Adults	81,822	81,822	81,822
Total Cost	$8,600,000	$11,600,000	$7,600,000
Total 2017 Cost	**$117,000,000**	**$140,300,000**	**$100,500,000**

We also researched whether the health benefits from coverage of adult dental would mitigate increased costs, but the results were inconclusive. Studies have found periodontal disease bacteria associated with the following conditions:

- brain abscesses (Silva, 2004)

[9] This Table excludes non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage. See footnote above.

[10] These numbers are based on high level estimates of the utilization and unit cost of covered services. National and Vermont specific data was used where possible. There are limitations to the data including some unknown corresponding benefits, implicit selection in the data, and missing data due to annual maximums (claims often not submitted once benefit maximums are met). If we chose to include coverage, we would further refine these estimates. For example, a PMPM variance of plus or minus 15% would not be unreasonable given the quality of the data provided to our actuaries.

- pulmonary disease (Suzuki and Delisle, 1984)
- cardiovascular disease (Haraszthy et al., 2000)
- adverse pregnancy outcomes (Offenbacher et al., 2006; Scannapieco et al., 2003b; Tarannum and Faizuddin, 2007; Vergnes and Sixou, 2007)
- respiratory disease (Scannapieco and Ho, 2001)
- cardiovascular disease (Blaizot et al., 2009; Janket et al., 2003; Paraskevas, 2008; Scannapieco et al., 2003a; Slavkin and Baum, 2000)
- coronary heart disease (Bahekar et al., 2007)
- diabetes (Chávarry et al., 2009; Löe, 1993; Taylor, 2001; Teeuw et al., 2010)

Despite these findings, it has been noted that "…the relationship between periodontal disease and these systemic diseases is not well understood, and there is conflicting evidence about whether periodontal treatment affects outcomes for these systemic conditions."[11]

A recent study has found positive outcomes associated with dental care for individuals who have cerebral vascular disease (stroke), coronary artery disease (heart disease), Type II Diabetes, or who are pregnant; however, the study "did not prove that the dental treatment has a beneficial effect beyond the mouth."[12] Due to these findings and its added costs, we decided to focus our efforts on reducing out of pocket costs for major medical for the first phase of GMC and to revisit the issue of covering adult dental at a later phase.

Adult vision

Adding coverage for adult vision is also an option for GMC. This benefit would cover exams and hardware once a year, which is consistent with the federal employee benefits. Due to the unique nature of this coverage, our actuaries used a conservative estimate of administrative expenses at 7 percent.

The following tables show the total annual cost by scenario. Each table shows the additional PMPM and cost of vision coverage for all adults in GMC, except for non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage.[13]

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[11] "2 Oral Health and Overall Health and Well-Being." Advancing Oral Health in America. Institute of Medicine Washington, DC: The National Academies Press, 2011, pg. 33, citing (Beck et al., 2008; Fogacci et al., 2011; Jeffcoat et al., 2003; Lopez et al., 2002, 2005; Macones et al., 2010; Michalowicz et al., 2006; Newnham et al., 2009; Offenbacher et al., 2006, 2009; Paraskevas et al., 2008; Polyzos et al., 2009, 2010; Sadatmansouri et al., 2006; Simpson et al., 2010; Tarannum and Faizuddin, 2007; Teeuw et al., 2010; Uppal et al., 2010).

[12] "Impact of Periodontal Therapy on General Health," Jeffcoat, Marjorie K. et al., American Journal of Preventive Medicine , Volume 47 , Issue 2 , 166 – 174, 2014.

[13] These cost analyses were developed prior to the Governor's final decisions and announcement not to pursue financing for GMC. These scenarios have not been updated to reflect the preferred population

Table B-1.3: Additional Cost of Adult Vision ($ Millions)[14]

Vision Benefit Applies to Adults Only	FEDVIP - BlueVision High Plan
Diagnostic	
Eye Exam	limit 1 / yr
Eyewear	
Lenses	limit 1 pair / yr
Frames	limit 1 pair / yr $150 allowance
Contact Lenses	limit 1 / yr $150 allowance in lieu of eyeglasses ($600 for medically necessary)
Estimated Cost Impact (includes Administrative Costs)	
Commercial	
"Premium" PMPM	$7.80
Estimated GMC Adults	259,150
Total Cost	$24,300,000
Medicaid (hardware only)	
"Premium" PMPM	$4.73
Estimated GMC Adults	81,822
Total Cost	$4,600,000
Total 2017 Cost	**$28,900,000**

Similar to dental, we decided to focus our efforts on reducing out of pocket costs for major medical for the first phase of GMC and, therefore, would not recommend adult vision coverage at this time. As noted above, a large portion of the pediatric population would have vision coverage under the recommended coverage.

<u>Hearing benefits</u>

assumptions in the financing plan due to the cost of actuarial services. Including the additional populations would further increase the costs of providing these services.

[14] This Table excludes non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage. See footnote above.

We also looked into covering hearing benefits. This benefit was modeled off of other public and commercial hearing coverage. It includes a $20 co-pay for hearing exams and covers one hearing aid every three years with no out of pocket costs. Since Medicaid already covers hearing exams and hearing aids, there is no additional Medicaid cost under GMC. Administrative expenses of 7 percent were assumed. Since this benefit would be administered with the medical benefit, this is likely a reasonable assumption. The following tables show the total annual cost by scenario. Each table shows the additional PMPM and cost of hearing coverage for all individuals in GMC, except for non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage.[15]

Table B-1.4 :Additional Cost of Hearing Coverage ($ Millions)[16]

Hearing Benefit Applies to Adults and Children	
Diagnostic	
Hearing Exam	limit 1 per year; $20 co-pay
DME	
Hearing Aids (includes fittings)	limit 1 per ear every 3 years; no cost to member
Estimated Cost Impact (includes Administrative Costs)	
Commercial	
"Premium" PMPM	$0.52
Estimated GMC Enrollees	307,414
Total Cost	$1,900,000
Medicaid	
"Premium" PMPM	$0.00
Estimated GMC Enrollees	-
Total Cost	$0
Total 2017 Cost	**$1,900,000**

[15] These cost analyses were developed prior to the Governor's final decisions and announcement not to pursue financing for GMC. These scenarios have not been updated to reflect the preferred population assumptions in the financing plan due to the cost of actuarial services. Including the additional populations would further increase the costs of providing these services.

[16] This Table excludes non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage. See footnote above.

As with dental and vision, we decided to focus our efforts on reducing out of pocket costs for major medical for the first phase of GMC and would not recommend hearing coverage at this time.

Long Term Care

Currently, Long Term Care (LTC), or nursing home level of care is provided to the Vermont Medicaid population and Medicare covers limited facility and home care services following a hospital stay. A cost estimate was developed assuming full LTC coverage would be extended to the entire Vermont population in 2017.

The cost estimate was based on the 2012 Vermont Health Care Expenditure data. The 2012 non-Medicaid and non-Medicare costs associated with home health and nursing home care were used as a starting point for the projection. It was assumed that the Medicare and Medicaid programs would continue to cover the LTC services in 2017 as they currently do. There is also an additional small amount of home health and nursing home costs that are covered by other Federal coverage in 2012. We assumed these services would also continue to be covered under their respective programs, and the costs were excluded from the projection. We also assumed that any Vermont resident that currently purchases private LTC coverage would drop this coverage and those costs would be transferred to the state.

Costs were trended from 2012 to 2017 using actual LTC trend from the VT expenditure analysis for the 2009 to 2012 time period.

Based on several LTC studies, a significant amount of LTC is either provided by unpaid caregivers or the need goes unmet. Cost estimates for the unpaid cost range between two and three times the current amounts paid for LTC. We applied an induced utilization factor to account for these costs. The studies we reviewed included the following:

- A November 2010 study produced by UMass Medical School's Center for Health Law and Economics and Office of Long-Term Support Studies on behalf of the Massachusetts Long-Term Care Financing Advisory Committee. This study indicated that $8.6 billion was paid for LTC costs in Massachusetts and that an additional $9.6 billion in cost was either unpaid or came from needs that went unmet. Applying this additional cost to the relative non-Medicaid and non-Medicare costs results in an induced utilization factor of about 5.0.[17]
- An AARP study titled "Valuing the Invaluable: 2011 Update" estimated that in 2009, $203 billion was paid for LTC costs nationally and an additional $405 billion was provided by unpaid care givers. Applying this additional cost to the relative non-Medicaid and non-Medicare costs results in an induced utilization factor of about 8.0.[18]

[17] http://www.mass.gov/eohhs/docs/eohhs/ltc/ma-ltcf-full.pdf
[18] http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

- An additional AARP study from September 2011 indicated that in 2004, 72% of older people living in the community received assistance exclusively from unpaid caregivers. This study further supports the above indication that the cost of unpaid care-giving is about two to three times the amount of total paid caregiving.[19]

Using the cost expenditure data, the trend assumption discussed above, and an induced utilization factor of 6.5, we developed a mid-level estimate of total 2017 Vermont LTC cost of $879 million. Given the uncertainty involved with estimating the cost of unpaid care, we also considered a lower induced utilization factor of 5.0 and a higher factor of 8.0. This range of induced utilization factors was based on the LTC studies referenced above. These factors produce low and high cost estimates of $660 million and $1,108 million. In addition, implementing a waiting period of 30 to 90 days could reduce the total cost estimate by 10% to 20%. The cost development is shown in the table below.

Table B-1.5: Long Term Services and Supports Cost Projection for Vermont under GMC 2017[20]

	Low	Mid	High
2012 Expenditure Analysis (Millions)	$109	$109	$109
PMPM Cost Trend	0.5%	1.0%	1.5%
Growth in Population that will use LTC	3.5%	3.5%	3.5%
Total Annual Trend	4.0%	4.5%	5.0%
Total Trend to 2017	1.217	1.246	1.276
2017 Trended Cost (Millions)	$132	$135	$139
Induced Utilization	5	6.5	8
Projected 2017 Cost (Millions)	**$660**	**$879**	**$1,108**

Again, we decided to focus our efforts on reducing out of pocket costs for major medical for the first phase of GMC and would not recommend that long term care coverage be included in Green Mountain Care.

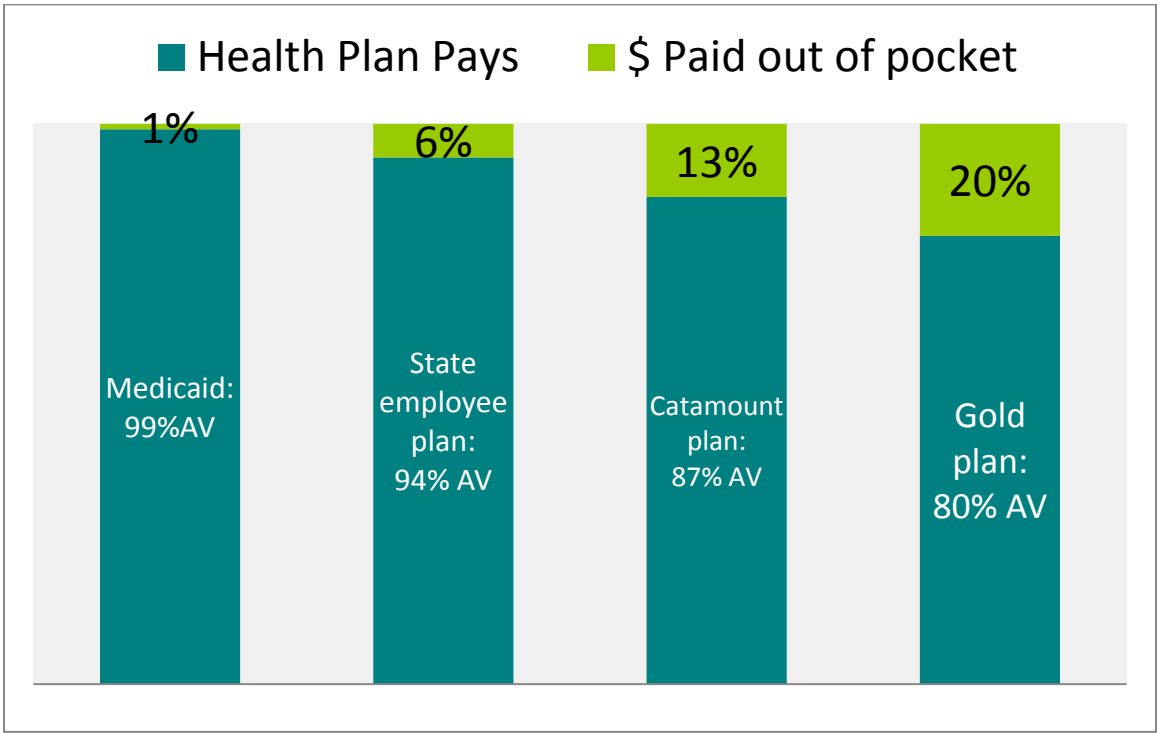
Cost-Sharing: Background

[19] http://www.longtermscorecard.org/~/media/Microsite/Files/Reinhard_raising_expectations_LTSS_scorecard_REPORT_WEB_v5.pdf

[20] This Table excludes non-resident Vermont employees, federal employees, and employees who have employer-sponsored coverage.

Cost-sharing is typically measured through actuarial value (AV). Actuarial value is the average amount as a percentage of total health care costs that a health plan would pay. The higher the AV, the less an individual would pay out of pocket in co-pays, deductibles, and co-insurance and the more paid for through public financing. For example, if GMC has an 80% AV, then on average 80% of the total cost is paid through public financing and the remaining 20% is paid through cost-sharing at the point of receiving a health service. Actual out of pocket costs for any individual or family will vary depending on their health care needs and utilization in any given year. The chart below shows examples of well-known plans and illustrates the difference between what the plan pays for and what the individual pays for health care services.

Figure B-1A. Examples of percentage of out of pocket spending with specific Vermont plan designs.



Under Act 48 of 2011, the legislature required that Green Mountain Care have at least an 80 percent actuarial value (AV) level, but also stated a preference for an 87 percent AV.[21] Act 48 also requires that we provide information to the Green Mountain Care Board about the cost of having no cost-sharing[22] and some plan designs which waive cost-sharing for certain types of services where there is evidence that greater utilization of these services would be beneficial to the health of the population. We also reviewed

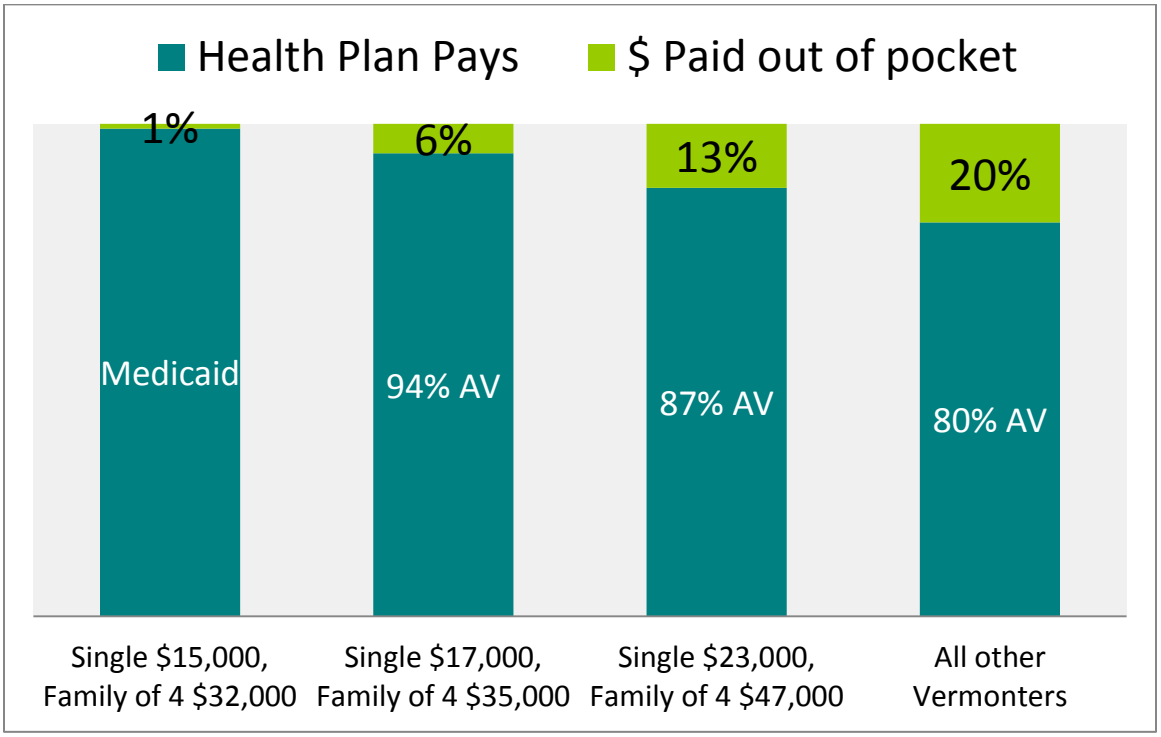
[21] 33 VSA 1822 and 1825.

[22] Relative cost of 100% AV plan is $201 million more than a 94% AV plan.

several health economic studies to determine what is currently known about the impacts of cost-sharing on the use of health services and international comparisons.[23]

Under federal law, GMC must also maintain more generous coverage of out of pocket costs for individuals who would currently receive cost-sharing reduction subsidies on a sliding scale or individuals who are on Medicaid.[24] The ACA's sliding scale of out of pocket costs is: Medicaid for individuals under 138% FPL; a 94 percent AV plan for individuals from 138% to 150% FPL; and an 87 percent AV plan for individuals from 150% to 200% FPL. The sliding scale affordability for out of pocket costs is illustrated in the figure below using 2014 income levels.

Figure B-1B. Examples of percentage of out of pocket spending using the ACA affordability sliding scale for out of pocket spending.[25]

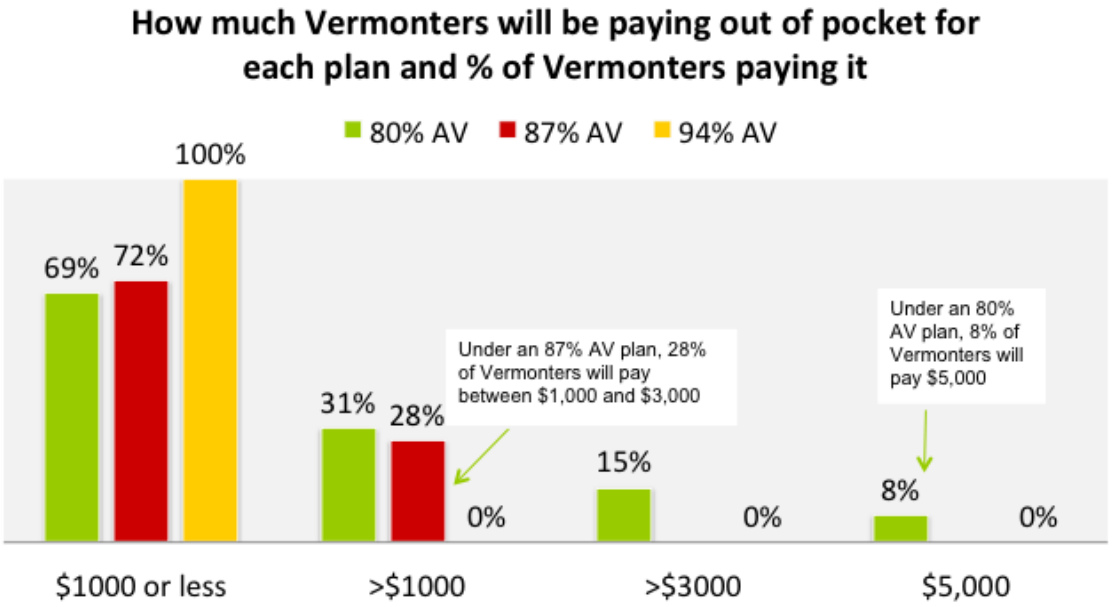


Another important consideration in plan design is how to distribute cost-sharing within the actuarial value level. For example, after the Affordable Care Act, most plans include a limitation on out of pocket costs (called the maximum out of pocket or MOOP). This represents the absolute total amount that any individual or family would pay in cost-sharing. The amount, however, must be viewed in relationship to health status, because young or healthy individuals use fewer health services and thus will never reach the type of spending capped by the MOOP due to their usage. The figure below illustrates

[23] See Appendices B-6 & B-7.
[24] ACA § 1332.
[25] Figure uses 2014 FPL income levels.

what Vermonters would pay in out of pocket costs for a deductible plan at different AV levels.

Figure B-1C. Distribution of Out Of Pocket Costs in Vermont Population



Taking into consideration the maximum out of pocket and the Act 48 and ACA legal parameters, we looked at a variety of plans ranging in AV from 80% AV up to Medicaid and employing different structures, such as co-pay only plans, deductible plans, and high deductible health plans. We started with almost thirty plans[26] and narrowed those plans down to the following seven plans within a range of AV levels and payment mechanisms, illustrated in the matrix, below:

Table B-1.6. Plan design matrix using ACA affordability sliding scale and Act 48 parameters

	80% AV	87% AV	94% AV	Medicaid AV
Option 1: Co-pay plan	Out of pocket costs look too expensive	✓	State employee plan No deductible No MOOP	
Option 2: Deductible Plan	✓	Catamount equivalent	✓	
Option 3: HDHP	✓ ✓	Does not meet HDHP requirements	Does not meet HDHP requirements	

[26] See appendix B-4

From here, we narrowed the plan designs down even further to four plan designs: a deductible and co-pay plan at 94 percent AV level, a deductible plan at the 87 percent AV level; and an innovative HDHP plan at the 80 percent AV level.[27] The co-pay plan at the 94 percent AV level is the SelectCare state employee plan modified to comply with federal requirements, the deductible plan at the 87 percent AV level is a modified design of Catamount Health, and the HDHP plan is an innovative plan design based on the economic research available.

It is important to note that in all 4 plan design options, preventive services are provided without any cost-sharing and mental health primary care services are provided with the same co-payments as for primary care health services.

The 94% AV co-pay/state employee plan is designed to only have co-payments. We have added a maximum out of pocket, which the state employee plan does not have, in order to comply with federal requirements and to ensure that Vermonters who use a lot of health services have financial protections.

The 94% AV deductible plan has a low deductible and maximum out of pocket. This plan was designed as a comparison point to the 94% AV co-pay/state employee plan to help determine which plan would provide the most comprehensive coverage to the Vermonters who need it most.

With the 87% AV plan we used a deductible plan similar to what was used under Catamount Health. The deductible plan looks like a typical insurance plan and reflects the kind of coverage with which many Vermonters are already familiar.

Under the 80% AV plan, the design is compliant with current Internal Revenue Service regulations for high-deductible health plans and may be paired with a health savings account (HSA). Health savings accounts are a tax-preferred vehicle that allows an individual to save money toward health care expenses without paying federal and state tax on that amount. This plan design has three main elements to it. The first is a high deductible health plan (HDHP). The second is an HSA for individuals who are not eligible for subsidies or a notional account for individuals who are eligible for cost-sharing subsidies, which can be applied against the annual deductible and copayments. The notional account could be funded by the state to achieve the reduced cost-sharing required by the ACA. The third element is a maximum out of pocket limit (MOOP), which serves to limit subscribers' financial exposure by capping total household cost-sharing per year. The following picture illustrates how cost-sharing is spread across these elements.

[27] See Appendix B-2.

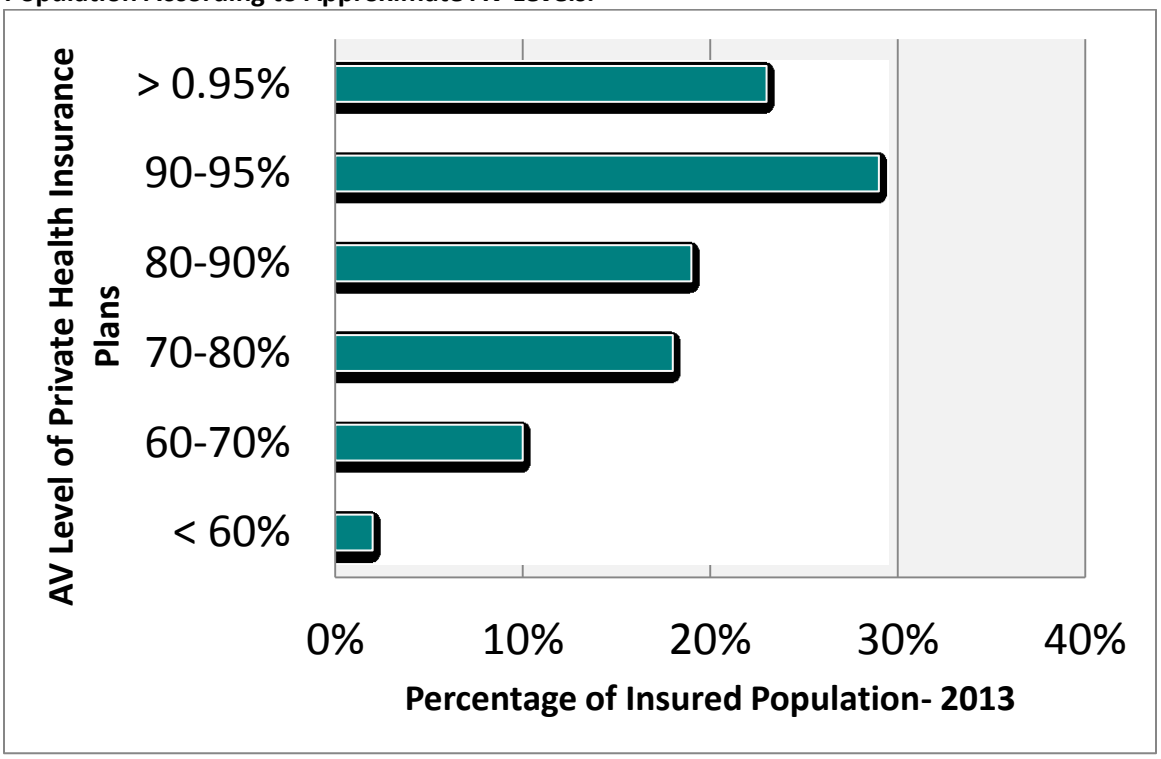
Cost-Sharing: Recommendation

Once the plans were narrowed down, we examined the ACA and Act 48 legal parameters in conjunction with operational and administrative simplicity, looked at the current market to determine where most Vermonters are today, and weighed issues of equity. As a result, we determined that the best level of coverage for Vermonters would be at the 94 percent AV level.

The fact that the ACA requires a sliding scale of affordability for out of pocket costs means that Vermont would either have to: have different plan designs to meet all the applicable AV levels; have one plan design and supplement that plan design through accounts or some other mechanism to meet the applicable AV levels; or bring all Vermonters not eligible for Medicaid up to the highest AV level, ensuring one plan design and administrative simplification. When faced with these options, we chose the 94 percent AV level to ensure operational and administrative simplicity while meeting all legal requirements.

We also chose the 94 percent AV level because when we looked at covered Vermonters who were not in Medicaid or Medicare, over 50% of Vermonters had a plan above 90 percent AV.

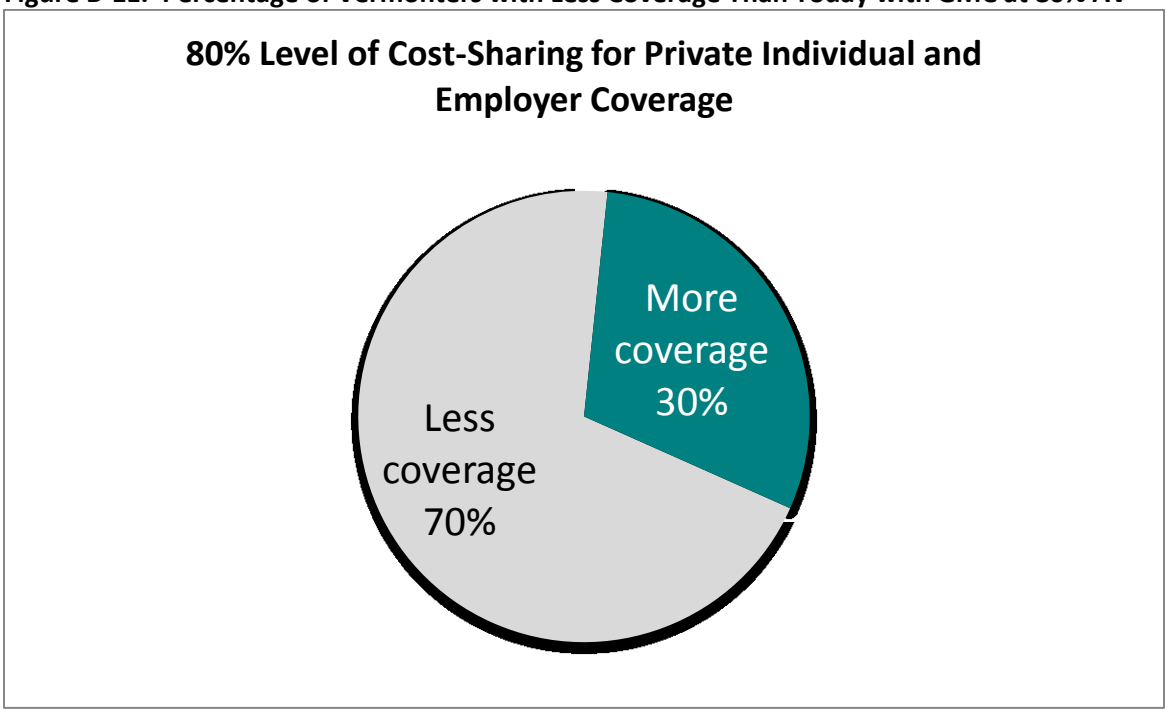
Figure B-1D. Vermont Private Health Insurance Coverage in 2013 and Percentage of Population According to Approximate AV Levels.



If we had recommended a plan that was less than 94 percent AV, many Vermonters would have less coverage of out of pocket costs than they do today.

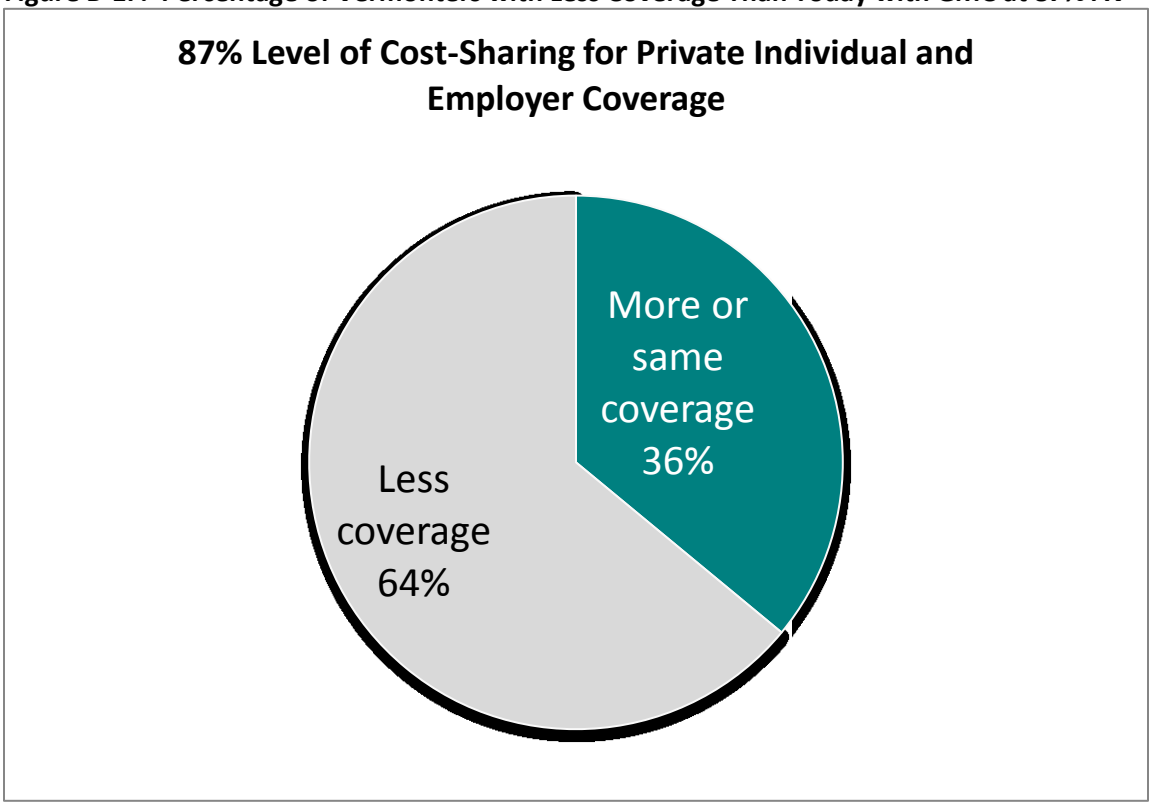
The following Figures illustrate the percentage of Vermonters who would be worse off at lower AV levels. The first Figure illustrates that 70% of Vermonters with employer sponsored insurance or who purchase through VHC today would be worse off if GMC had an AV of 80%. Only 30% would be better off with GMC at an 80% AV than today.

Figure B-1E. Percentage of Vermonters with Less Coverage Than Today with GMC at 80% AV



The second Figure illustrates that 64% of Vermonters with employer sponsored insurance or who purchase through VHC today would be worse off if GMC had an AV of 87%.

Figure B-1F. Percentage of Vermonters with Less Coverage Than Today with GMC at 87% AV



Finally, we also considered issues of equity. Act 48 requires consideration of the costs for Vermonters who need chronic care. At a low AV level, everyone would pay less in taxes, but people needing medical care would pay more in out of pocket costs than healthier people. A 94 percent AV level helps alleviate this disparity between the sick and the healthy and ensures that more of the costs are paid through the income-sensitive public premium.

Green Mountain Care - Secondary Coverage

Act 48 anticipates that Green Mountain Care will provide secondary coverage to Vermonters who have another source of primary health coverage, such as seniors who have Medicare. Until primary benefits and cost-sharing is finalized under Green Mountain Care, it is difficult to finalize secondary coverage. Secondary coverage typically wraps around the primary coverage plan for covered services and for cost-sharing. Additional analysis is needed after the primary benefits are determined in order to design secondary coverage for those on Medicare and covered by military insurance.

Because of this we recommend that secondary coverage be a later phase of GMC, but talk about some of the considerations below.

Medicare and Green Mountain Care

We examined a number of approaches for providing supplemental coverage for Vermonters to have Medicare as their primary coverage. Three options for expanding coverage were presented in the 2013 Green Mountain Care report authored by the University of Massachusetts and Wakely Consulting.[28] It is important to note that none of these options reduce Medicare benefits or otherwise harm Medicare coverage.

All of our models of GMC to date have continued the role of Medicare as the primary payer for the elderly and disabled and assumed that Medicare Supplemental insurance ("Medigap" policies) will continue to be available as required by federal law.

Maintaining a supplemental insurance market creates complexity in the system for health care providers and increases the overall administrative costs needed for the system to function. While the state may not eliminate this market, we have looked at how GMC might be attractive to seniors in lieu of supplemental policies.

It is important to keep in mind three important aspects of Medicare:

1) Seniors will always be enrolled in Medicare for primary coverage, just like today. Also, seniors will always have the choice of supplemental policies, Medicare Advantage, and Medicare Part D policies.

2) The fundamental flaw with Medicare cost-sharing has been the underinsurance for prescription drugs and uncapped Part B (hospital) liability facing seniors. When combined with the large amount of spending needed under Medicare Part D to hit the catastrophic coverage, this is a huge out of pocket risk for the elderly. The limitations of Part D were the impetus for Vermont to maintain its prescription drug coverage for seniors when Part D was implemented. An additional benefit of the ACA is the closing of the Part D "donut hole" in 2019. Out of pocket spending for Part B will remain as the major flaw in Medicare and necessitate many seniors purchasing supplemental coverage.

3) Other than drug coverage and the out of pocket maximum, Medicare supplemental coverage induces utilization that likely has relatively little value in improving health, and the supplemental market is relatively inefficient because of high administrative costs of administering these policies.[29]

We modeled one additional potential policy option for supplementing Medicare coverage through GMC, which was to provide a sliding-scale maximum out of pocket limit. Medicare does not currently have a limit on out of pocket costs and providing this

[28] This report is available here: http://hcr.vermont.gov/public_engagement/benefits. Medicare is discussed in detail in Appendices 6 and 7.

[29] This is illustrated by the Medical Loss Ratio for these plans.

limit through GMC would ensure that those on Medicare will have the same limits as all other Vermonters. A spreadsheet detailing this analysis and the costs is attached as Appendix B-10.

GMC Will Integrate Existing Coverage

The state currently provides wrap-around coverage for Medicare through three programs:

- Medicaid provides additional benefits and reduced cost-sharing for seniors whose income is at the poverty level, also commonly referred to as "Dual Eligibles"
- Medicaid provides additional coverage through Medicare "buy-in" programs, also called Service Limited Medicare Beneficiary (SLMB), Qualified Medicare Beneficiary (QMB), and Qualified Individual (QI1) programs. These programs help low-income Medicare beneficiaries who are not eligible for Medicaid pay all or some of their Medicare cost, including premiums, co-payments, and deductibles. The current income limit for these programs are
    - 0-100% FPL for QMB, which pays for Medicare premiums and out of pocket costs
    - 100-120% FPL for SLMB, which covers Medicare Part B premiums
    - 120-135% FPL for QI1, which covers Medicare Part B premiums
- Medicaid provides a pharmacy program, which wrap around Medicare Part D, called VPharm

The existing programs would be integrated into GMC in the following ways:

- Seniors who are eligible for both Medicare and Medicaid ("Dual Eligibles") would continue to have coverage consistent with current coverage and their coverage would continue to be funded with Medicaid-funds. These seniors will see no change over time.
- Seniors currently eligible for SLMB, QMB will, and QI also see no change.
- Seniors with VPharm coverage will see no change, except that VPharm premiums are eliminated to reduce administrative expenses from having both a tax and a premium system just for VPharm.

Green Mountain Care and the Supplemental Market

While working on plan designs, we also considered the effects the plan design might have on a supplemental market. Supplemental health insurance policies are typically designed to add on more comprehensive health coverage. They "wrap around" and complement basic health insurance either through covering more services or covering out of pocket costs.[30] An example of supplemental coverage of services currently available is adult dental and vision care. An example of supplemental health insurance

[30] Insurance Basics. Supplemental Policies. www.healthcare.gov

covering out of pocket costs 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 Medicare coverage and helps pay some of the health care costs that Medicare does not cover.[31]

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.

The level of supplemental insurance should correspond with the degree of coverage provided by GMC. If GMC coverage is basic, there is a stronger likelihood that there will be a larger supplemental insurance market presence. Because the covered services for GMC are set at a level commonly found in today's private insurance markets, it is likely that there will be a supplemental market limited to dental, vision, and long-term care. These markets exist today and we would expect them to continue.

Of greater concern would be a new market of supplemental insurance for cost-sharing, similar to the Medicare "Medigap" insurance products currently available. As discussed earlier, this type of market adds administrative complexity and would have the potential to shift unnecessary costs to the state. We took this into consideration when choosing the 94% AV plan design. It was determined that a plan design with a high AV would help avoid the need for a supplemental cost-sharing insurance market, which would only add complexity and cost to the system.

Conclusion

Under Green Mountain Care, many components of the benefits would stay the same:

- Preventive care is 100% covered without any cost,
- The same medical services are covered for the majority of Vermonters,
- Vermonters can still see their doctor,
- Vermonters can still receive care out of state when traveling or if their primary coverage is currently in a border state,
- Medicare benefits remain the same, because Medicare remains the primary coverage,
- Medicaid benefits remain the same.

The biggest potential change for some Vermonters is what they pay when they seek care. To ensure that Vermonters have access to comprehensive and affordable care, we

[31] Your Medicare Coverage Choices. http://www.medicare.gov/navigation/medicare-basics/coverage-choices.aspx

would recommend a 94 percent AV plan covering all of the essential health benefits under the ACA.

Appendix B-2. Recommended GMC Cost-Sharing Designs

Appendix B-2

VT Plan Options

Current Proposed Plan Designs - High Level Comparison File

December 16, 2014

Plan Type	State Plan - Original	State Plan - Revised	Catamount - Original	Catamount - Revised	Catamount - Subsidy Plan	HDHP-Recommended 80%
Actuarial Value		93.5%		87.0%	93.5%	80% Base (83%-94% subsidies)
Deductible	$0 - Med; $25 - Rx	$0 - Med, $75 - Rx (non-generics)	$500 - Med; $0 - Rx	$500 - Med; $0 - Rx	$100 - Med; $0 - Rx	$1,300 - IP $1,300 - Non-IP
MOOP	unlimited - Med; $775 - Rx (non-preferred brand excluded)	$5,000 - Med; $1,300 - Rx	$1,050 - Med; $1,250 - Rx	$1,600 - Med; $1,250 - Rx	$650 - Med; $200 - Rx	$2,100
Account Funding	N/A	N/A	N/A	N/A	N/A	80% - $0 83% - $200 87% - $500 94% - $1,200
Member Cost Sharing						
Inpatient Admission (non-MH/SA)	$250	$300	20%	20%	20%	$250
Inpatient Admissions MH/SA	$0	$0	20%	20%	20%	$250
Outpatient MH/SA	$0	$0	20%	20%	20%	$50
Outpatient Surgery	$0	$150	20%	20%	20%	$75
ER Visit	$50	$75	20%	20%	20%	$75
Ambulance	$0	$0	20%	20%	20%	$15
DME	$0	$0	20%	20%	20%	$15
Lab/X-Rays	$0	$0	20%	20%	20%	$15
PCP Visit	$20	$25	$10	$10	$10	$5
SPC Visit	$20	$35	$10	$20	$20	$15
Generic	10%	$10	$10	$10	$5	$5
Brand	20%	20%	$35	$35	$15	$15
Non-Brand	40%	40%	$35	$55	$30	$40

DEDUCTIBLE APPLIES TO SHADED CELLS

Red is a change from the original plan (state and Catamount only)

Notes:

1 Plan Designs are based on current estimates of allowed costs under the "base" scenario for GMC for the various plans.

2 To the extent the scenarios change, the plan designs will also need to be updated. Plan designs should be further refined closer to the implementation of GMC to ensure the cost sharing is as close as possible to the targeted actuarial value.

3 The HDHP Scenario 1 is a high level estimate. Neither the federal AVC or Wakely's model can accommodate the double deductible. If this plan is selected further analysis should be completed to more accurate determine the appropriate cost sharing for the plan.

4 Actual actuarial values depend on the members who are covered under GMC and the services these members receive. The resulting actuarial value could vary from the target, possibly significantly.

Vermont 2017 Plan Design Options
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	State Plan - Original Copay 94%			State Plan - Revised Copay 94%		
Wakely AV	92.6%			93.5%		
Federal AV (2016 Draft)	N/A			92.4%		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$0	N/A	N/A	$0	N/A	N/A
Family	$0	N/A	N/A	$0	N/A	N/A
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	N/A	N/A	N/A	$5,000	N/A	N/A
Family	N/A	N/A	N/A	$10,000	N/A	N/A
Medical/Rx Deductibles Combined?	No			No		
Medical/Rx MOOPs Combined?	No			No		
Inpatient Hospital	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Medical		$ 250.00	N		$ 300.00	N
Surgical		$ 250.00	N		$ 300.00	N
Maternity		$ 250.00	N		$ 300.00	N
Mental Health	100%		N	100%		N
Chemical Dependency	100%		N	100%		N
Skilled Nursing Facility	100%		N	100%		N
Outpatient Hospital						
Emergency Room		$ 50.00	N		$ 75.00	N
Ambulatory Surgery	100%		N		$ 150.00	N
Radiology	100%		N	100%		N
Laboratory	100%		N	100%		N
Maternity Visits	100%		N	100%		N
Mental Health	100%		N	100%		N
Chemical Dependency	100%		N	100%		N
Other	100%		N	100%		N
Inpatient Physician						
Medical/Surgical	100%		N	100%		N
Mental Health	100%		N	100%		N
Chemical Dependency	100%		N	100%		N
Maternity	100%		N	100%		N
Outpatient Physician						
Physician Office Visits		$ 20.00	N		$ 25.00	N
Specialist Office Visits		$ 20.00	N		$ 35.00	N
Mental Health		$ 20.00	N		$ 25.00	N
Chemical Dependency		$ 20.00	N		$ 25.00	N
Other		$ 20.00	N		$ 25.00	N
Preventive Care						
Physical Exams. Etc.	100%		N	100%		N
Immunizations	100%		N	100%		N
Screenings	100%		N	100%		N
Well Childcare	100%		N	100%		N
Outpatient Miscellaneous						
Allergy		$ 20.00	N		$ 25.00	N
Ambulance	100%		N	100%		N
Chemotherapy	100%		N	100%		N
Chiropractor		$ 20.00	N		$ 25.00	N
Dialysis	100%		N	100%		N
DME	100%		N	100%		N
Hearing	100%		N	100%		N
Hearing Aids	100%		N	100%		N
Home Health Care	100%		N	100%		N
Laboratory	100%		N	100%		N
Physical Therapy		$ 20.00	N		$ 25.00	N
Podiatry Services	100%		N	100%		N
Radiology/X-Ray	100%		N	100%		N
Speech		$ 20.00	N		$ 25.00	N
Rx Inputs						
	Retail	**Mail Order**		**Retail**	**Mail Order**	
Annual Deductibles	$25	$25		$75	$75	
Annual MOOP	$775			$1,300		
Deductible/MOOP Applies?						
Generic	Y/Y			N/Y		
Brand Formulary	Y/Y			Y/Y		
Brand Non Formulary	Y/N			Y/Y		
Specialty	Y/N			Y/Y		
Member Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	10%	10%				
Brand Formulary	20%	20%		20%	20%	
Brand Non Formulary	40%	40%		40%	40%	
Specialty	40%	40%		40%	40%	
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic				$ 10.00	$ 25.00	
Brand Formulary						
Brand Non Formulary						
Specialty						

Vermont 2017 Plan Design Options
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	Catamount Plan - Original Deductible 87%			Catamount Plan - Revised Deductible 87%			Catamount Plan - Revised Deductible 94% Subsidy		
Wakely AV	88.5%			87.0%			93.5%		
Federal AV (2016 Draft)	89.4%			87.5%			94.1%		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$500	N/A	N/A	$500	N/A	N/A	$0	N/A	N/A
Family	$1,000	N/A	N/A	$1,000	N/A	N/A	$0	N/A	N/A
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$1,050	N/A	N/A	$1,600	N/A	N/A	$650	N/A	N/A
Family	$2,100	N/A	N/A	$3,200	N/A	N/A	$1,300	N/A	N/A
Medical/Rx Deductibles Combined?	No			No			No		
Medical/Rx MOOPs Combined?	No			No			No		
Inpatient Hospital	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Medical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Surgical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Maternity	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Mental Health	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Chemical Dependency	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Skilled Nursing Facility	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Outpatient Hospital									
Emergency Room	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Ambulatory Surgery	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Radiology	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Laboratory	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Maternity Visits	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Mental Health	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Chemical Dependency	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Inpatient Physician									
Medical/Surgical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Mental Health	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Chemical Dependency	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Maternity	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Outpatient Physician									
Physician Office Visits	0%	$ 10.00	N	0%	$ 10.00	N	0%	$ 10.00	N
Specialist Office Visits	0%	$ 10.00	N	0%	$ 20.00	N	0%	$ 20.00	N
Mental Health	0%	$ 10.00	N	0%	$ 10.00	N	0%	$ 10.00	N
Chemical Dependency	0%	$ 10.00	N	0%	$ 10.00	N	0%	$ 10.00	N
Preventive Care									
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous									
Ambulance	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Dialysis	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
DME	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Physical Therapy	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Radiology/X-Ray	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Rx Inputs									
	Retail	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Annual Deductibles	$0	$0		$0	$0		$0	$0	
Annual MOOP	$1,250			$1,250			$200		
Deductible/MOOP Applies?									
Generic	N/Y			N/Y			N/Y		
Brand Formulary	N/Y			N/Y			N/Y		
Brand Non Formulary	N/Y			N/Y			N/Y		
Specialty	N/Y			N/Y			N/Y		
Member Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	0%	0%		0%	0%		0%	0%	
Brand Formulary	0%	0%		0%	0%		0%	0%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%	
Specialty	0%	0%		0%	0%		0%	0%	
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$ 10.00	$ 20.00		$ 10.00	$ 25.00		$ 5.00	$ 12.50	
Brand Formulary	$ 35.00	$ 70.00		$ 35.00	$ 87.50		$ 15.00	$ 37.50	
Brand Non Formulary	$ 55.00	$ 110.00		$ 55.00	$ 137.50		$ 30.00	$ 75.00	
Specialty	$ 55.00	$ 110.00		$ 55.00	$ 137.50		$ 30.00	$ 75.00	

Vermont 2017 Plan Design Options
DRAFT - For illustrative and discussion purposes only

	80% Recommended HDHP 80%		
Wakely AV	**79.9%**		
Federal AV (2016 Draft)	**79.7%**		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$1300 IP/$1300 Non-IP	N/A	N/A
Family	$2600 IP/$2600 Non-IP	N/A	N/A
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$2,100	N/A	N/A
Family	$4,200	N/A	N/A
Medical/Rx Deductibles Combined?	Yes		
Medical/Rx MOOPs Combined?	Yes		

	Plan Coinsurance	Copayments	Deductible Applies?
Inpatient Hospital			
Medical		$ 250.00	Y
Surgical		$ 250.00	Y
Maternity		$ 250.00	Y
Mental Health		$ 250.00	Y
Chemical Dependency		$ 250.00	Y
Skilled Nursing Facility		$ 75.00	Y
Outpatient Hospital			
Emergency Room		$ 75.00	Y
Ambulatory Surgery		$ 75.00	Y
Radiology		$ 50.00	Y
Laboratory		$ 50.00	Y
Maternity Visits		$ 50.00	Y
Mental Health		$ 50.00	Y
Chemical Dependency		$ 50.00	Y
Other		$ 50.00	N
Inpatient Physician			
Medical/Surgical	100%		Y
Mental Health	100%		Y
Chemical Dependency	100%		Y
Maternity	100%		Y
Outpatient Physician			
Physician Office Visits		$ 5.00	N
Specialist Office Visits		$ 15.00	N
Mental Health		$ 5.00	N
Chemical Dependency		$ 5.00	N
Other		$ 15.00	N
Preventive Care			
Physical Exams. Etc.	100%	$ -	N
Immunizations	100%	$ -	N
Screenings	100%	$ -	N
Well Childcare	100%	$ -	N
Outpatient Miscellaneous			
Ambulance		$ 15.00	Y
Dialysis		$ 15.00	Y
DME		$ 15.00	Y
Physical Therapy		$ 15.00	Y

Rx Inputs

	Retail	Mail Order
Annual Deductibles	$0	$0

	Retail	Mail Order
Member Coinsurance		
Generic	0%	0%
Brand Formulary	0%	0%
Brand Non Formulary	0%	0%
Specialty	0%	0%

	Retail	Mail Order
Member Copay		
Generic	$ 5.00	$ 15.00
Brand Formulary	$ 15.00	$ 45.00
Brand Non Formulary	$ 40.00	$ 120.00
Specialty	$ 40.00	$ 120.00

Appendix B-3. Vermont Essential Health Benefits Detail

VERMONT EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Health Maintenance Organization
Issuer Name	The Vermont Health Plan, LLC
Product Name	CDHP-HMO
Plan Name	BlueCare, The Vermont Health Plan, LLC, CDHP
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (State CHIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Primary Care Visit to Treat an Injury or Illness	No							No
2	**Specialist Visit**	Covered	Specialist Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery Physician/Surgical Services	No							Yes
6	**Hospice Services**	Covered	Hospice Services	No						Must meet hospice requirements for benefit eligibility.	Yes
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No					Excluded UNLESS member qualifies for coverage due to sabbatical or attending college in a foreign country.		No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Not Covered								Refer to Infertility Drug limitation in Generic, Preferred and Non-Preferred Prescription Drug categories.	
10	**Long-Term/ Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Covered	Private-Duty Nursing	Yes	2000	Other	Covered up to $2,000 per plan year			Requires prior approval and recertification of treatment plan every 60 days.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam (Adult)	Yes	1	Other	1 routine eye exam per calendar year		Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.		No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers or Facilities	No							No
14	**Home Health Care Services**	Covered	Home Health Care Services	No							No
15	**Emergency Room Services**	Covered	Emergency Room Services	No					Excludes benefits for an emergency room services that does not meet definition of Emergency Service.		Yes
16	**Emergency Transportation/ Ambulance**	Covered	Emergency Transportation/ Ambulance	No					Insured's condition must meet the criteria for an emergency medical condition. Insured must get approval within 48 hours after emergency air or water transport.		No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	1	Other	Coverage for either day of admission OR day of discharge but not both.				No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physician and Surgical Services	Yes	1	Other	May limit the number of visits covered by one Provider in a given day.				Yes
19	**Bariatric Surgery**	Covered	Bariatric Surgery	Yes	1	Other	Covered up to $10,000 per lifetime.				No
20	**Cosmetic Surgery**	Covered	Cosmetic Surgery	No					Cosmetic Surgery is an excluded benefit except for prior approval for reconstruction as detailed in certificate of coverage.		No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	No						Covered by participating facility only for Acute Care. Includes room, board, general nursing care, medication and drugs given by SNF during a covered stay and medical services included in the rates of a SNF.	No
22	**Prenatal and Postnatal Care**	Covered	Prenatal and Postnatal Care	No						See Maternity Office Visits and Inpatient Hospital Services for additional benefit information.	Yes
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Delivery and All Inpatient Services for Maternity Care	No						Covered as an Inpatient Hospital Stay.	No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral Health Outpatient Services	No						Includes individual and group psychotherapy, family and couples therapy, intensive programs, partial hospital day treatment, psychological testing when integral to treatment, psychotherapy programs to improve compliance with prescribed medical treatment regimens for diabetes, hypertension, ischemic heart disease and emphysema.	Yes
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/Behavioral Health Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes hospitalization, residential treatment programs.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
26	**Substance Abuse Disorder Outpatient Services**	Covered	Substance Abuse Disorder Outpatient Services	No						Includes detoxification in outpatient rehab facility (including services for the patient's family when necessary).	Yes
27	**Substance Abuse Disorder Inpatient Services**	Covered	Substance Abuse Disorder Inpatient Services	No					Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.	Includes detoxification in an inpatient rehabilitation facility.	No
28	**Generic Drugs**	Covered	Generic Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.				Yes
29	**Preferred Brand Drugs**	Covered	Preferred Brand Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
30	**Non-Preferred Brand Drugs**	Covered	Non-Preferred Brand Drugs	Yes	90	Other	Limited to a 90-day supply for retail and home delivery (mail order) per fill.			The limit quantity applies per script on retail and home delivery.	Yes
31	**Specialty Drugs**	Covered	Specialty Drugs	Yes	30	Other	Limited to a 30-day supply.		ONLY Participating Specialty pharmacies may be utilized for Specialty drugs.		Yes

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
32	**Outpatient Rehabilitation Services**	Covered	Outpatient Rehabilitation Services	Yes	30	Other	Up to 30 outpatient sessions combined per plan year.			Cardiac Rehabilitation is covered up to 36 visits per cardiac event. Typically include physical, occupational and speech therapy but may also include radiation therapy, chemotherapy, dialysis, infusion therapy.	Yes
33	**Habilitation Services**	Covered	Habilitation Services	No						Autism Coverage per Vermont State Mandate for ages zero to six years.	No
34	**Chiropractic Care**	Covered	Chiropractic Care	Yes	12	Other	Prior Approval is required after the 12th visit.			Prior approval required after 12 visits; includes treatment for neuromusculoskeletal conditions by a network provider working within the scope of their license.	No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No						Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, and devices. Threshold applies.	Yes
36	**Hearing Aids**	Not Covered									
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic Test (X-Ray and Lab Work)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Care/Screening/ Immunization	No							No
40	**Routine Foot Care**	Covered	Routine Foot Care	No					Covered for Diabetics ONLY; excluded for all other members.		No
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
43	**Routine Eye Exam for Children**	Covered	Routine Eye Exam for Children	Yes	1	Other	1 routine eye exam per member per calendar year.		Does not cover the evaluation and fitting of contact lenses or other supplemental tests.		No
44	**Eye Glasses for Children**	Covered	Eye Glasses for Children	No						Refer to "Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery" on Other tab for more information.	No
45	**Dental Check-Up for Children**	Covered	Dental Check-Up for Children	Yes	2	Treatments per year					No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Nutritional Counseling	Yes	3	Visits per year	3 visits per plan year		Visits for treatment of diabetes do not count toward this visit limit.		No
2	**Outpatient Surgery Physician/ Surgical Services**	Covered	Neuropsychological Testing	Yes	8	Hours per year					No
3	**Hospice Services**	Covered	Home Health Aide	Yes	100	Hours per month				For personal care services only.	No
4	**Outpatient Rehabilitation Services**	Covered	Outpatient physical, speech and occupational therapy	Yes	30	Visits per year	Up to 30 outpatient sessions combined per plan year.			Covered up to 30 visits combined per plan year.	No
5	**Other**	Covered	Preventive Care	No						Includes routine physical examinations, immunizations, well-child care, screening mammogram, screening colonoscopy, preventive GYN.	No
6	**Other**	Covered	Dental Services (not Routine)	No						Includes treatment for or in connection with an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment is started with six months of the accident; also includes surgery to correct gross deformity from major disease or surgery with service occurring within six months of the onset of disease or within six months of surgery.	No
7	**Inpatient Physician and Surgical Services**	Covered	Sterilization Reversal	Yes	1	Other	Procedures per lifetime			Covers only one attempt at reversal of sterilization.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
8	**Durable Medical Equipment**	Covered	Eye Glasses or Contact Lenses to replace the lens of an eye when the lens was not replaced at the time of surgery.	Yes	1	Other	1 set of accompanying eyeglasses or contact lenses for the original prescription and one set for each new prescription.				Yes
9	**Durable Medical Equipment**	Covered	Dental prosthetics	No					Repair or replacement of dental appliances or dental prosthetics.	With prior approval and only of required to treat an accidental injury (except injury as a result of chewing or biting); or to correct gross deformity resulting from major disease or Surgery; to treat obstructive sleep apnea; or to treat craniofacial disorders, including temporomandibular joint syndrome.	No
10	**Generic Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
11	**Preferred Brand Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
12	**Non-Preferred Brand Drugs**	Covered	Infertility medications	Yes	4	Months per year	Cover up to four months of fertility medication per plan year when attempt to conceive through natural means.				No
13	**Other**	Covered	Nutritional Formulae or supplements	Yes	2500	Other	Up to $2,500 per year for medical foods prescribed for the medically necessary treatment of an inherited metabolic disease or formulae and supplements administered through a feeding tube.				No
14	**Prenatal and Postnatal Care**	Covered	Maternity Office Visits	No						Includes coverage by a Physician or other Professional during a woman's pregnancy for pre-natal visits and other care and post-natal visits.	No
15	**Other**	Covered	Transplant Services - deceased donor	Yes	35000	Other	For transplants using a deceased donor, benefits are limited to $35,000 per solid organ transplant for search, removal, storage, and transportation of the organ.				No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
16	**Emergency Room Services**	Covered	Emergency room physician services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
17	**Emergency Room Services**	Covered	Emergency mental health and substance use physician and facility services	No					Insured's condition must meet the criteria for an emergency medical condition.		No
18	**Mental/Behavioral Health Outpatient Services**	Covered	Mental/Behavioral health office visits	No							No
19	**Substance Abuse Disorder Outpatient Services**	Covered	Substance use disorder office visits	No							No
20	**Outpatient Rehabilitation Services**	Covered	Cardiac rehabilitation services	Yes	36	Other	36 visits per cardiac event; three supervised exercise sessions per week up to total of 36 sessions for cardiac and pulmonary rehab programs.				No
21	**Hospice Services**	Covered	Hospice Services Homemaker Services	Yes	100	Hours per month					No
22	**Hospice Services**	Covered	Hospice Continuous Care Services in Home	Yes	5	Days per admission	OR 120 hours of continuous care.			For in home care.	No
23	**Hospice Services**	Covered	Hospice Respite Care	Yes	72	Hours per month					No
24	**Hospice Services**	Covered	Hospice Social Services Visits	Yes	6	Visits per lifetime					No
25	**Hospice Services**	Covered	Hospice Bereavement visits	Yes	2	Visits per lifetime				Two bereavement visits following death.	No

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
26	**Generic Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
27	**Preferred Brand Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
28	**Non-Preferred Brand Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
29	**Specialty Drugs**	Covered	Antibiotics and Narcotic Day Supply Limitation	Yes	30	Other	Antibiotics and Narcotics are limited to a 30-day supply both at retail and home delivery (mail order).				No
30	**Other**	Covered	Transplant Services - Live donor	Yes	65000	Other	For transplants using a live donor, benefits are limited to $65,000 for the live donor's surgical expenses and storage and transportation of the organ for each covered organ transplant procedure completed. Costs for a donor must be incurred within 120 days from the date of the donor's surgery.				No
31	**Other**	Covered	Transplant Recipient - Benefit Coverage Time Period	Yes	1	Other	From 30 days before the transplant to 365 days after the transplant for bone marrow transplants OR From five days before the transplant to 365 days after the transplant.				No
32	**Durable Medical Equipment**	Covered	Pre-fabricated knee braces	No					Custom-fabricated or custom-molded knee braces.		No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	11
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	11
ANESTHETICS	LOCAL ANESTHETICS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	20
ANTIBACTERIALS	AMINOGLYCOSIDES	9
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	20
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	18
ANTIBACTERIALS	BETA-LACTAM, OTHER	5
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	12
ANTIBACTERIALS	MACROLIDES	5
ANTIBACTERIALS	QUINOLONES	8
ANTIBACTERIALS	SULFONAMIDES	4
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	2
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	4
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	7
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	8
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	4
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9
ANTIDEPRESSANTS	TRICYCLICS	9
ANTIEMETICS	ANTIEMETICS, OTHER	10
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	8
ANTIFUNGALS	NO USP CLASS	26
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2
ANTIMIGRAINE AGENTS	PROPHYLACTIC	4

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	7
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	10
ANTINEOPLASTICS	ALKYLATING AGENTS	8
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	3
ANTINEOPLASTICS	ANTIMETABOLITES	3
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	6
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	3
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	12
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	3
ANTINEOPLASTICS	RETINOIDS	3
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	12
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	6
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	3
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	9
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	5
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	4
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	12
ANTIVIRALS	ANTIHERPETIC AGENTS	6
ANXIOLYTICS	ANXIOLYTICS, OTHER	4
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	21
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	2
BLOOD GLUCOSE REGULATORS	INSULINS	10
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	8
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	1
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	8
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	6
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	8
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	10
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	13
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	9
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	4
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	4
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	4
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	6
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	7
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	6
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	3
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	3
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	7
DENTAL AND ORAL AGENTS	NO USP CLASS	8
DERMATOLOGICAL AGENTS	NO USP CLASS	35
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	17
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	6
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	4
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	2

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	LAXATIVES	3
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	6
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	7
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	9
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	23
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	6
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	3
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	9
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	5
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	24
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	4
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	10
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	3
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	15
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	4
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	10
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	11

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	14
OTIC AGENTS	NO USP CLASS	6
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	6
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	11
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	3
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	10
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	6
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	5
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	6
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	3
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	5
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	6
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	4

Appendix B-4. GMC Plan Designs Considered

Appendix B-4

General Notes

1. Deductibles do not apply to pharmacy benefits except for the HDHPs.
2. In accordance with the ACA, all copays and coinsurance apply to the MOOP.
3. For copay plans, it is assumed that there would be no additional physician copay for inpatient and outpatient services.
4. Mail Order copays are assumed to be 2.5 Retail for Generic and Brand Formulary drugs and 3 times Retail for Brand Non-Formulary and Specialty.
5. All copay plans have no individual or family deductible.
6. Allowed amount is normalized to $492 in the Wakely model for purposes of estimating the AV. This is based on the prior GMC analysis and will be updated as the 2017 cost projections are refined.
7. For the HSA contributions, the impact to the AV is determined looking at the one year of contribution in isolation. That is, any carryover from prior years is not considered.
8. Plan designs are only for discussion purposes. Actual plan designs could vary, potentially materially, once all assumptions and input is incorproated.

Vermont 2017 Plan Design Options
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	Copay 80% Option 1			Copay 80% Option 2			Copay 80% Option 3		
Wakely AV	**81.5%**			**80.8%**			**80.6%**		
Federal AV (2015 AVC)	**72.2%**			**70.7%**			**70.4%**		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$0	$0	$0	$0	$0	$0	$0	$0	$0
Family	$0	$0	$0	$0	$0	$0	$0	$0	$0
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$6,600	$0	$0	$6,000	$0	$0	$5,600	$0	$0
Family	$13,200	$0	$0	$12,000	$0	$0	$11,200	$0	$0
Medical/Rx Deductibles Combined?	No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes		
	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?
Inpatient Hospital									
Medical	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Surgical	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Maternity	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Mental Health	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Chemical Dependency	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Skilled Nursing Facility	0%	$ 3,500.00	N	0%	$ 3,750.00	N	0%	$ 4,000.00	N
Outpatient Hospital									
Emergency Room	0%	$ 1,200.00	N	0%	$ 1,400.00	N	0%	$ 1,600.00	N
Ambulatory Surgery	0%	$ 850.00	N	0%	$ 1,000.00	N	0%	$ 1,250.00	N
Radiology	0%	$ 375.00	N	0%	$ 425.00	N	0%	$ 500.00	N
Laboratory	0%	$ 275.00	N	0%	$ 300.00	N	0%	$ 350.00	N
Maternity Visits	0%	$ 250.00	N	0%	$ 275.00	N	0%	$ 350.00	N
Mental Health	0%	$ 55.00	N	0%	$ 70.00	N	0%	$ 70.00	N
Chemical Dependency	0%	$ 55.00	N	0%	$ 70.00	N	0%	$ 70.00	N
Inpatient Physician									
Medical/Surgical	100%	$ -	N	100%	$ -	N	100%	$ -	N
Mental Health	100%	$ -	N	100%	$ -	N	100%	$ -	N
Chemical Dependency	100%	$ -	N	100%	$ -	N	100%	$ -	N
Maternity	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Physician									
Physician Office Visits	0%	$ 55.00	N	0%	$ 70.00	N	0%	$ 70.00	N
Specialist Office Visits	0%	$ 65.00	N	0%	$ 80.00	N	0%	$ 80.00	N
Mental Health	0%	$ 55.00	N	0%	$ 70.00	N	0%	$ 70.00	N
Chemical Dependency	0%	$ 55.00	N	0%	$ 70.00	N	0%	$ 70.00	N
Preventive Care									
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous									
Ambulance	0%	$ 600.00	N	0%	$ 650.00	N	0%	$ 700.00	N
Dialysis	0%	$ 70.00	N	0%	$ 80.00	N	0%	$ 90.00	N
DME	0%	$ 70.00	N	0%	$ 80.00	N	0%	$ 90.00	N
Physical Therapy	0%	$ 65.00	N	0%	$ 70.00	N	0%	$ 80.00	N
Radiology/X-Ray	0%	$ 70.00	N	0%	$ 80.00	N	0%	$ 90.00	N
Rx Inputs									
Member Coinsurance	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	0%	0%		0%	0%		0%	0%	
Brand Formulary	0%	0%		0%	0%		0%	0%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%	
Specialty	0%	0%		0%	0%		0%	0%	
Member Copay	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	$ 20.00	$ 50.00		$ 25.00	$ 62.50		$ 25.00	$ 62.50	
Brand Formulary	$ 40.00	$ 100.00		$ 50.00	$ 125.00		$ 60.00	$ 150.00	
Brand Non Formulary	$ 75.00	$ 225.00		$ 85.00	$ 255.00		$ 95.00	$ 285.00	
Specialty	$ 100.00	$ 300.00		$ 110.00	$ 330.00		$ 120.00	$ 360.00	

Vermont 2017 Plan Design Options
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	Option 1			Copay 87% Option 2			Option 3		
Wakely AV	**88.2%**			**88.1%**			**87.6%**		
Federal AV (2015 AVC)	**79.3%**			**78.3%**			**77.2%**		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$0	$0	$0	$0	$0	$0	$0	$0	$0
Family	$0	$0	$0	$0	$0	$0	$0	$0	$0
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$6,600	$0	$0	$5,200	$0	$0	$4,500	$0	$0
Family	$13,200	$0	$0	$10,400	$0	$0	$9,000	$0	$0
Medical/Rx Deductibles Combined?	No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes		
Inpatient Hospital	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Medical	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Surgical	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Maternity	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Mental Health	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Chemical Dependency	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Skilled Nursing Facility	0%	$ 750.00	N	0%	$ 750.00	N	0%	$ 1,000.00	Y
Outpatient Hospital									
Emergency Room	0%	$ 300.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Ambulatory Surgery	0%	$ 200.00	N	0%	$ 225.00	N	0%	$ 250.00	Y
Radiology	0%	$ 200.00	N	0%	$ 200.00	N	0%	$ 225.00	Y
Laboratory	0%	$ 175.00	N	0%	$ 150.00	N	0%	$ 175.00	Y
Maternity Visits	0%	$ 175.00	N	0%	$ 150.00	N	0%	$ 175.00	Y
Mental Health	0%	$ 40.00	N	0%	$ 65.00	N	0%	$ 75.00	Y
Chemical Dependency	0%	$ 40.00	N	0%	$ 65.00	N	0%	$ 75.00	Y
Inpatient Physician									
Medical/Surgical	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Mental Health	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Chemical Dependency	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Maternity	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Outpatient Physician									
Physician Office Visits	0%	$ 40.00	N	0%	$ 65.00	N	0%	$ 75.00	N
Specialist Office Visits	0%	$ 50.00	N	0%	$ 75.00	N	0%	$ 85.00	N
Mental Health	0%	$ 40.00	N	0%	$ 65.00	N	0%	$ 75.00	N
Chemical Dependency	0%	$ 40.00	N	0%	$ 65.00	N	0%	$ 75.00	N
Preventive Care									
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous									
Ambulance	0%	$ 300.00	N	0%	$ 300.00	N	0%	$ 350.00	N
Dialysis	0%	$ 60.00	N	0%	$ 85.00	N	0%	$ 95.00	N
DME	0%	$ 60.00	N	0%	$ 85.00	N	0%	$ 95.00	N
Physical Therapy	0%	$ 50.00	N	0%	$ 75.00	N	0%	$ 85.00	N
Radiology/X-Ray	0%	$ 60.00	N	0%	$ 85.00	N	0%	$ 95.00	N
Rx Inputs									
Member Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	0%	0%		0%	0%		0%	0%	
Brand Formulary	0%	0%		0%	0%		0%	0%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%	
Specialty	0%	0%		0%	0%		0%	0%	
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$ 10.00	$ 25.00		$ 12.00	$ 30.00		$ 15.00	$ 37.50	
Brand Formulary	$ 20.00	$ 50.00		$ 25.00	$ 62.50		$ 30.00	$ 75.00	
Brand Non Formulary	$ 60.00	$ 180.00		$ 75.00	$ 225.00		$ 80.00	$ 240.00	
Specialty	$ 75.00	$ 225.00		$ 100.00	$ 300.00		$ 110.00	$ 330.00	

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	Option 1			Copay 94% Option 2			Option 3		
Wakely AV	**94.4%**			**94.6%**			**94.9%**		
Federal AV (2015 AVC)	**86.3%**			**84.9%**			**84.9%**		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$0	$0	$0	$0	$0	$0	$0	$0	$0
Family	$0	$0	$0	$0	$0	$0	$0	$0	$0
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$6,000	$0	$0	$3,500	$0	$0	$2,000	$0	$0
Family	$12,000	$0	$0	$7,000	$0	$0	$4,000	$0	$0
Medical/Rx Deductibles Combined?	No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes		
	Plan Coinsurance	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Inpatient Hospital									
Medical	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Surgical	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Maternity	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Mental Health	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Chemical Dependency	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Skilled Nursing Facility	0%	$ 200.00	N	0%	$ 300.00	N	0%	$ 400.00	Y
Outpatient Hospital									
Emergency Room	0%	$ 100.00	N	0%	$ 150.00	N	0%	$ 200.00	Y
Ambulatory Surgery	0%	$ 40.00	N	0%	$ 60.00	N	0%	$ 70.00	Y
Radiology	0%	$ 50.00	N	0%	$ 60.00	N	0%	$ 80.00	Y
Laboratory	0%	$ 35.00	N	0%	$ 60.00	N	0%	$ 70.00	Y
Maternity Visits	0%	$ 35.00	N	0%	$ 60.00	N	0%	$ 70.00	Y
Mental Health	0%	$ 15.00	N	0%	$ 20.00	N	0%	$ 30.00	Y
Chemical Dependency	0%	$ 15.00	N	0%	$ 20.00	N	0%	$ 30.00	Y
Inpatient Physician									
Medical/Surgical	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Mental Health	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Chemical Dependency	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Maternity	100%	$ -	N	100%	$ -	N	100%	$ -	Y
Outpatient Physician									
Physician Office Visits	0%	$ 15.00	N	0%	$ 20.00	N	0%	$ 30.00	N
Specialist Office Visits	0%	$ 25.00	N	0%	$ 30.00	N	0%	$ 40.00	N
Mental Health	0%	$ 15.00	N	0%	$ 20.00	N	0%	$ 30.00	N
Chemical Dependency	0%	$ 15.00	N	0%	$ 20.00	N	0%	$ 30.00	N
Preventive Care									
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous									
Ambulance	0%	$ 65.00	N	0%	$ 80.00	N	0%	$ 125.00	N
Dialysis	0%	$ 30.00	N	0%	$ 35.00	N	0%	$ 50.00	N
DME	0%	$ 30.00	N	0%	$ 35.00	N	0%	$ 50.00	N
Physical Therapy	0%	$ 25.00	N	0%	$ 30.00	N	0%	$ 45.00	N
Radiology/X-Ray	0%	$ 30.00	N	0%	$ 35.00	N	0%	$ 50.00	N
Rx Inputs									
Member Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	0%	0%		0%	0%		0%	0%	
Brand Formulary	0%	0%		0%	0%		0%	0%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%	
Specialty	0%	0%		0%	0%		0%	0%	
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$ 8.00	$ 20.00		$ 12.00	$ 30.00		$ 25.00	$ 62.50	
Brand Formulary	$ 20.00	$ 50.00		$ 30.00	$ 75.00		$ 50.00	$ 125.00	
Brand Non Formulary	$ 50.00	$ 150.00		$ 80.00	$ 240.00		$ 100.00	$ 300.00	
Specialty	$ 75.00	$ 225.00		$ 110.00	$ 330.00		$ 125.00	$ 375.00	

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	Deductible 80%											
	Option 1			Option 2			Option 3			Option 4		
Wakely AV	80.8%			79.9%			79.7%			79.6%		
Federal AV (2015 AVC)	75.2%			74.8%			77.0%			77.3%		
Deductible	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$1,000	$0	$0	$1,750	$0	$0	$2,500	$0	$0	$2,000	$0	$0
Family	$2,000	$0	$0	$3,500	$0	$0	$5,000	$0	$0	$4,000	$0	$0
MOOP	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$6,500	$0	$0	$5,000	$0	$0	$3,500	$0	$0	$5,000	$0	$0
Family	$13,000	$0	$0	$10,000	$0	$0	$7,000	$0	$0	$10,000	$0	$0
Medical/Rx Deductibles Combined?	No			No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes			Yes		
Inpatient Hospital	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?
Medical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Surgical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Maternity	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Mental Health	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Chemical Dependency	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Skilled Nursing Facility	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Outpatient Hospital												
Emergency Room	0%	$ 150.00	Y	0%	$ 100.00	Y	0%	$ 75.00	Y	0%	$ 100.00	Y
Ambulatory Surgery	0%	$ 200.00	Y	0%	$ 125.00	Y	0%	$ 100.00	Y	0%	$ 125.00	Y
Radiology	0%	$ 70.00	Y	0%	$ 50.00	Y	0%	$ 30.00	Y	0%	$ 50.00	Y
Laboratory	0%	$ 65.00	Y	0%	$ 45.00	Y	0%	$ 25.00	Y	0%	$ 45.00	Y
Maternity Visits	0%	$ 50.00	Y	0%	$ 35.00	Y	0%	$ 30.00	Y	0%	$ 35.00	Y
Mental Health	0%	$ 45.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Chemical Dependency	0%	$ 45.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Inpatient Physician												
Medical/Surgical	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Mental Health	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Chemical Dependency	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Maternity	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Outpatient Physician												
Physician Office Visits	0%	$ 45.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Specialist Office Visits	0%	$ 45.00	N	0%	$ 35.00	N	0%	$ 30.00	N	0%	$ 35.00	N
Mental Health	0%	$ 45.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Chemical Dependency	0%	$ 45.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Preventive Care												
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous												
Ambulance	0%	$ 65.00	Y	0%	$ 55.00	Y	0%	$ 55.00	Y	80%	$ -	Y
Dialysis	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 35.00	Y	80%	$ -	Y
DME	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y	80%	$ -	Y
Physical Therapy	0%	$ 40.00	N	0%	$ 40.00	N	0%	$ 35.00	N	80%	$ -	Y
Radiology/X-Ray	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 35.00	Y	80%	$ -	Y
Rx Inputs												
Member Coinsurance	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	0%	0%		0%	0%		0%	0%		20%	20%	
Brand Formulary	0%	0%		0%	0%		0%	0%		20%	20%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%		20%	20%	
Specialty	0%	0%		0%	0%		0%	0%		20%	20%	
Member Copay	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	$ 12.00	$ 30.00		$ 15.00	$ 37.50		$ 18.00	$ 45.00		$ -	$ -	
Brand Formulary	$ 25.00	$ 62.50		$ 30.00	$ 75.00		$ 35.00	$ 87.50		$ -	$ -	
Brand Non Formulary	$ 50.00	$ 150.00		$ 60.00	$ 180.00		$ 70.00	$ 210.00		$ -	$ -	
Specialty	$ 75.00	$ 225.00		$ 90.00	$ 270.00		$ 100.00	$ 300.00		$ -	$ -	

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	Deductible 87%											
	Option 1			Option 2			Option 3			Option 4		
Wakely AV	87.0%			87.0%			87.2%			87.1%		
Federal AV (2015 AVC)	80.1%			82.1%			84.3%			86.4%		
Deductible	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$500	$0	$0	$750	$0	$0	$1,000	$0	$0	$1,000	$0	$0
Family	$1,000	$0	$0	$1,500	$0	$0	$2,000	$0	$0	$2,000	$0	$0
MOOP	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$4,500	$0	$0	$3,000	$0	$0	$2,200	$0	$0	$2,500	$0	$0
Family	$9,000	$0	$0	$6,000	$0	$0	$4,400	$0	$0	$5,000	$0	$0
Medical/Rx Deductibles Combined?	No			No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes			Yes		
Inpatient Hospital	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?
Medical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Surgical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Maternity	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Mental Health	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Chemical Dependency	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Skilled Nursing Facility	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Outpatient Hospital												
Emergency Room	0%	$ 150.00	Y	0%	$ 125.00	Y	0%	$ 80.00	Y	0%	$ 100.00	Y
Ambulatory Surgery	0%	$ 175.00	Y	0%	$ 150.00	Y	0%	$ 100.00	Y	0%	$ 125.00	Y
Radiology	0%	$ 70.00	Y	0%	$ 50.00	Y	0%	$ 30.00	Y	0%	$ 50.00	Y
Laboratory	0%	$ 65.00	Y	0%	$ 45.00	Y	0%	$ 25.00	Y	0%	$ 45.00	Y
Maternity Visits	0%	$ 50.00	Y	0%	$ 35.00	Y	0%	$ 30.00	Y	0%	$ 35.00	Y
Mental Health	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 20.00	N
Chemical Dependency	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 20.00	N
Inpatient Physician												
Medical/Surgical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Mental Health	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Chemical Dependency	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Maternity	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Outpatient Physician												
Physician Office Visits	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 20.00	N
Specialist Office Visits	0%	$ 35.00	N	0%	$ 30.00	N	0%	$ 20.00	N	0%	$ 30.00	N
Mental Health	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 20.00	N
Chemical Dependency	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 20.00	N
Preventive Care												
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous												
Ambulance	0%	$ 65.00	Y	0%	$ 55.00	Y	0%	$ 55.00	Y	85%	$ -	Y
Dialysis	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 35.00	Y	85%	$ -	Y
DME	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	85%	$ -	Y
Physical Therapy	0%	$ 40.00	N	0%	$ 40.00	N	0%	$ 35.00	N	85%	$ -	Y
Radiology/X-Ray	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 35.00	Y	85%	$ -	Y
Rx Inputs												
Member Coinsurance	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	0%	0%		0%	0%		0%	0%		15%	15%	
Brand Formulary	0%	0%		0%	0%		0%	0%		15%	15%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%		15%	15%	
Specialty	0%	0%		0%	0%		0%	0%		15%	15%	
Member Copay	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	$ 8.00	$ 20.00		$ 12.00	$ 30.00		$ 15.00	$ 37.50		$ -	$ -	
Brand Formulary	$ 20.00	$ 50.00		$ 25.00	$ 62.50		$ 30.00	$ 75.00		$ -	$ -	
Brand Non Formulary	$ 35.00	$ 105.00		$ 50.00	$ 150.00		$ 60.00	$ 180.00		$ -	$ -	
Specialty	$ 60.00	$ 180.00		$ 70.00	$ 210.00		$ 90.00	$ 270.00		$ -	$ -	

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	Deductible 94%											
	Option 1			Option 2			Option 3			Option 4		
Wakely AV	93.9%			94.1%			93.9%			94.1%		
Federal AV (2015 AVC)	87.2%			90.9%			92.9%			91.4%		
Deductible	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$100	$0	$0	$250	$0	$0	$400	$0	$0	$250	$0	$0
Family	$200	$0	$0	$500	$0	$0	$800	$0	$0	$500	$0	$0
MOOP	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*	*In-Network*	*Out-of-Netwo*	*Out-of-Area*
Individual	$2,000	$0	$0	$1,000	$0	$0	$600	$0	$0	$1,500	$0	$0
Family	$4,000	$0	$0	$2,000	$0	$0	$1,200	$0	$0	$3,000	$0	$0
Medical/Rx Deductibles Combined?	No			No			No			No		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes			Yes		
Inpatient Hospital	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?	Plan Coinsurance	Copayments	Deductible Applies?
Medical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Surgical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Maternity	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Mental Health	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Chemical Dependency	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Skilled Nursing Facility	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Outpatient Hospital												
Emergency Room	0%	$ 125.00	Y	0%	$ 100.00	Y	0%	$ 75.00	Y	0%	$ 100.00	Y
Ambulatory Surgery	0%	$ 175.00	Y	0%	$ 150.00	Y	0%	$ 100.00	Y	0%	$ 125.00	Y
Radiology	0%	$ 70.00	Y	0%	$ 50.00	Y	0%	$ 30.00	Y	0%	$ 50.00	Y
Laboratory	0%	$ 65.00	Y	0%	$ 45.00	Y	0%	$ 25.00	Y	0%	$ 45.00	Y
Maternity Visits	0%	$ 50.00	Y	0%	$ 35.00	Y	0%	$ 25.00	Y	0%	$ 35.00	Y
Mental Health	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 10.00	N	0%	$ 15.00	N
Chemical Dependency	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 10.00	N	0%	$ 15.00	N
Inpatient Physician												
Medical/Surgical	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Mental Health	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Chemical Dependency	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Maternity	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y	90%	$ -	Y
Outpatient Physician												
Physician Office Visits	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 10.00	N	0%	$ 15.00	N
Specialist Office Visits	0%	$ 25.00	N	0%	$ 25.00	N	0%	$ 20.00	N	0%	$ 25.00	N
Mental Health	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 10.00	N	0%	$ 15.00	N
Chemical Dependency	0%	$ 20.00	N	0%	$ 15.00	N	0%	$ 10.00	N	0%	$ 15.00	N
Preventive Care												
Physical Exams. Etc.	100%	$ -	N	100%	$ -	N	100%	$ -	N	100%	$ -	N
Outpatient Miscellaneous												
Ambulance	0%	$ 65.00	Y	0%	$ 55.00	Y	0%	$ 55.00	Y	90%	$ -	Y
Dialysis	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 30.00	Y	90%	$ -	Y
DME	100%	$ -	Y	100%	$ -	Y	100%	$ -	Y	90%	$ -	Y
Physical Therapy	0%	$ 40.00	N	0%	$ 40.00	N	0%	$ 30.00	N	90%	$ -	Y
Radiology/X-Ray	0%	$ 40.00	Y	0%	$ 40.00	Y	0%	$ 25.00	Y	90%	$ -	Y
Rx Inputs												
Member Coinsurance	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	0%	0%		0%	0%		0%	0%		10%	10%	
Brand Formulary	0%	0%		0%	0%		0%	0%		10%	10%	
Brand Non Formulary	0%	0%		0%	0%		0%	0%		10%	10%	
Specialty	0%	0%		0%	0%		0%	0%		10%	10%	
Member Copay	Retail	Mail Order		Retail	Mail Order		Retail	Mail Order		Retail	Mail Order	
Generic	$ 8.00	$ 20.00		$ 10.00	$ 25.00		$ 12.00	$ 30.00		$ -	$ -	
Brand Formulary	$ 15.00	$ 37.50		$ 20.00	$ 50.00		$ 25.00	$ 62.50		$ -	$ -	
Brand Non Formulary	$ 35.00	$ 105.00		$ 50.00	$ 150.00		$ 55.00	$ 165.00		$ -	$ -	
Specialty	$ 60.00	$ 180.00		$ 70.00	$ 210.00		$ 80.00	$ 240.00		$ -	$ -	

Vermont 2017 Plan Design Options
DRAFT - For illustrative and discussion purposes only

	HDHP 80%			HDHP 80%			HDHP 87%			HDHP 94%		
Annual HSA Contribution	$0.00			$120.00			$840.00			$1,800.00		
Wakely AV	78.5%			79.9%			86.7%			93.9%		
Federal AV (2015 AVC)	71.1%			73.0%			81.1%			88.6%		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$2,000	$0	$0	$2,000	$0	$0	$2,000	$0	$0	$2,000	$0	$0
Family	$4,000	$0	$0	$4,000	$0	$0	$4,000	$0	$0	$4,000	$0	$0
Medical/Rx Deductibles Combined?	Yes			Yes			Yes			Yes		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes			Yes		
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$4,250	$0	$0	$4,250	$0	$0	$4,250	$0	$0	$4,250	$0	$0
Family	$8,500	$0	$0	$8,500	$0	$0	$8,500	$0	$0	$8,500	$0	$0
	Plan Coinsurance	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Inpatient Hospital												
Medical	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Surgical	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Maternity	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Mental Health	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Chemical Dependency	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Skilled Nursing Facility	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Outpatient Hospital												
Emergency Room		$ 65.00	Y		$ 65.00	Y		$ 65.00	Y		$ 65.00	Y
Ambulatory Surgery	85%		Y	85%		Y	85%		Y	85%		Y
Radiology	85%		Y	85%		Y	85%		Y	85%		Y
Laboratory	85%		Y	85%		Y	85%		Y	85%		Y
Maternity Visits	85%		Y	85%		Y	85%		Y	85%		Y
Mental Health		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y
Chemical Dependency		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y
Inpatient Physician												
Medical/Surgical	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Mental Health	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Chemical Dependency	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Maternity	85%		Y	85%		Y	85%	$ -	Y	85%		Y
Outpatient Physician												
Physician Office Visits		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y
Specialist Office Visits		$ 30.00	Y		$ 30.00	Y		$ 30.00	Y		$ 30.00	Y
Mental Health		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y
Chemical Dependency		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y		$ 20.00	Y
Preventive Care												
Physical Exams. Etc.	100%		N	100%		N	100%	$ -	N	100%		N
Outpatient Miscellaneous												
Ambulance	85%		Y	85%		Y	85%		Y	85%		Y
Dialysis	85%		Y	85%		Y	85%		Y	85%		Y
DME	85%		Y	85%		Y	85%		Y	85%		Y
Physical Therapy		$ 30.00	Y		$ 30.00	Y		$ 30.00	Y		$ 30.00	Y
Radiology/X-Ray	85%		Y	85%		Y	85%		Y	85%		Y
Rx Inputs												
Plan Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic												
Brand Formulary												
Brand Non Formulary												
Specialty												
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$ 10.00	$ 25.00		$ 10.00	$ 25.00		$ 10.00	$ 25.00		$ 10.00	$ 25.00	
Brand Formulary	$ 20.00	$ 50.00		$ 20.00	$ 50.00		$ 20.00	$ 50.00		$ 20.00	$ 50.00	
Brand Non Formulary	$ 50.00	$ 150.00		$ 50.00	$ 150.00		$ 50.00	$ 150.00		$ 50.00	$ 150.00	
Specialty	$ 75.00	$ 225.00		$ 75.00	$ 225.00		$ 75.00	$ 225.00		$ 75.00	$ 225.00	

Vermont 2017 Plan Design Options
DRAFT - For illustrative and discussion purpose

	HDHP BCBSVT 80%			HDHP BCBSVT 80%			HDHP BCBSVT 87%			HDHP BCBSVT 94%		
Annual HSA Contribution	$0.00			$100.00			$720.00			$1,680.00		
Wakely AV	79.5%			80.7%			86.7%			94.3%		
Federal AV (2015 AVC)	75.2%			76.7%			84.6%			93.8%		
Deductible	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$2,500	$0	$0	$2,500	$0	$0	$2,500	$0	$0	$2,500	$0	$0
Family	$5,000	$0	$0	$5,000	$0	$0	$5,000	$0	$0	$5,000	$0	$0
Medical/Rx Deductibles Combined?	Yes			Yes			Yes			Yes		
Medical/Rx MOOPs Combined?	Yes			Yes			Yes			Yes		
MOOP	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*	*In-Network*	*Out-of-Network*	*Out-of-Area*
Individual	$2,500	$0	$0	$2,500	$0	$0	$2,500	$0	$0	$2,500	$0	$0
Family	$5,000	$0	$0	$5,000	$0	$0	$5,000	$0	$0	$5,000	$0	$0
Inpatient Hospital	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**	**Plan Coinsurance**	**Copayments**	**Deductible Applies?**
Medical	100%		Y	100%		Y	100%		Y	100%		Y
Surgical	100%		Y	100%		Y	100%		Y	100%		Y
Maternity	100%		Y	100%		Y	100%		Y	100%		Y
Mental Health	100%		Y	100%		Y	100%		Y	100%		Y
Chemical Dependency	100%		Y	100%		Y	100%		Y	100%		Y
Skilled Nursing Facility	100%		Y	100%		Y	100%		Y	100%		Y
Outpatient Hospital												
Emergency Room	100%		Y	100%		Y	100%		Y	100%		Y
Ambulatory Surgery	100%		Y	100%		Y	100%		Y	100%		Y
Radiology	100%		Y	100%		Y	100%		Y	100%		Y
Laboratory	100%		Y	100%		Y	100%		Y	100%		Y
Maternity Visits	100%		Y	100%		Y	100%		Y	100%		Y
Mental Health	100%		Y	100%		Y	100%		Y	100%		Y
Chemical Dependency	100%		Y	100%		Y	100%		Y	100%		Y
Inpatient Physician												
Medical/Surgical	100%		Y	100%		Y	100%		Y	100%		Y
Mental Health	100%		Y	100%		Y	100%		Y	100%		Y
Chemical Dependency	100%		Y	100%		Y	100%		Y	100%		Y
Maternity	100%		Y	100%		Y	100%		Y	100%		Y
Outpatient Physician												
Physician Office Visits	100%		Y	100%		Y	100%		Y	100%		Y
Specialist Office Visits	100%		Y	100%		Y	100%		Y	100%		Y
Mental Health	100%		Y	100%		Y	100%		Y	100%		Y
Chemical Dependency	100%		Y	100%		Y	100%		Y	100%		Y
Preventive Care												
Physical Exams. Etc.	100%		N	100%		N	100%		N	100%		N
Outpatient Miscellaneous												
Ambulance	100%		Y	100%		Y	100%		Y	100%		Y
Dialysis	100%		Y	100%		Y	100%		Y	100%		Y
DME	100%		Y	100%		Y	100%		Y	100%		Y
Physical Therapy	100%		Y	100%		Y	100%		Y	100%		Y
Radiology/X-Ray	100%		Y	100%		Y	100%		Y	100%		Y
Rx Inputs												
Plan Coinsurance	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	100%	100%		100%	100%		100%	100%		100%	100%	
Brand Formulary	100%	100%		100%	100%		100%	100%		100%	100%	
Brand Non Formulary	100%	100%		100%	100%		100%	100%		100%	100%	
Specialty	100%	100%		100%	100%		100%	100%		100%	100%	
Member Copay	**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**		**Retail**	**Mail Order**	
Generic	$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	
Brand Formulary	$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	
Brand Non Formulary	$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	
Specialty	$ -	$ -		$ -	$ -		$ -	$ -		$ -	$ -	

Appendix B-5. Presentation to the Green Mountain Care Board
December 4, 2014

Green Mountain Care: Benefits Background Information

Robin J. Lunge, J.D., MHCDS
Director of Health Care Reform, AOA

Devon J. Green, J.D.
Special Counsel on HCR, AOA

December 4, 2014

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Discussion for Today

- Background on Green Mountain Care
- GMC's legal parameters for the benefit plan
- Background on benefits

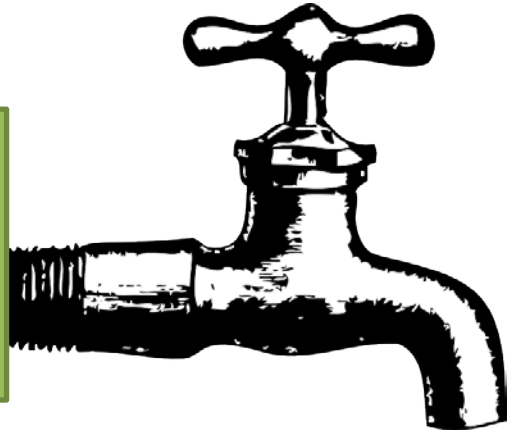
BACKGROUND ON GREEN MOUNTAIN CARE

Health Care Reform Goals: Why Reform?

Four Design & Implementation Zones

Green Mountain Care
- Who's covered?
- For what benefits/services?

Green Mountain Care
- What is the governance?
- What is the business model?
- Who does what?



Payments for services
- What methodology?
- What level?
- How are they inflated over time?

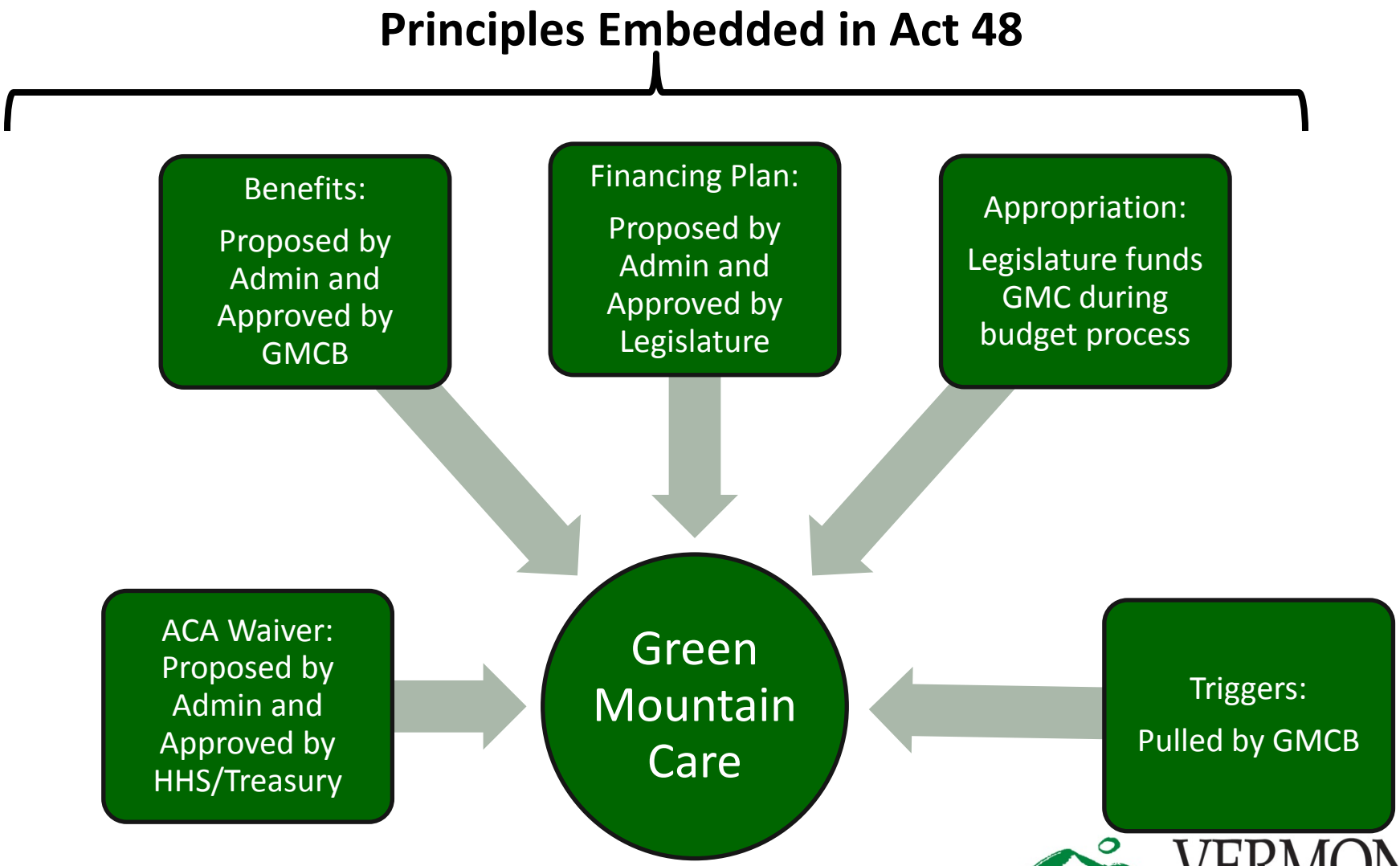
Revenues in
- What sources?
- How do they grow over time?

Informs revenue needs

GMC: Who is covered?

- All Vermonters by virtue of residency
  - Primary for most
  - Secondary for those with other coverage
- Secondary coverage examples:
  - Medicare – Seniors are still covered by Medicare as they are now.
  - Some employees who chose employer-sponsored coverage
- Primary benefits determine extent and cost of the secondary coverage

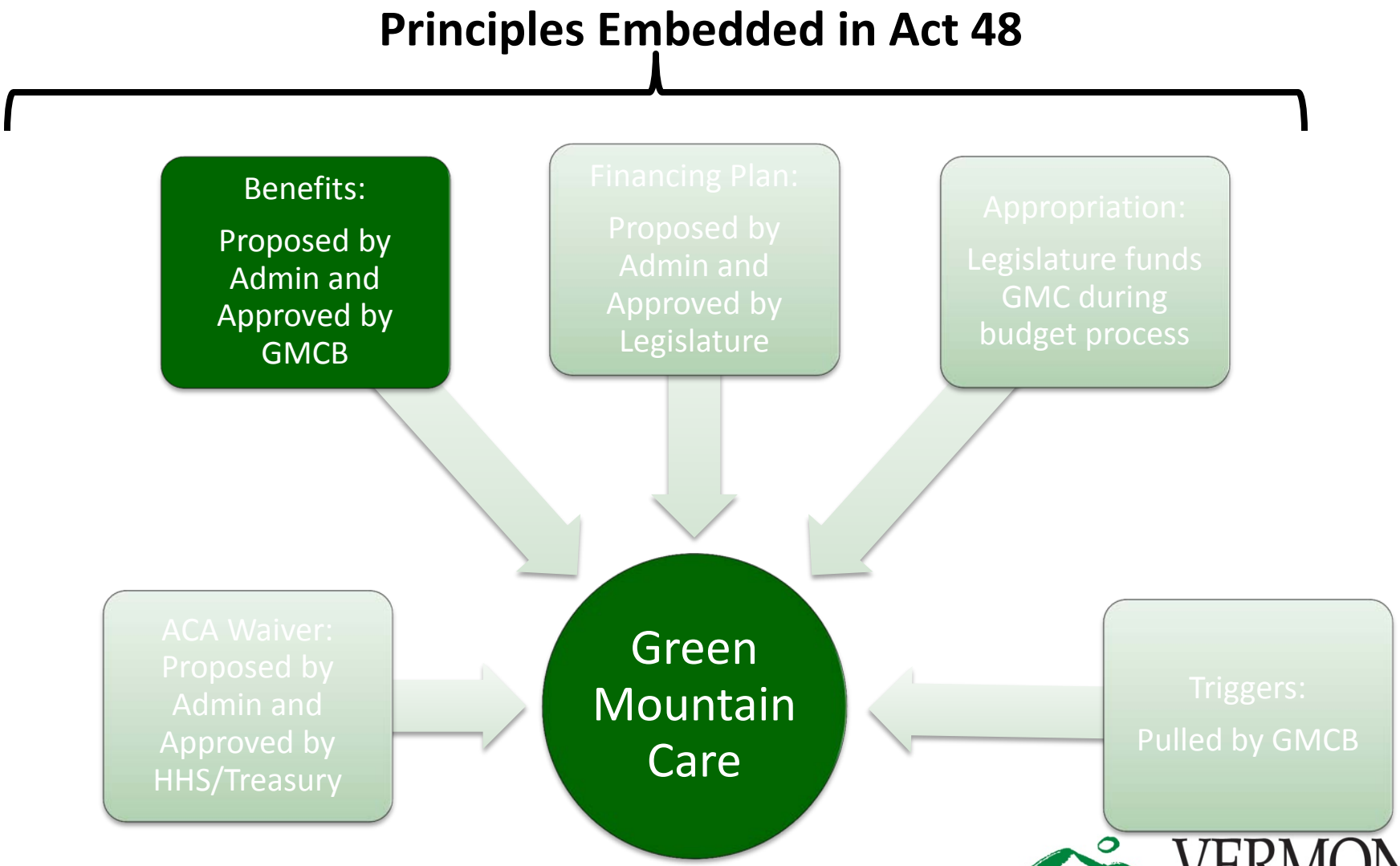
The Process: What Needs to Happen?



GMCB Role by Statute

- Defines Green Mountain Care benefits
- Evaluates GMC planning based on the “triggers”
- Proposes annual GMC budget after implementation

The Process: What Needs to Happen?



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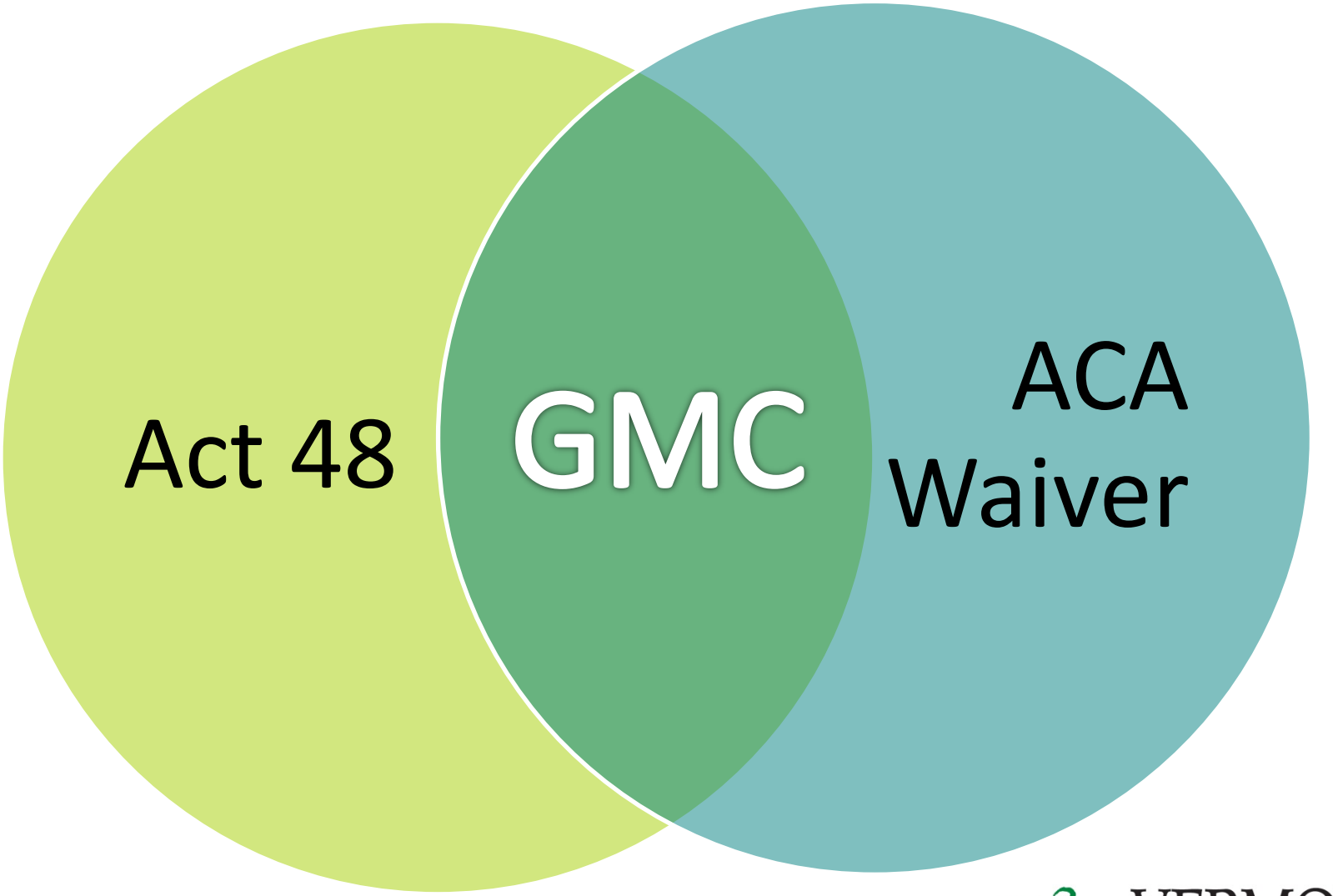
GMCB Role by Statute

- **Defines Green Mountain Care benefits**
  - Today begins this process with background information on what people have today and the legal parameters going forward.
- Evaluates GMC planning based on the "triggers"
- Proposes annual GMC budget after implementation

GMC'S LEGAL PARAMETERS FOR BENEFIT PLAN

GMC's Legal Parameters



GMC's Legal Parameters

2010– ACA

- Federal law requiring states to have Exchanges selling health insurance

2011– Act 48

- Vermont law setting out process for a publicly-financed, universal health care system: GMC

2017—ACA Waiver

- To implement GMC, Vermont needs a waiver from the ACA

Review of Waivers

	Medicaid Waiver (1115)	ACA Waiver (1332)	All-Payer Waiver (1115A)
What is it?	Allows VT to run Medicaid as a managed care organization and to expand Medicaid programs and services	Will allow Vermont to offer publicly-funded universal health care coverage under Green Mountain Care	Will allow Vermont to move away from fee for service and work towards all-payer rate-setting for health care services (like MD)
When do we get it?	VT has had this waiver since 2005. VT renewed it in 2013 and it will be renewed again for 2017	VT cannot be approved for this waiver until 2017	VT is applying for this waiver as soon as possible
	The Medicaid and the ACA Waiver will be done at the same time through a coordinated process		

GMC's Legal Parameters– ACA Waiver

- Vermont can request a waiver of the following requirements under the ACA
  - Qualified health plans– insurance plans sold on Exchange (Vermont Health Connect)
  - Exchanges (Vermont Health Connect)
  - Premium tax credits and cost sharing subsidies paid to insurers
  - Individual penalty
  - Large employer penalty

GMC's Legal Parameters– ACA Waiver

The ACA Waiver requires the state to:

- Cover the same or more people than under the ACA
- Provide coverage that is as good or better than the ACA
- Provide coverage that is as affordable or more affordable than the ACA
- Not increase the federal deficit

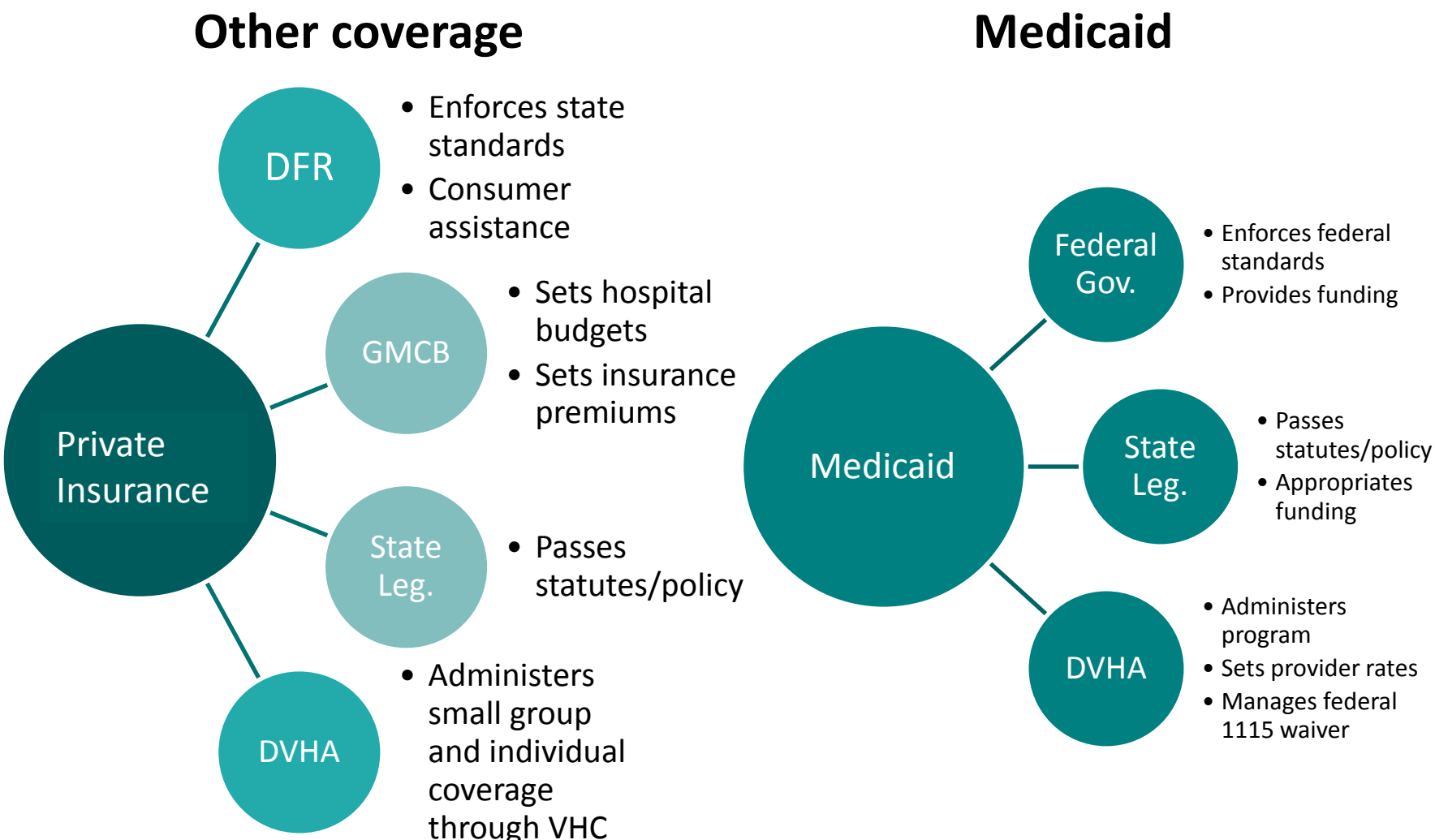
The ACA allows for a coordinated process with Vermont's Medicaid waiver

GMC's Legal Parameters– Medicaid

GMC Medicaid Goals

- One program– Green Mountain Care
- Two different covered services packages
- Cost sharing stays the same– is integrated into sliding scale
- Federal protections remain the same
- Medicaid funding stream, then separate payers

Current Medicaid System



GMC Medicaid

GMC's Legal Parameters– Medicaid

- Under state law, Medicaid benefits must be the same as the Medicaid benefit package on January 1, 2014 for the first year of Green Mountain Care
  - Same covered services
    - See next slide
  - Same cost-sharing
    - $1-$3 for prescriptions
    - $3 per day for hospital
    - $3 per visit for dental
- After the first year, the GMCB may modify optional Medicaid benefits, but must maintain federal mandatory Medicaid benefits and meet waiver requirements

GMC's Legal Parameters– Medicaid

Medicaid Mandatory	Medicaid Optional
Inpatient hospital services	Prescription drugs
Outpatient hospital services	Clinic services
EPSDT	Physical therapy
Home health services	Occupational therapy
Physician services	Speech, hearing and language disorder services
Rural Health Clinic services	Respiratory care services
FQHC services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental services
Nurse Midwife services	Dentures
Pediatric and Family Nurse Practitioner Services	Prosthetics
Freestanding Birth Center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling for pregnant women	Personal care
Medical or surgical services by a dentist	Hospice
Nursing facility services for age 21 & older	Case management + more

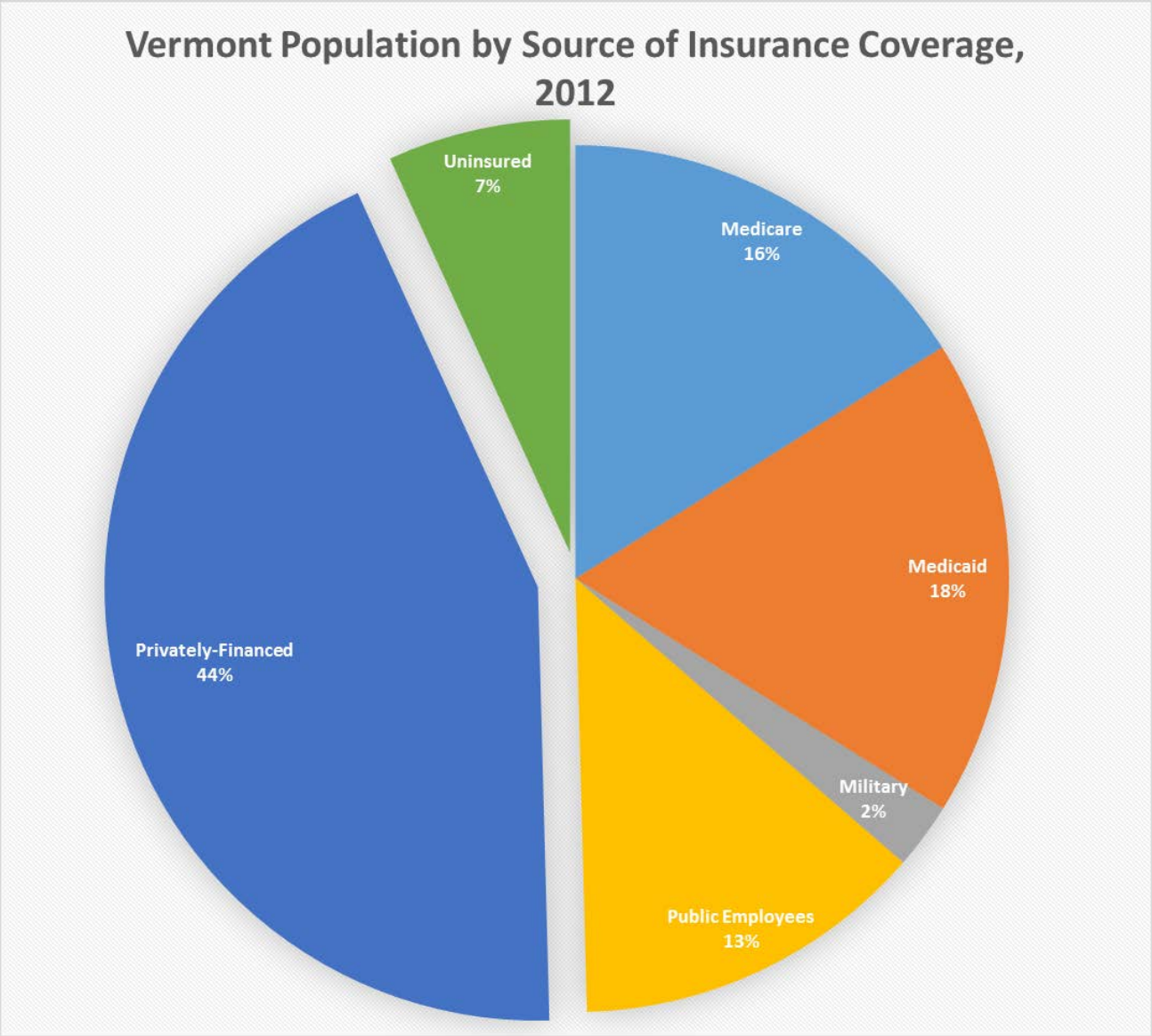
GMCB Role for GMC Benefits

In this process, GMCB:

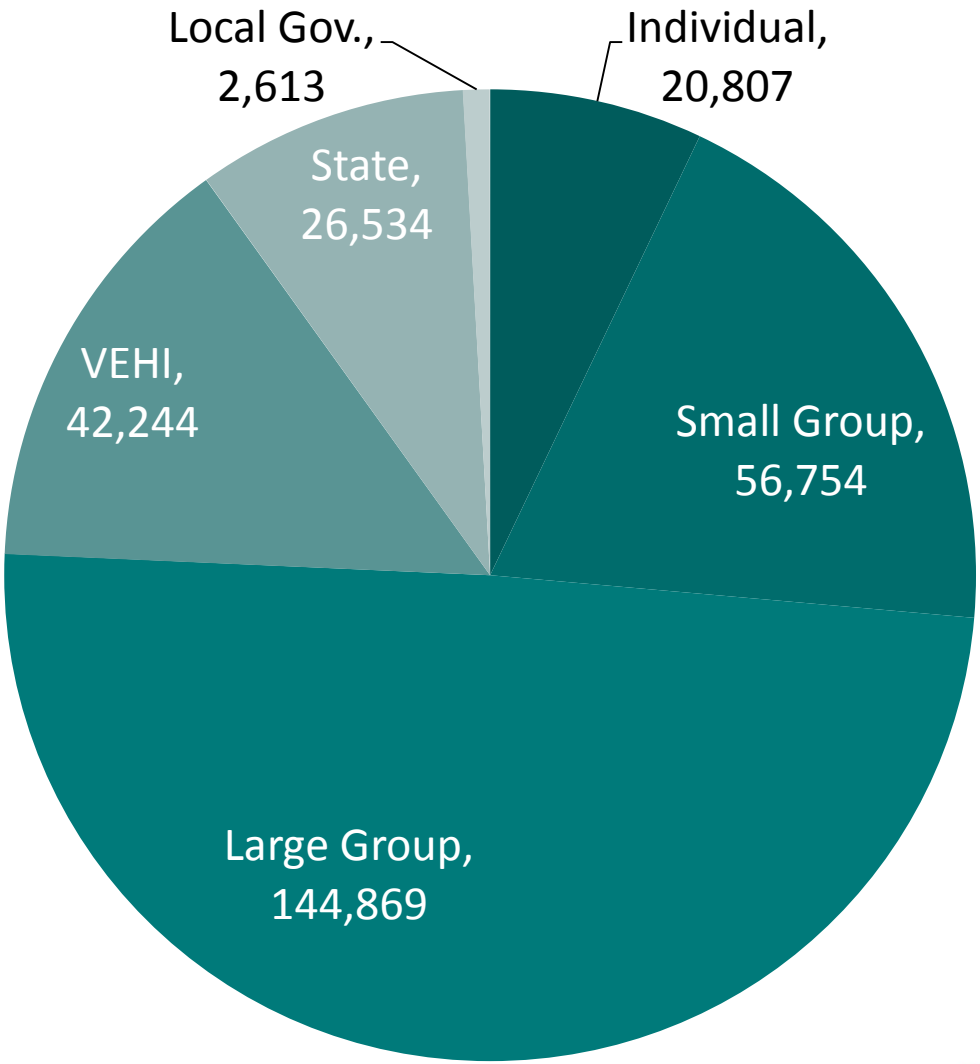
- Defines primary coverage benefits within Act 48 and ACA Waiver parameters
  - Covered services
  - Level of cost sharing
  - Cost sharing
- Keeps Medicaid benefits the same for year one

BACKGROUND ON BENEFITS

Vermont Health Care Coverage Today



Vermont Health Care Coverage Today



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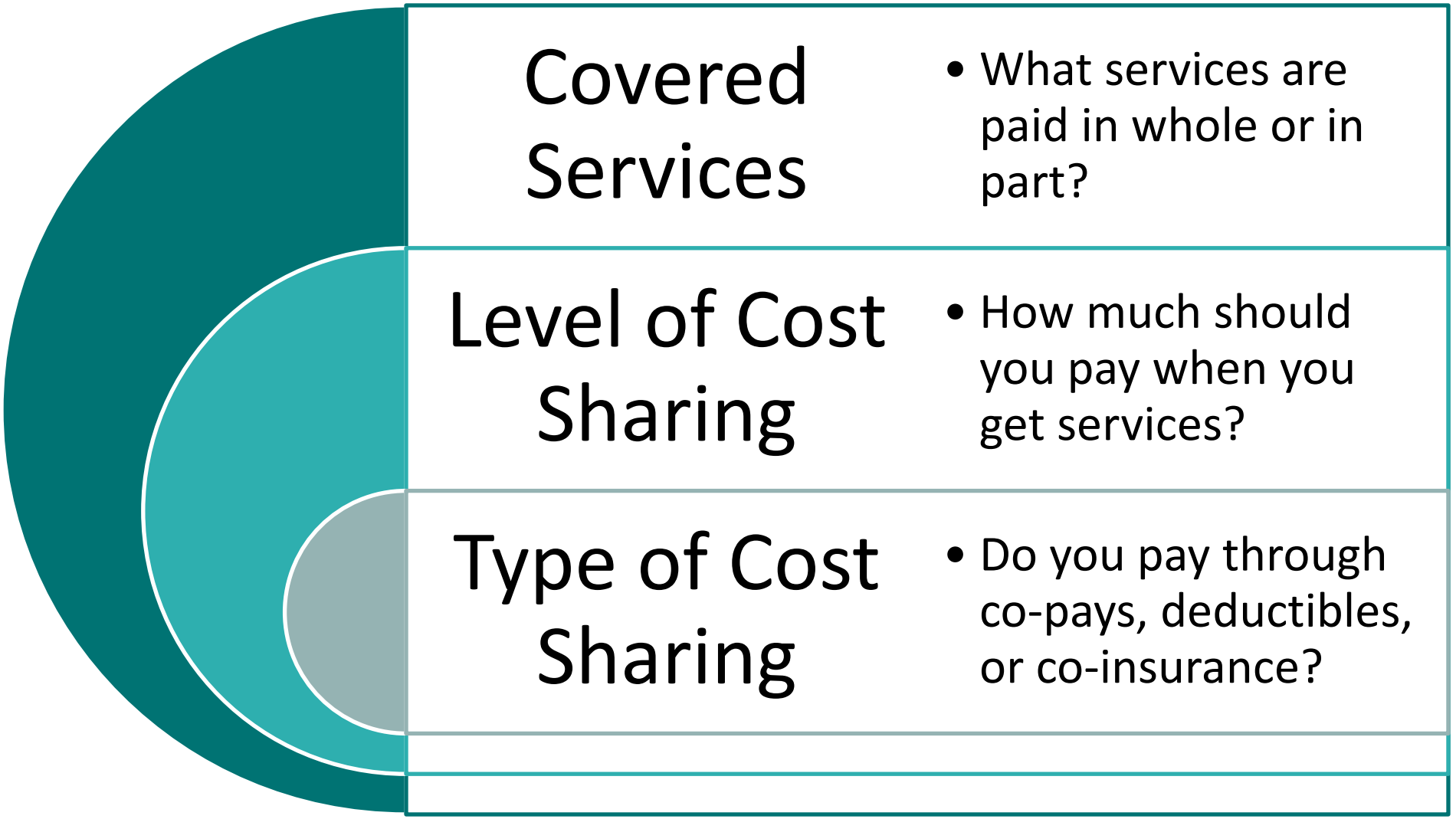
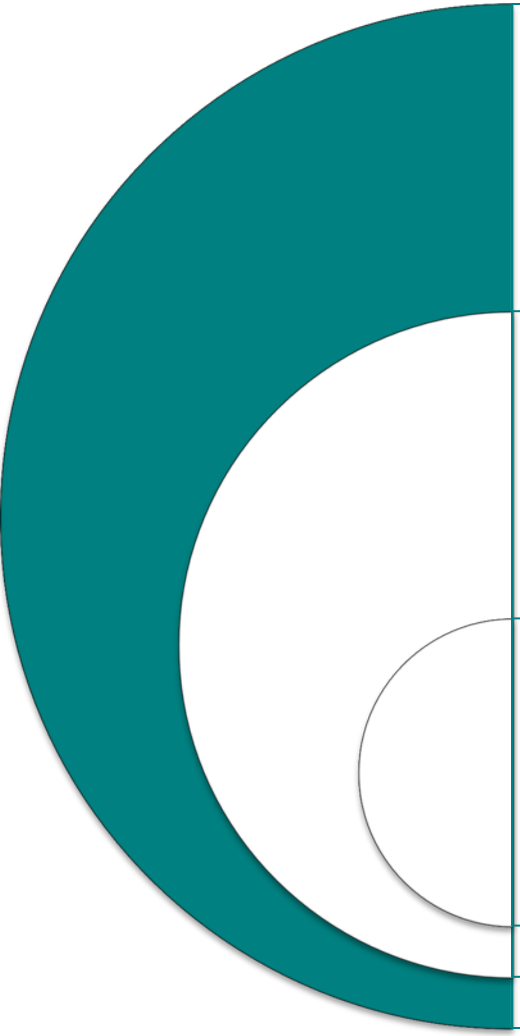
Benefits Background



Benefits and Covered Services



Covered Services	• What services are paid in whole or in part?
Level of Cost Sharing	• How much should you pay when you get services?
Type of Cost Sharing	• Do you pay through co-pays, deductibles, or co-insurance?

Definition: Covered Services

What are covered services?

- Covered services are services, medication, or medical devices that health care coverage pays for in part or completely
- Current examples of covered services typically included in health insurance:
  - Doctor visits
  - Hospital services
  - Specialist visits

Covered Services Today

	Essential Health Benefit	State Employee and Retirees		VEHI Education Employees and Retirees	
		SelectCare	Total Choice	300 Ded	VHP
Chiropractic	Limit 12 visits then prior approval required	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Prior approval required after 12th visit	Prior approval required after 12th visit
Infertility	Not covered	Up to $50,000 lifetime max	Up to $50,000 lifetime max	Not covered	Not covered
Bariatric Surgery	Covered	Covered, medical necessity	Covered, medical necessity	With prior approval	With prior approval
Fertility Drugs	Covered	Covered	Covered	Covered	Covered
Routine Eye Exams	1/year for children	$100/2 years	$100/2 years	Not covered	1/year

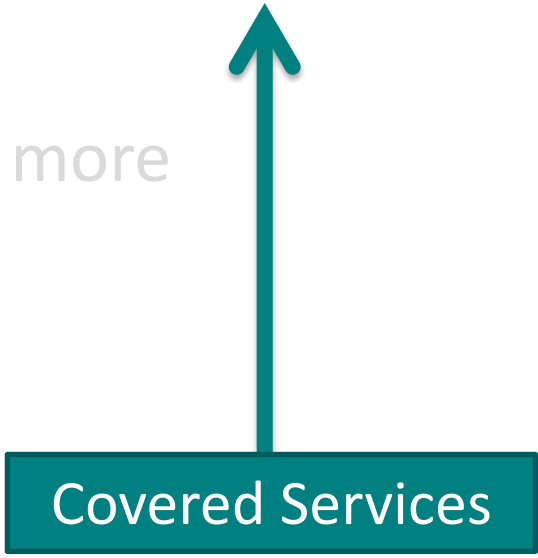
GMC Covered Services Parameters

- Federal law requires that GMC cover as many or more services than the ACA
  - Means that GMC must include the ACA's essential health benefits as covered services
- State law requires GMC to have the same covered services as Catamount
  - The ACA's essential health benefits have more covered services than Catamount

GMC Benefits and Affordable Care Act

The Affordable Care Act Waiver requires state to:

- Cover the same or more people than under the ACA
- Provide coverage that is as good or better than the ACA
- Provide coverage that is as affordable or more affordable than the ACA
- Not increase the federal deficit



EHB Covered Services

Essential Benefits include all state mandates and the following services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services, and chronic disease management
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

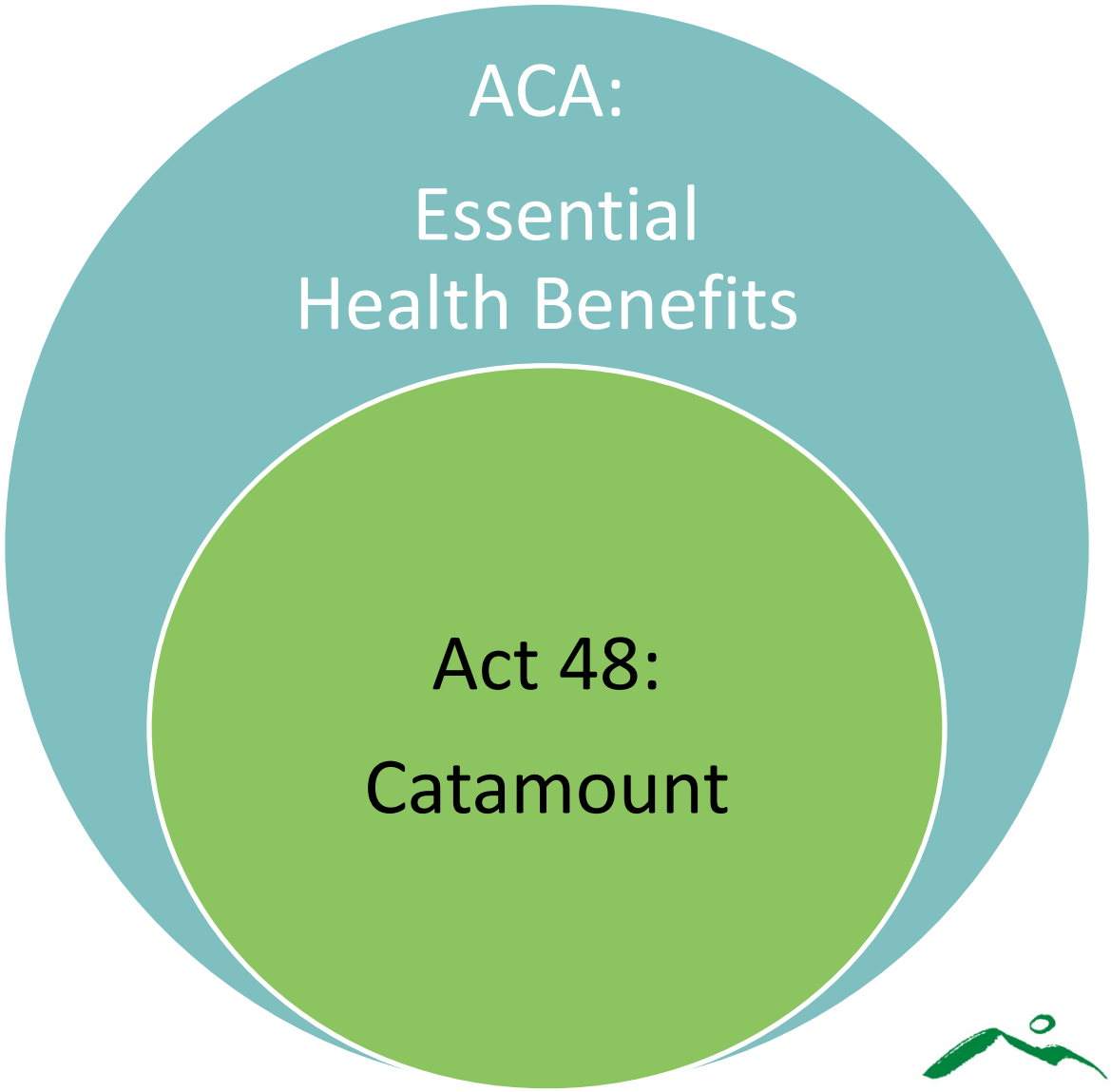
Above and beyond Catamount and other plans

Covered Services – Mental Health

Mental Health Consideration:

- Parity is required by federal law
- VT's laws exceed federal requirements by applying to non-group market, too
- Differences in out-of-network coverage are not limits considered by HHS to carry over to the definition of essential health benefit

GMCB Legal Parameters



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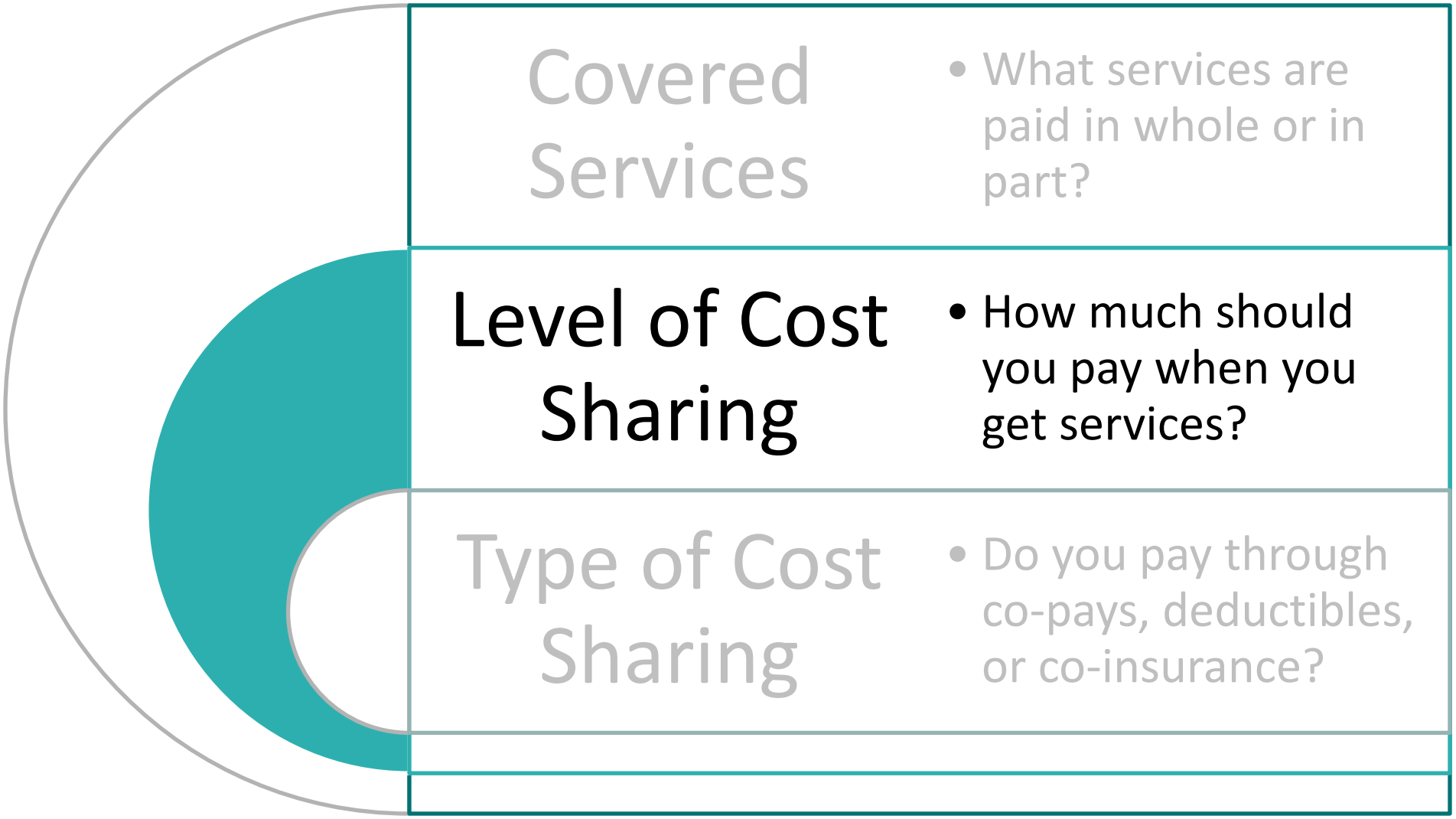
GMC Benefits and Covered Services

State law requires GMCB to consider adding the following services:

- Adult dental
- Adult vision
- Hearing
- Long Term Care Services and Supports

Vermont will not receive any extra federal funding to cover these services

Benefits and Level of Cost Sharing



Level of Cost Sharing: Definitions

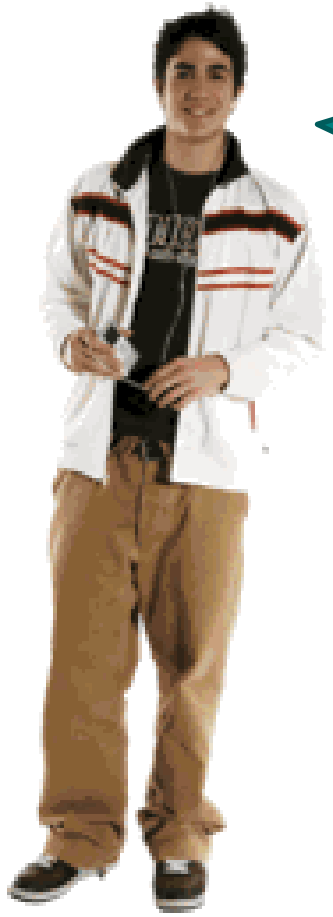
What is cost sharing?

- Cost sharing is the part of the plan that you pay when you receive covered services
- Includes:
  - Deductibles
  - Co-Pays
  - Coinsurance
- Does NOT include
  - Premiums

Level of Cost Sharing

- Plans can have different levels of cost sharing but still cover the same services

I pay a $20 co-pay when I see my therapist

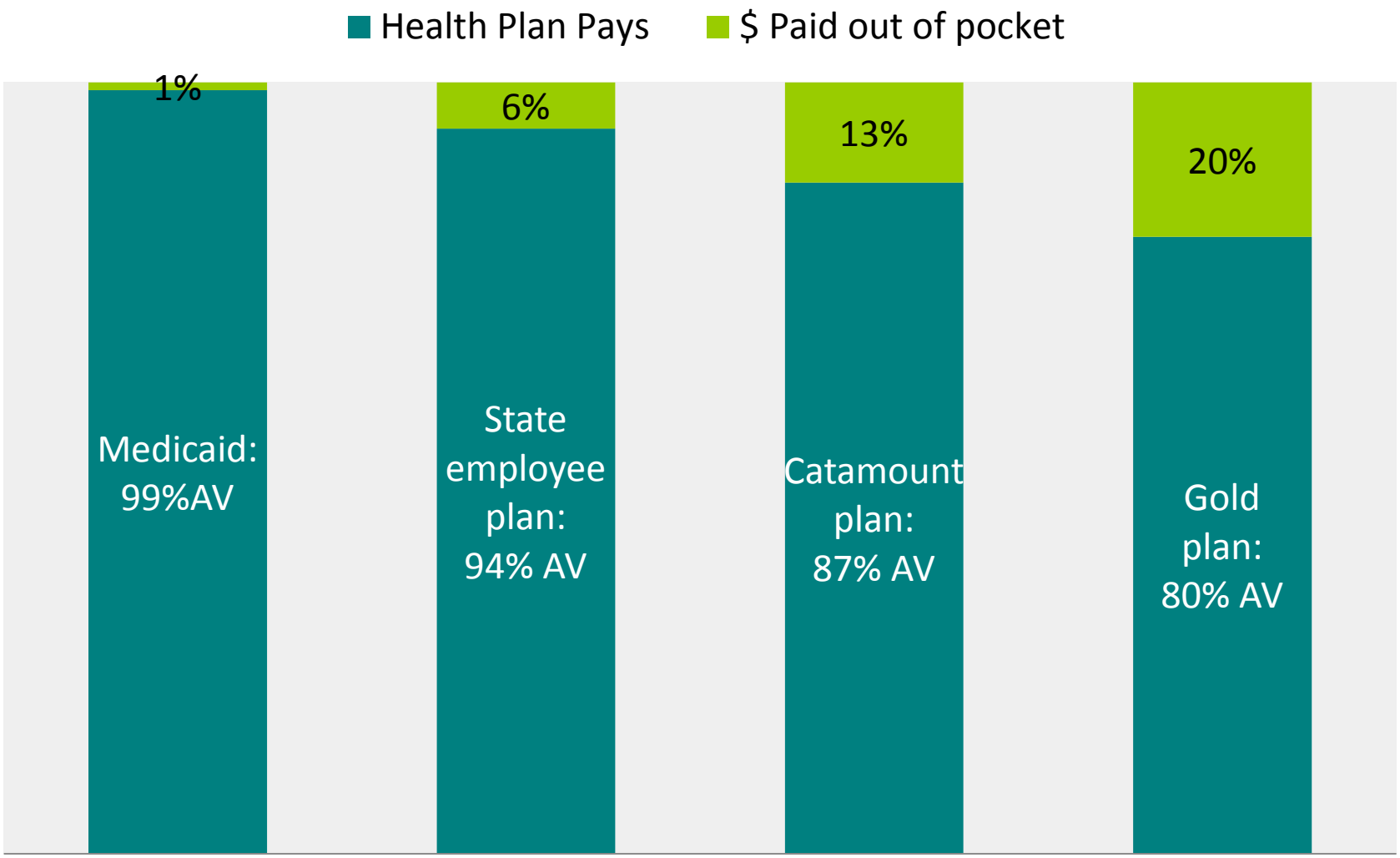


I pay a $50 co-pay when I see my therapist

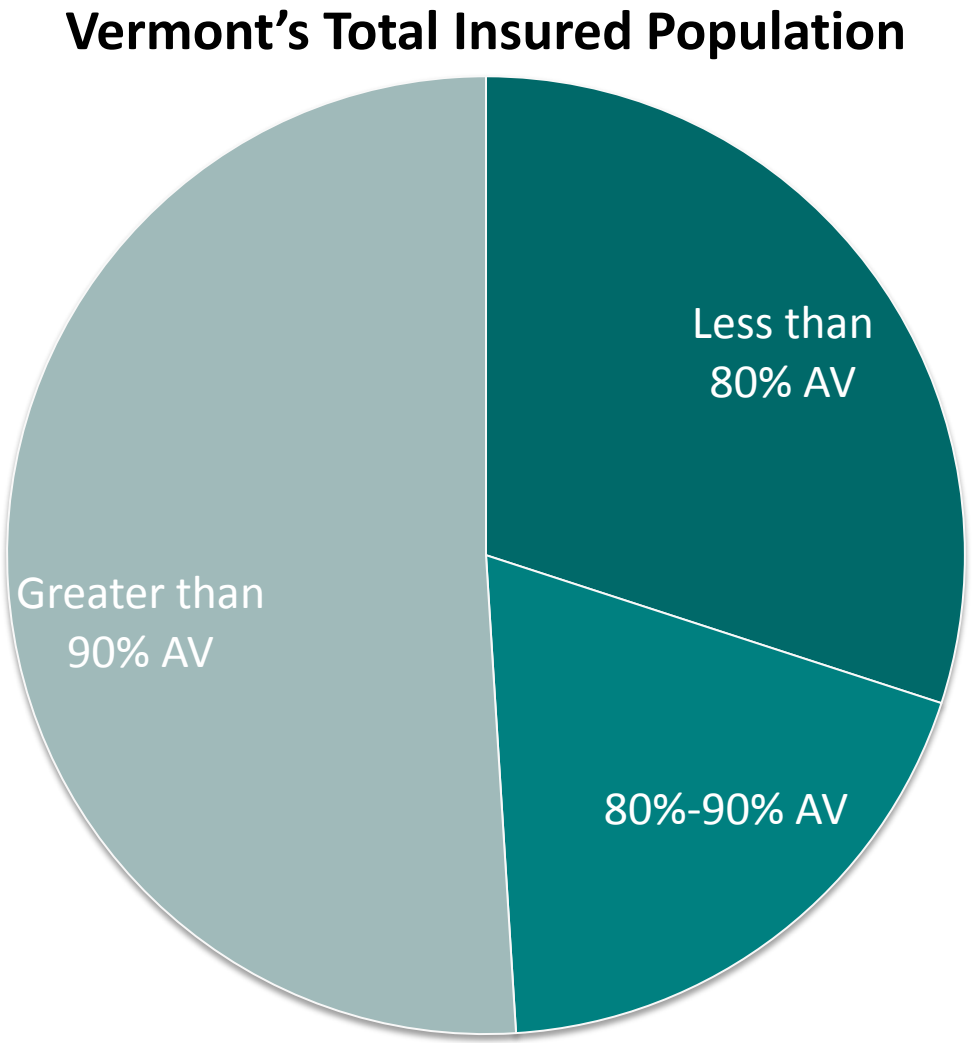
Level of Cost Sharing

- These different levels of cost sharing are called actuarial value (AV)
- Actuarial value means the total average costs of covered services that your plan will cover
- In a plan with a high AV, you will pay less in co-pays, co-insurance, and deductibles
- A plan with a low AV, you will pay more in co-pays, co-insurance, and deductibles

Level of Cost Sharing—AV Examples



Level of Cost Sharing – 2013

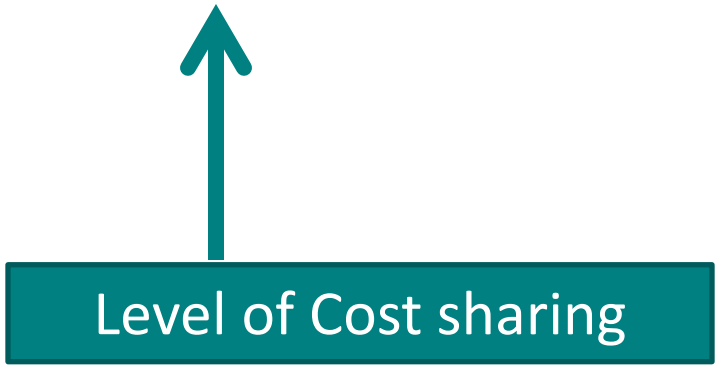


VERMONT HEALTH CARE REFORM

GMC Benefits and Level of Cost Sharing

The Affordable Care Act Waiver requires state to:

- Cover the same or more people than under the ACA
- Provide coverage that is as good or better than the ACA
- Provide coverage that is as affordable or more affordable than the ACA
- Not increase the federal deficit



GMC Benefits and Level of Cost Sharing

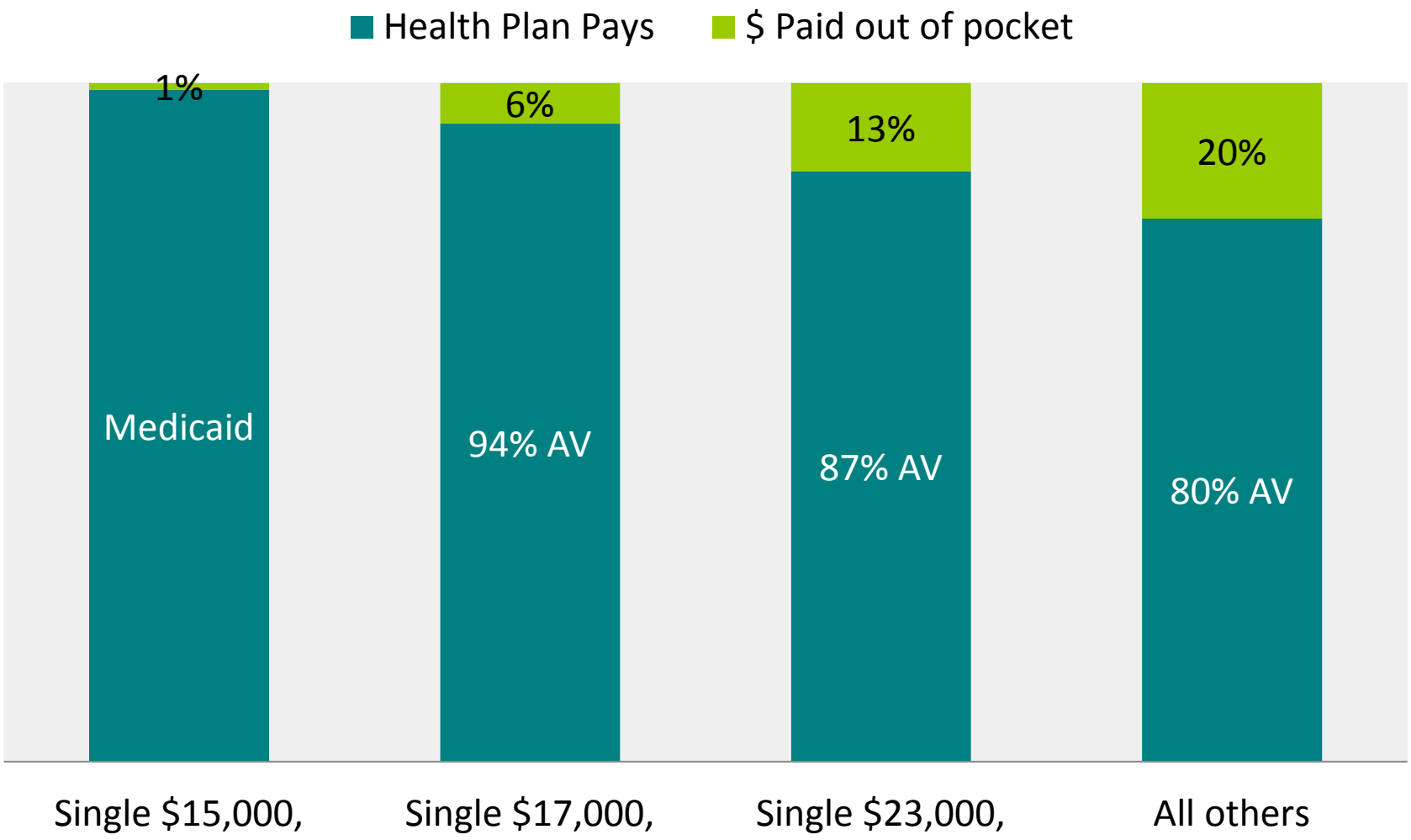
- Act 48 states that the GMC plan must be have at least an 80% AV
  - This looks like a gold plan in Vermont Health Connect

- Act 48 preferred an 87% AV plan for GMC
  - This is close to a platinum plan in Vermont Health Connect

GMC Benefits and Cost Sharing

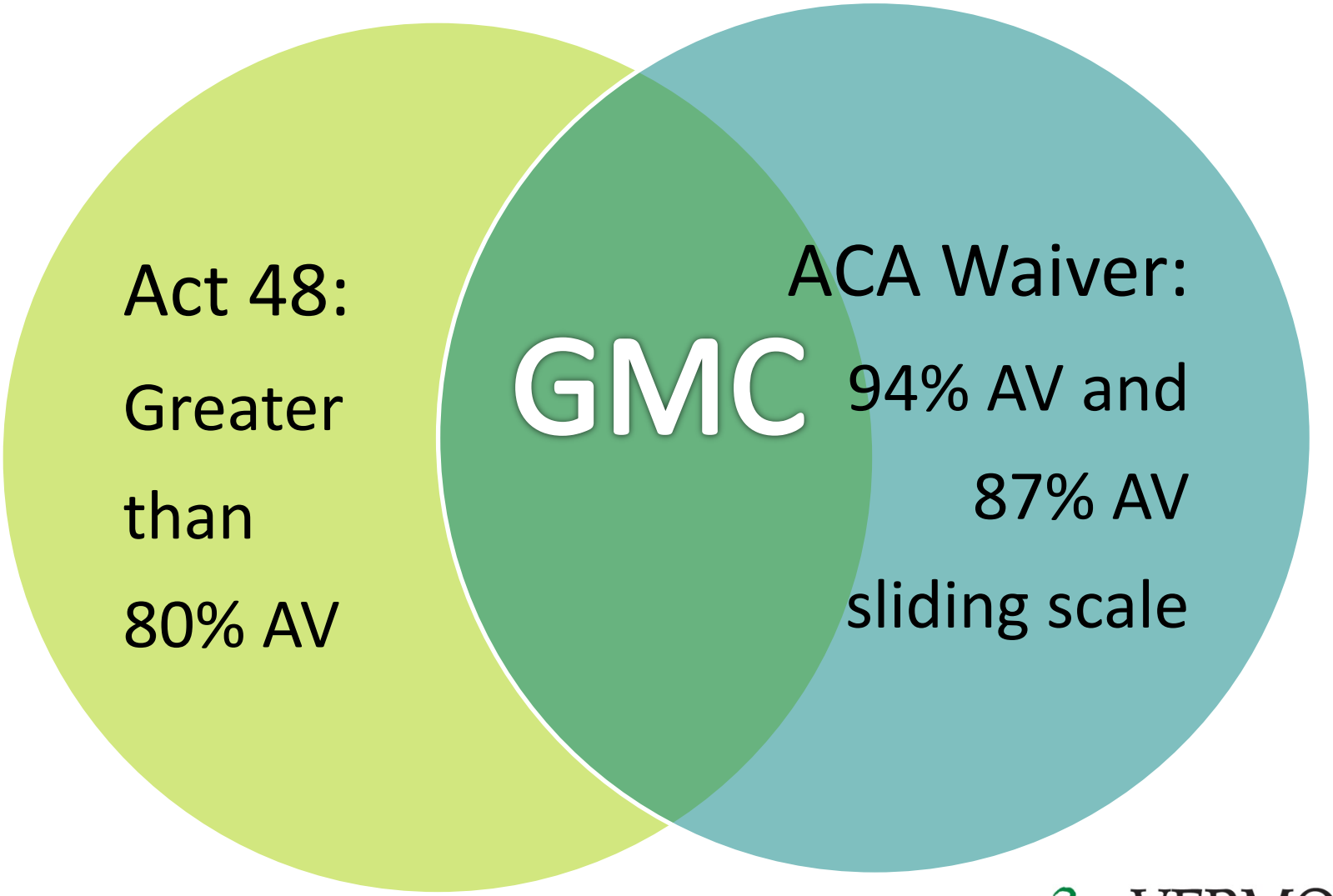
- The Affordable Care Act requires us to provide coverage that is as affordable or more affordable than the ACA.
- This means that people who are eligible to pay lower out of pocket costs through cost sharing reductions in Vermont Health Connect will pay lower out of pocket costs under GMC

ACA Cost Sharing Sliding Scale

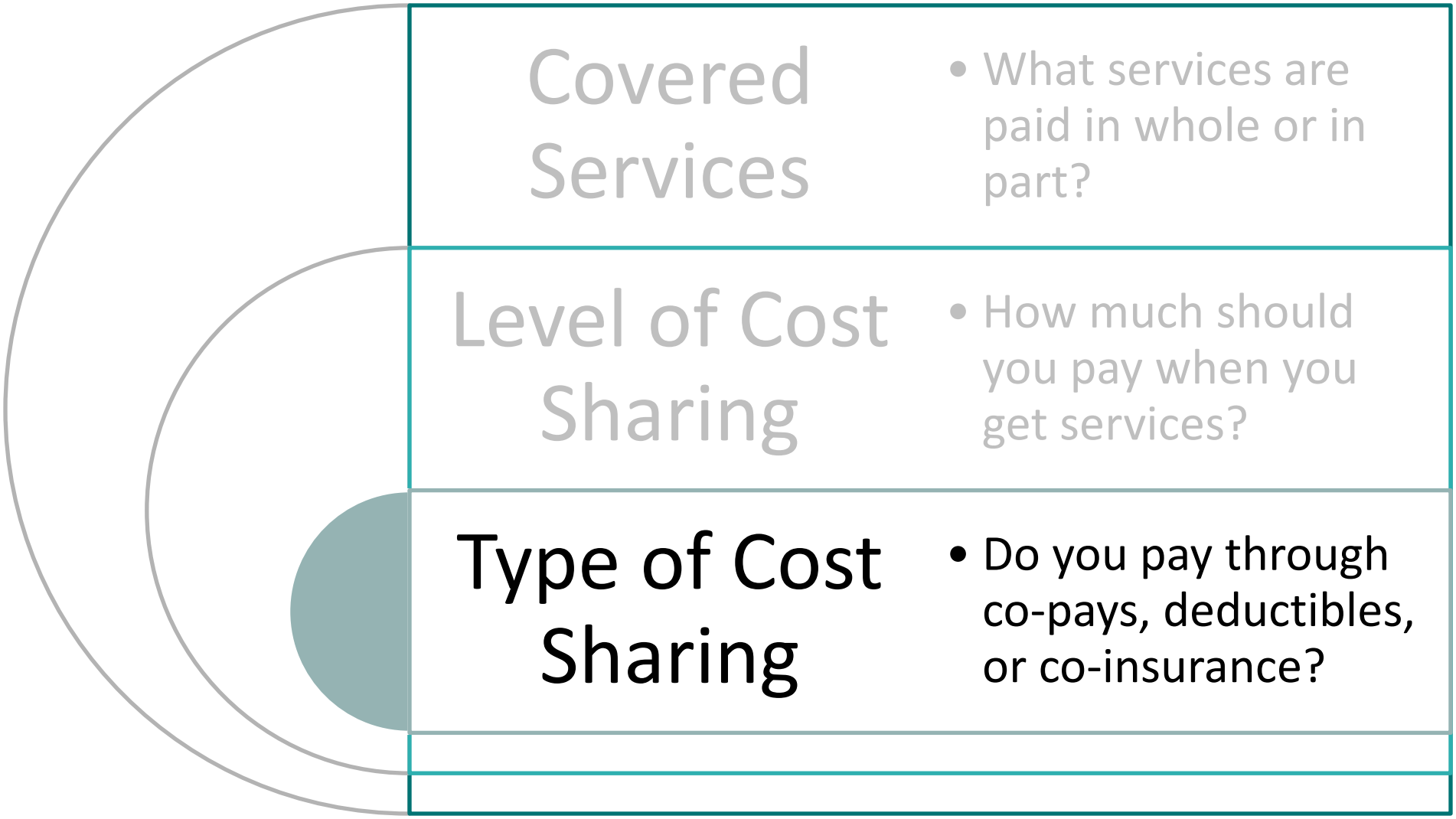


VERMONT HEALTH CARE REFORM

GMCB's Legal Parameters



Benefits and Type of Cost Sharing



Type of Cost Sharing: Definitions

What is a deductible?

- The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
  - Preventive services are covered 100%
  - Deductible may not apply to all services, like primary care physician's visits

Type of Cost Sharing: Definitions

What is co-insurance?

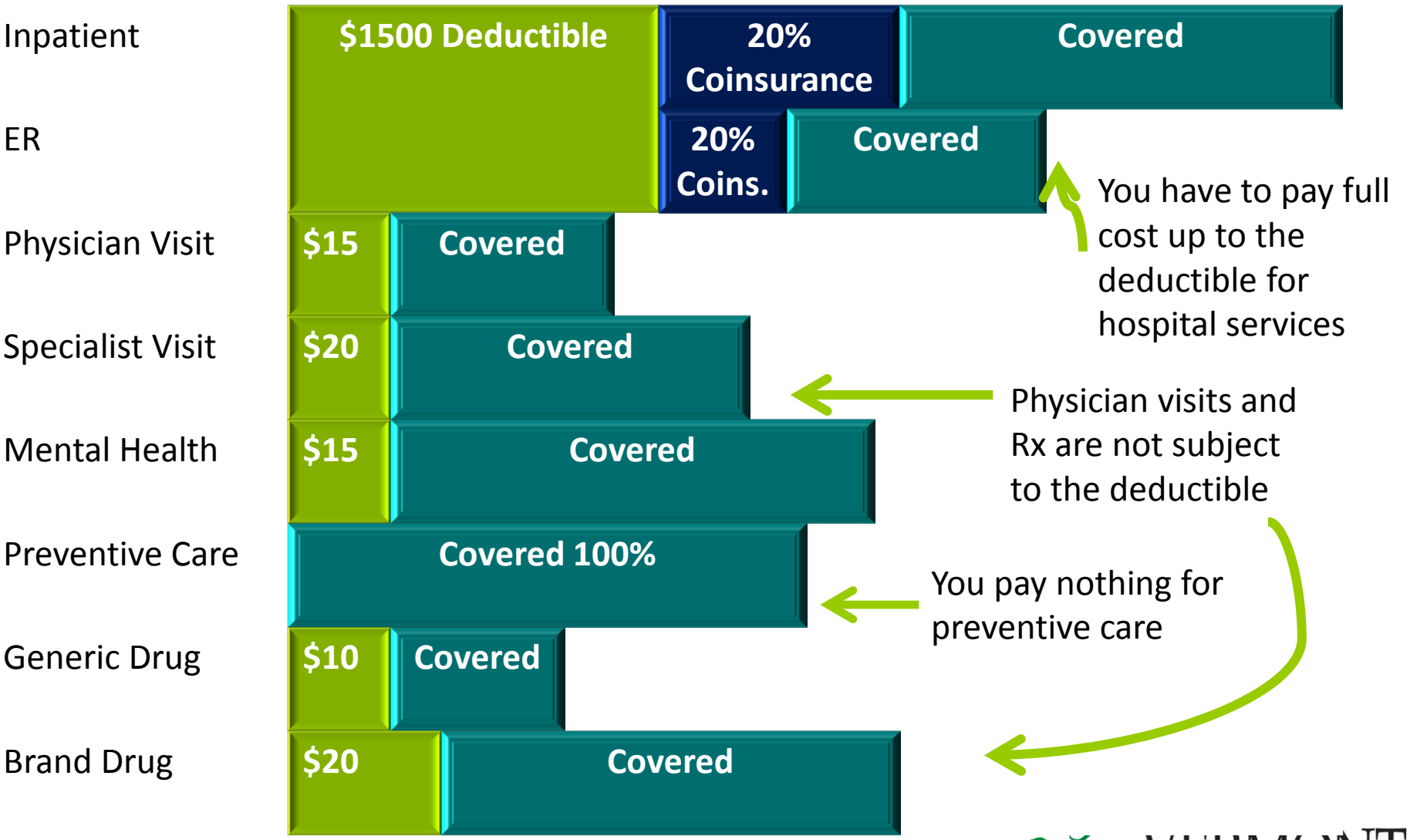
- Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.
- For example, if the cost of a hospital service under your health plan is $1,000, your coinsurance payment of 20% would be $200. The health insurance or plan pays the rest of the allowed amount.

Type of Cost Sharing: Definition

What is a co-pay?

- A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Type of Cost Sharing: Plan Example



VERMONT HEALTH CARE REFORM

Type of Cost Sharing: Plan Example

- Family of four. One child with diabetes. Parent A with cholesterol and high blood pressure meds. Parent B to receive colonoscopy. Other child breaks arm in a ski accident.

	Units	Cost /unit	Allowed Costs	Deductible	Co-pay	Co-ins
PCP Visits	8	$100	$800	N/A	$120	N/A
Diab. meds (generic)	12	$144	$1,728	N/A	$120	N/A
Cholesterol meds	12	$79	$948	N/A	$240	N/A
ER & Hosp. services	1	$3,000	$3,000	$1500	N/A	$300
Colonoscopy (preventive)	1	$4,300	$4,300	$0	$0	$0
Total cost				**$10,776**		
Family pays				**$2,280**		

Questions?

Appendix B-6. Presentation to the Green Mountain Care Board
December 11, 2014

Green Mountain Care: Lay of the Land for Covered Services and Level of Cost Sharing

Robin J. Lunge, J.D., MHCDS
Director of Health Care Reform, AOA

Devon J. Green, J.D.
Special Counsel on HCR, AOA

December 11, 2014

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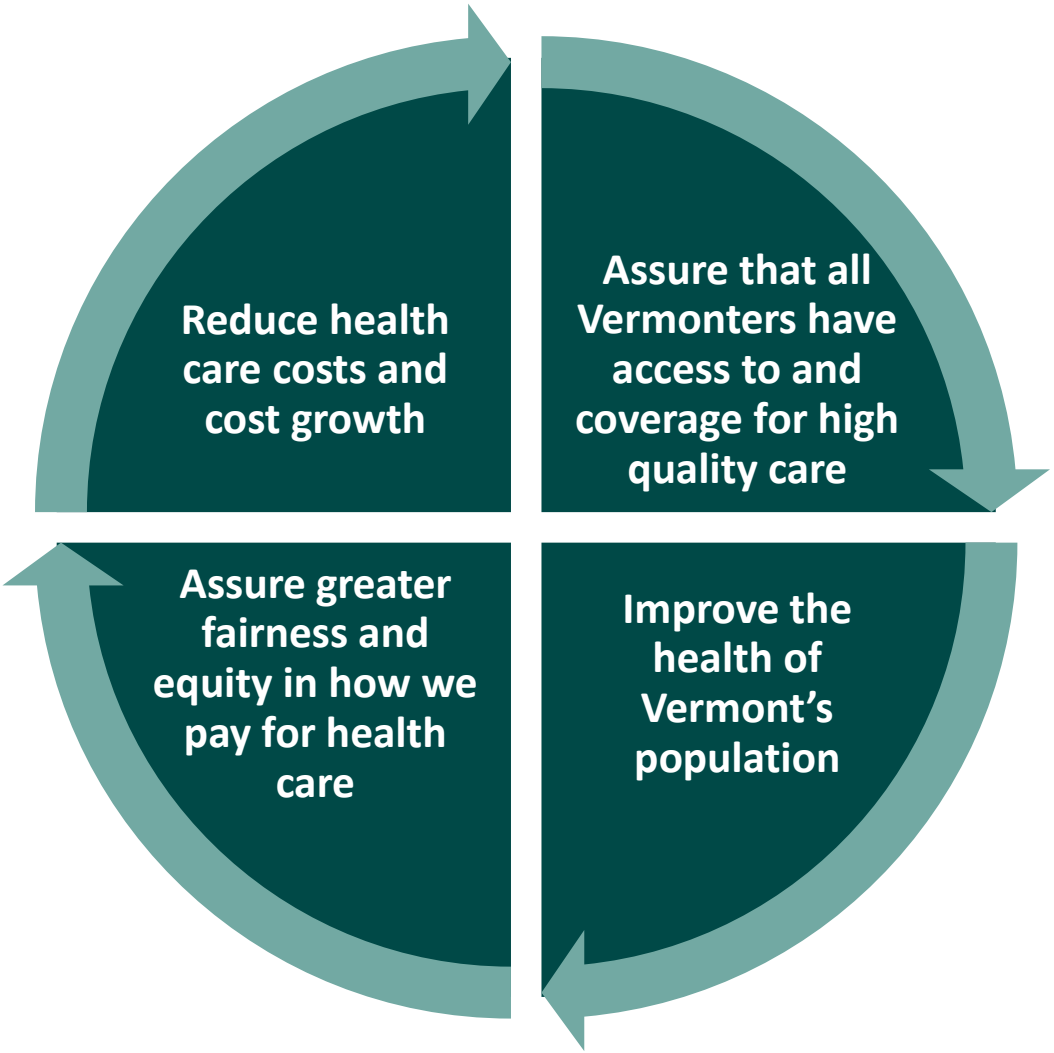
HEALTH CARE REFORM

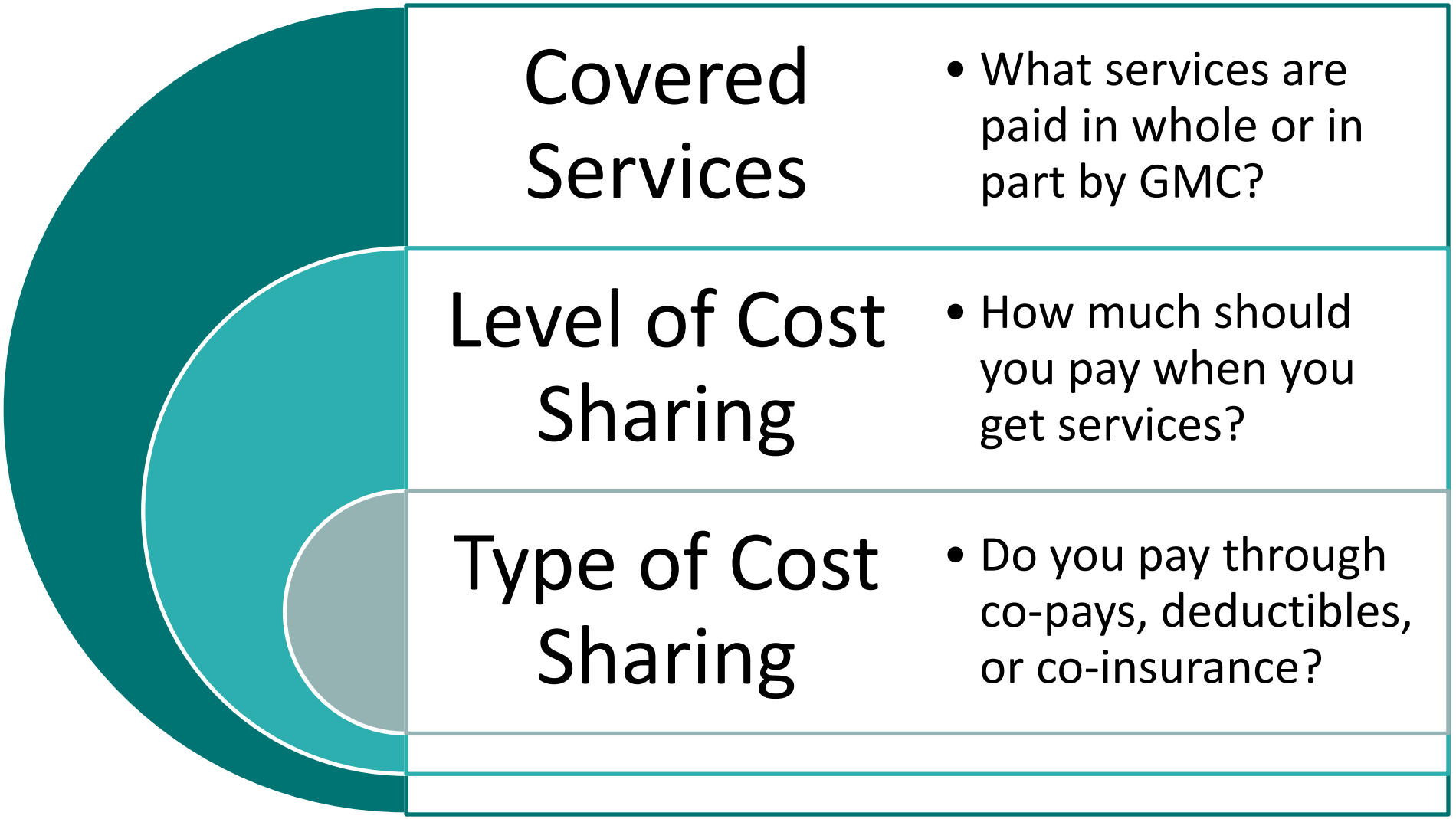
Discussion for Today

- Covered Services
  - Today's covered services
  - Overview of covered services in other states
  - Overview of covered services in other countries
- Level of Cost Sharing
  - Level of cost sharing in Vermont today
  - Overview of level of cost sharing in other countries
- Benefit design public input

Health Care Reform Goals: Why Reform?



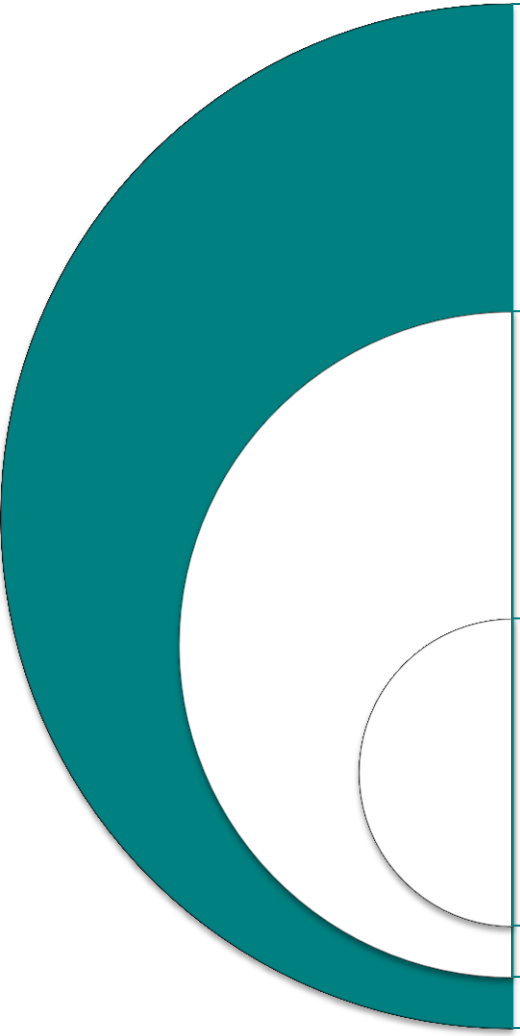
GMC Benefits



Design Considerations

- Federal and state requirements for benefits
- Equity
- Administrative cost & complexity
- Options fit together, easy to explain
- Individual out of pocket cost (average & max)
- Medical cost & utilization
- Change from current/expected
- Federal & state tax implications

GMC Benefits and Covered Services



Covered Services	• What services are paid in whole or in part by GMC?
Level of Cost Sharing	• How much should you pay when you get services?
Type of Cost Sharing	• Do you pay through co-pays, deductibles, or co-insurance?

Covered Services Today

	Essential Health Benefit	State Employee and Retirees		VEHI Education Employees and Retirees	
		SelectCare	Total Choice	300 Ded	VHP
Chiropractic	Limit 12 visits then prior approval required	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Limit 60 visits per year (total visits for PT, OT, ST, Chiro)	Prior approval required after 12th visit	Prior approval required after 12th visit
Infertility	Not covered	Up to $50,000 lifetime max	Up to $50,000 lifetime max	Not covered	Not covered
Bariatric Surgery	Covered	Covered, medical necessity	Covered, medical necessity	With prior approval	With prior approval
Fertility Drugs	Covered	Covered	Covered	Covered	Covered
Routine Eye Exams	1/year for children	$100/2 years	$100/2 years	Not covered	1/year

Covered Services Today

State Mandates stay in place:

- Maternity coverage
- Outpatient contraceptive services, including sterilization
- Home health care
- Emergency room services
- Newborn coverage
- Autism spectrum disorders for children
- Chiropractic services
- Prosthetic devices
- Mammograms
- Anesthesia for dental procedures performed on certain covered persons
- Child Vaccine benefits
- Prostate screenings
- Colorectal cancer screening
- Diabetes treatment
- Mental health and substance abuse
- Clinical trials for cancer patients
- Chemotherapy treatment
- Orally administered anticancer medication
- Treatment of inherited metabolic diseases
- Craniofacial disorders
- Off-label use

GMCB's Legal Parameters

- Green Mountain Care must have all of the ACA's essential health benefits (EHBs)
- State law requires GMCB to consider adding the following services:
  - Adult dental
  - Adult vision
  - Hearing
  - Long Term Care
- Vermont will not receive any extra federal funding to cover these services

Covered Services State Comparison– Dental EHB

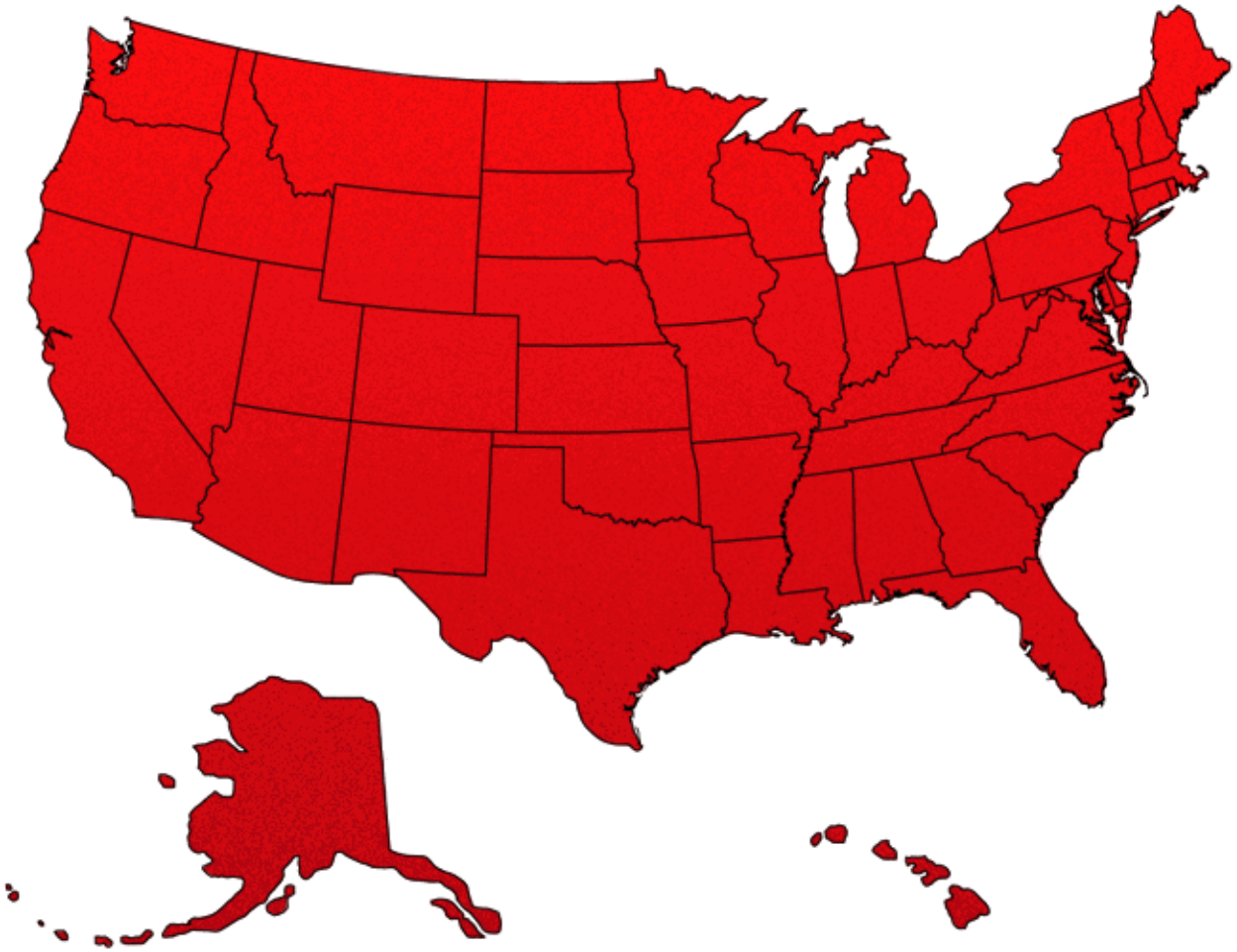
- At the last meeting, GMCB requested an overview of how adult dental is covered in other states
- We examined the essential health benefits package of each state as well as the Medicaid covered services to compare adult dental coverage

Covered Services State Comparison– Dental EHB

- All essential health benefits packages must include coverage of pediatric dental. Vermont covers pediatric dental up to age 21:
  - Prevention, evaluation and diagnosis, including radiographs when indicated
  - Periodic prophylaxis, including topical fluoride applied in a dentists office
  - Periodontal therapy
  - Treatment of injuries
  - Treatment of disease of bone and soft tissue
  - Oral surgery for tooth removal and abscess drainage
  - Treatment of anomalies
  - Endodontics (root canal therapy)
  - Restoration of decayed teeth
  - Replacement of missing teeth, including fixed and removable prosthetics (i.e. crowns, bridges, partial dentures and complete dentures)

Covered Services State Comparison– Dental EHB

Adult dental & health insurance: no states cover as EHB



Covered Services State Comparison– Dental EHB

Adult dental & health insurance:

- The U.S. Territories, except for Puerto Rico, covers:
  - 2 check-ups per year

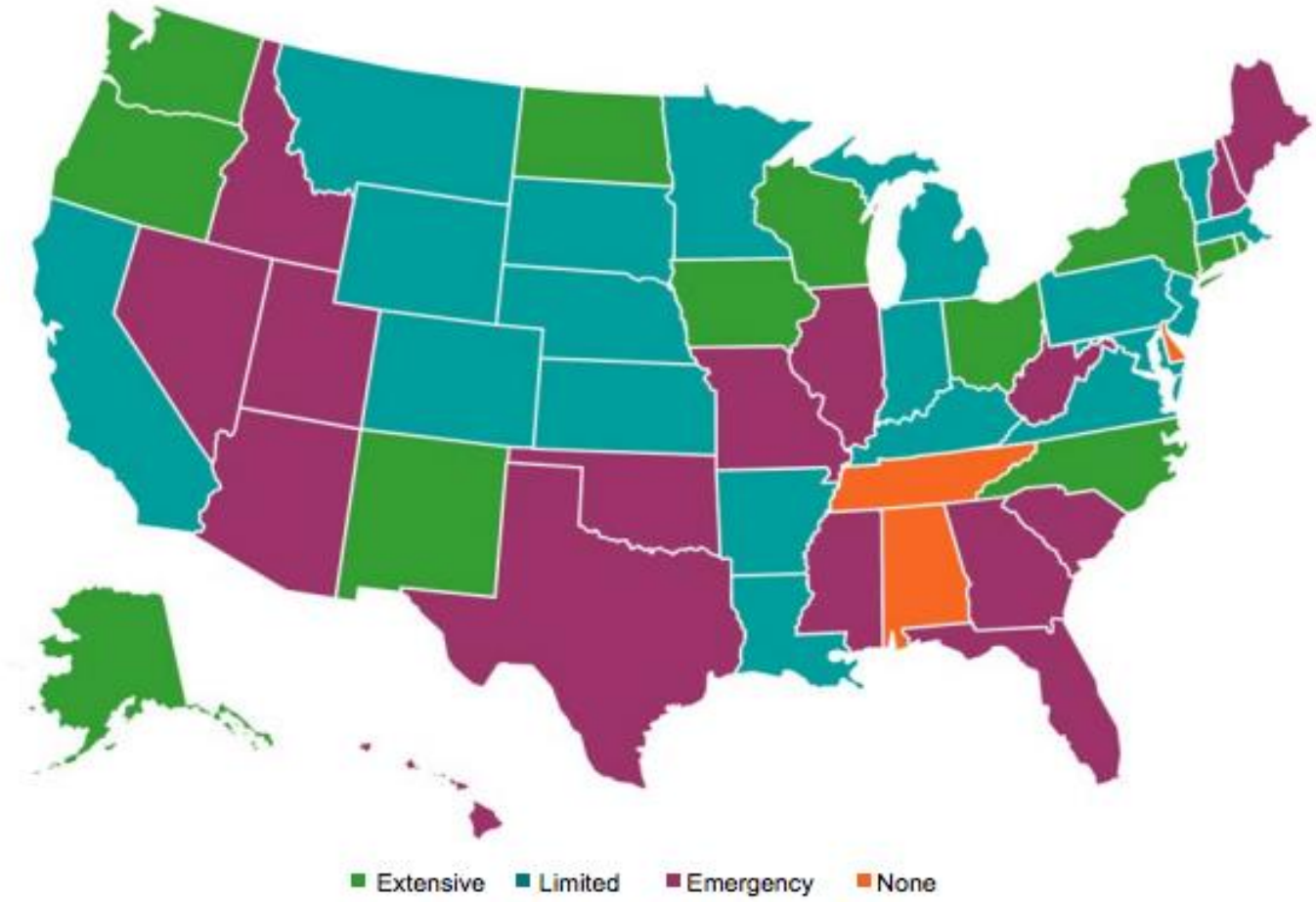
  NOTE: Feds chose federal health insurance as benchmark plan due to unique nature of territory markets
- Puerto Rico covers
  - 2 check-ups per year
  - X-rays once every three years

Covered Services State Comparison– Dental Medicaid

- Under Vermont Medicaid, adults with income up to 138% FPL receive dental under Medicaid
  - $510 per beneficiary per year
  - Beneficiaries pay $3.00 per visit for dental services
- Benefit primarily limited by access to providers
  - Source: Green Mountain Care Board: Vermont Dental Landscape Study, 2013.

Covered Services State Comparison– Dental Medicaid

- Adult Dental & Medicaid



Source: Yarbrough C, Vujicic M, Nasseh K., *More than 8 Million Adults Could Gain Dental Benefits through Medicaid Expansion.* Health Policy Resources Center Research Brief. American Dental Association. February 2014.

Covered Services State Comparison– Dental Medicaid

Benefit Level	Definition
None	No dental benefits.
Emergency	Relief of pain and infection. While many services might be available, care may only be delivered under defined emergency situations.
Limited	Includes benefits that have a per-person annual expenditure cap of $1,000 or less.
Extensive	Includes benefits that have a per-person annual expenditure cap of at least $1,000.

Covered Services International Comparison

- Health care systems in other countries generally cover:
  - Inpatient
  - Outpatient
  - Specialists
  - Clinical laboratory tests
  - Diagnostic imaging
  - Physical therapy
  - Pharmacy
- There is more variation in vision and dental coverage
- Comparisons of mental health coverage aren't readily available

Covered Services– International

	In-Patient	Out-patient	Specialist	Clinical	Imaging	Phys. Therapy	Pharmacy
Canada	✓	✓	✓	✓	✓	✗	✗
France	✓	✓	✓	✓	✓	✓	✓
Germany	✓	✓	✓	✓	✓	✓	✓
Japan	✓	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓	✓	✓	✗	✓
Switz.	✓	✓	✓	✓	✓	✓	✓
U.K.	✓	✓	✓	✓	✓	✓	✓

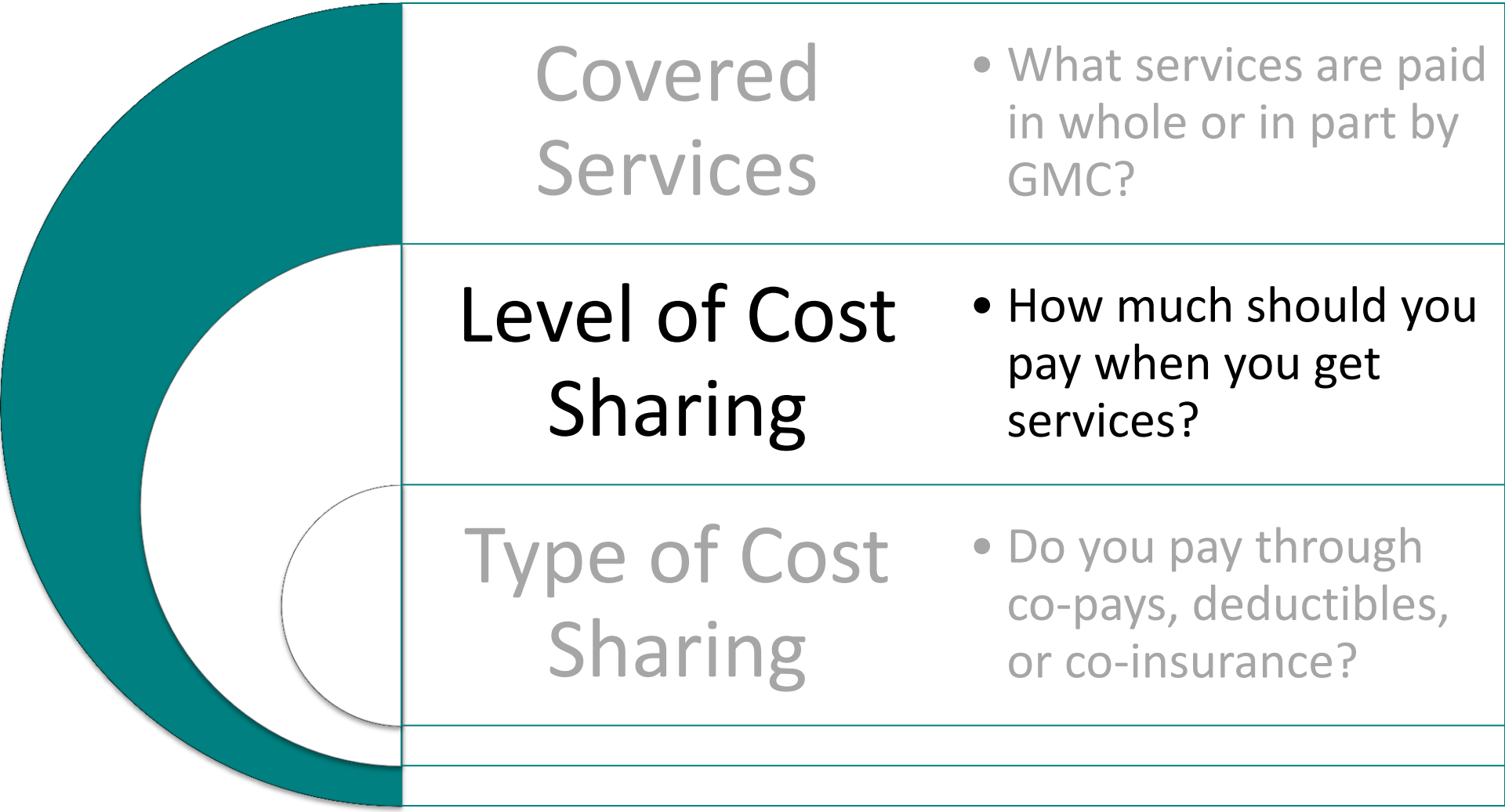
Source: Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing. Data from 2007 or last available year, http://dx.doi.org/10.1787/5kmfxfq9qbnr-en

Covered Services– International

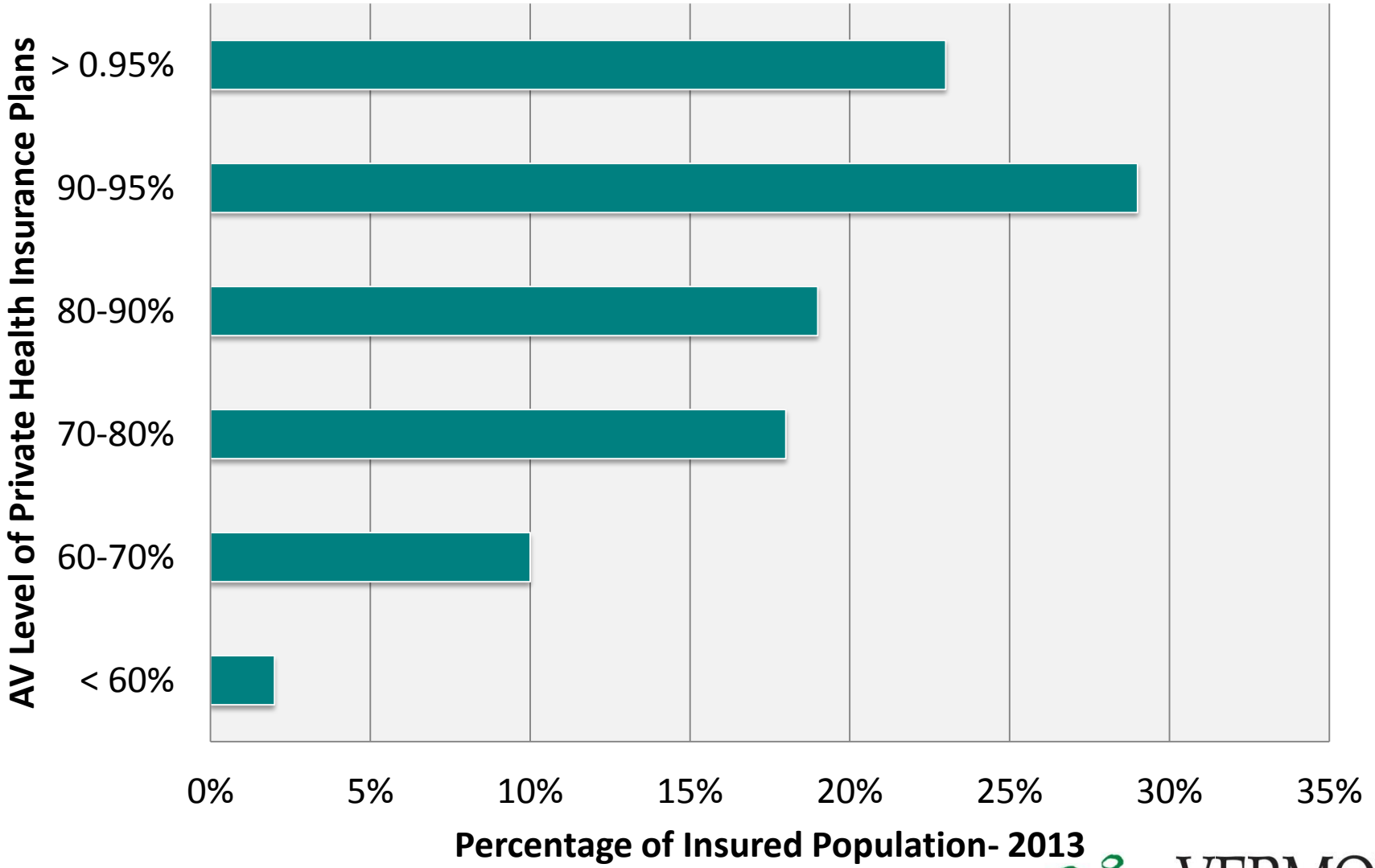
	Eyeglasses and/or contact lenses	Dental Care	Dental Prostheses
Canada	✗	✗	✗
France	½	½	½
Germany	½	✓	½
Japan	✗	✓	✓
Sweden	✗	½	½
Switzerland	½	✗	✗
United Kingdom	✗	✓	✓

Source: Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing. Data from 2007 or last available year, http://dx.doi.org/10.1787/5kmfxfq9qbnr-en

GMC Benefits and Covered Services



Level of Cost Sharing Today– Vermont



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Excise Tax on “Cadillac” Plans

- In 2018, a 40% excise tax will be assessed on the cost of coverage for health plans that exceed a certain annual limit
  - $10,200 for individual coverage
  - $27,500 for couples and family coverage
  - Numbers are for 2018, will be indexed to inflation

Excise Tax on "Cadillac" Plans

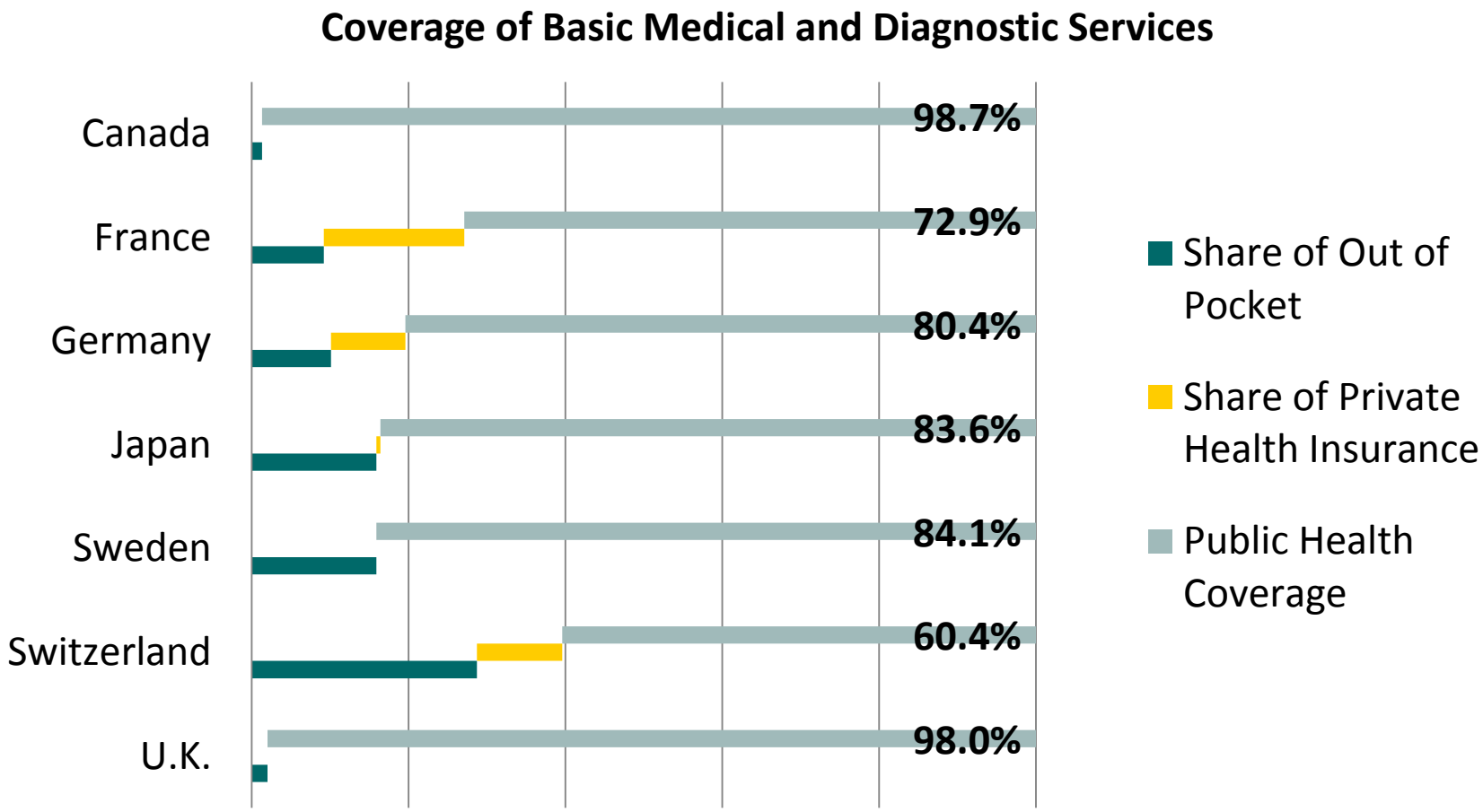
EXHIBIT 1

Employers' Responses to the Excise Tax, 2013

The International Foundation of Employee Benefit Plans asked 879 single-employer plans if they were taking action to avoid the 2018 excise tax.	
Yes	16.8%
No, but considering	40.0%
No, no plan to do so	13.5%
Not sure	9.6%
Not applicable, have no high-cost plans	20.0%
Employers that answered "yes," by size	
0–50	4.1%
51–499	13.1%
500–4,999	18.2%
5,000–9,999	18.5%
10,000+	29.4%

SOURCE International Foundation of Employee Benefit Plans, "2013 Employer-Sponsored Health Care: ACA's Impact: Survey Results," 2013.

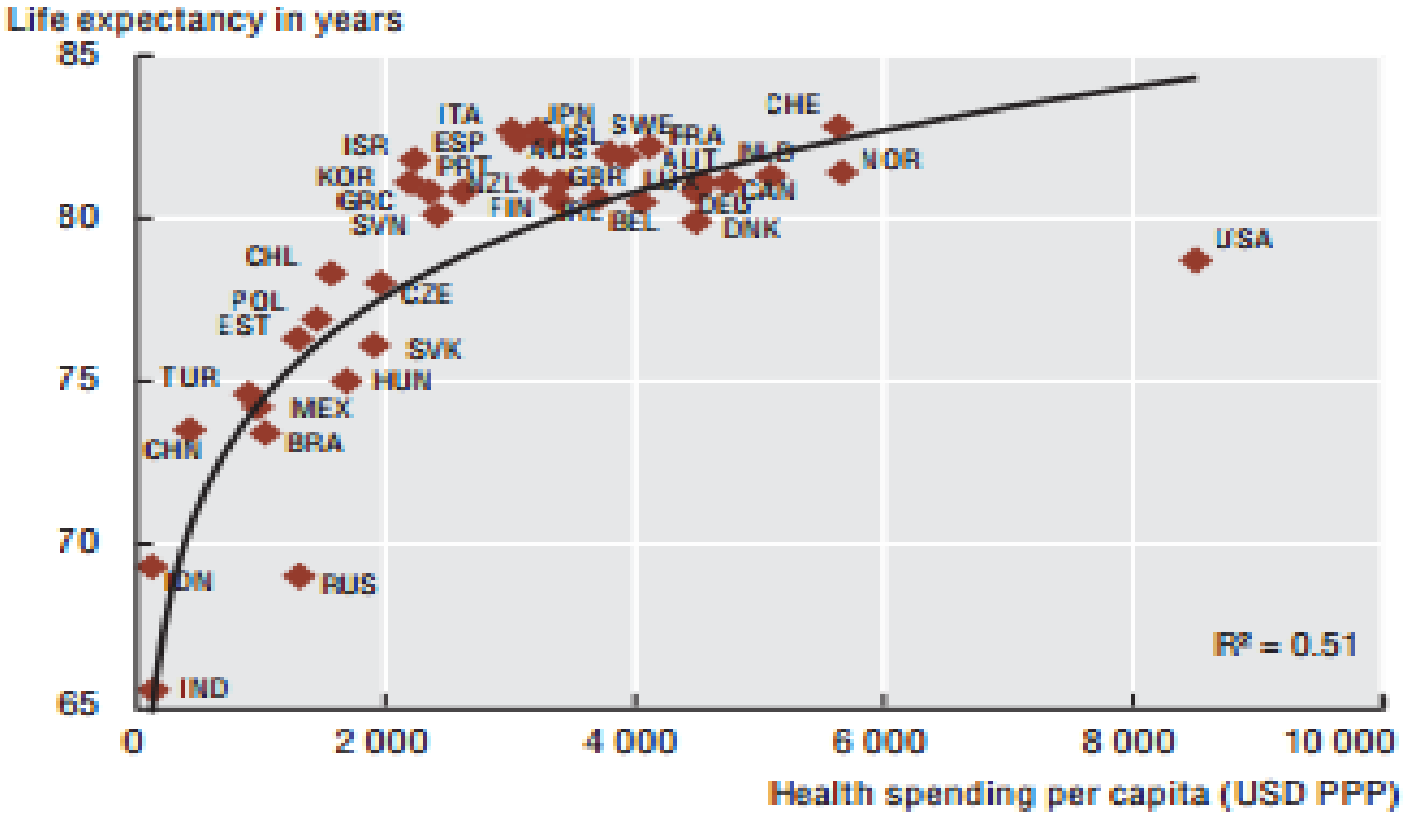
Level of Cost Sharing– International



Source: Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing. Data from 2007 or last available year http://dx.doi.org/10.1787/5kmfxfq9qbnr-en

Spending and Health Outcomes

Life Expectancy at birth and health spending per capita, 2011 (or nearest year)



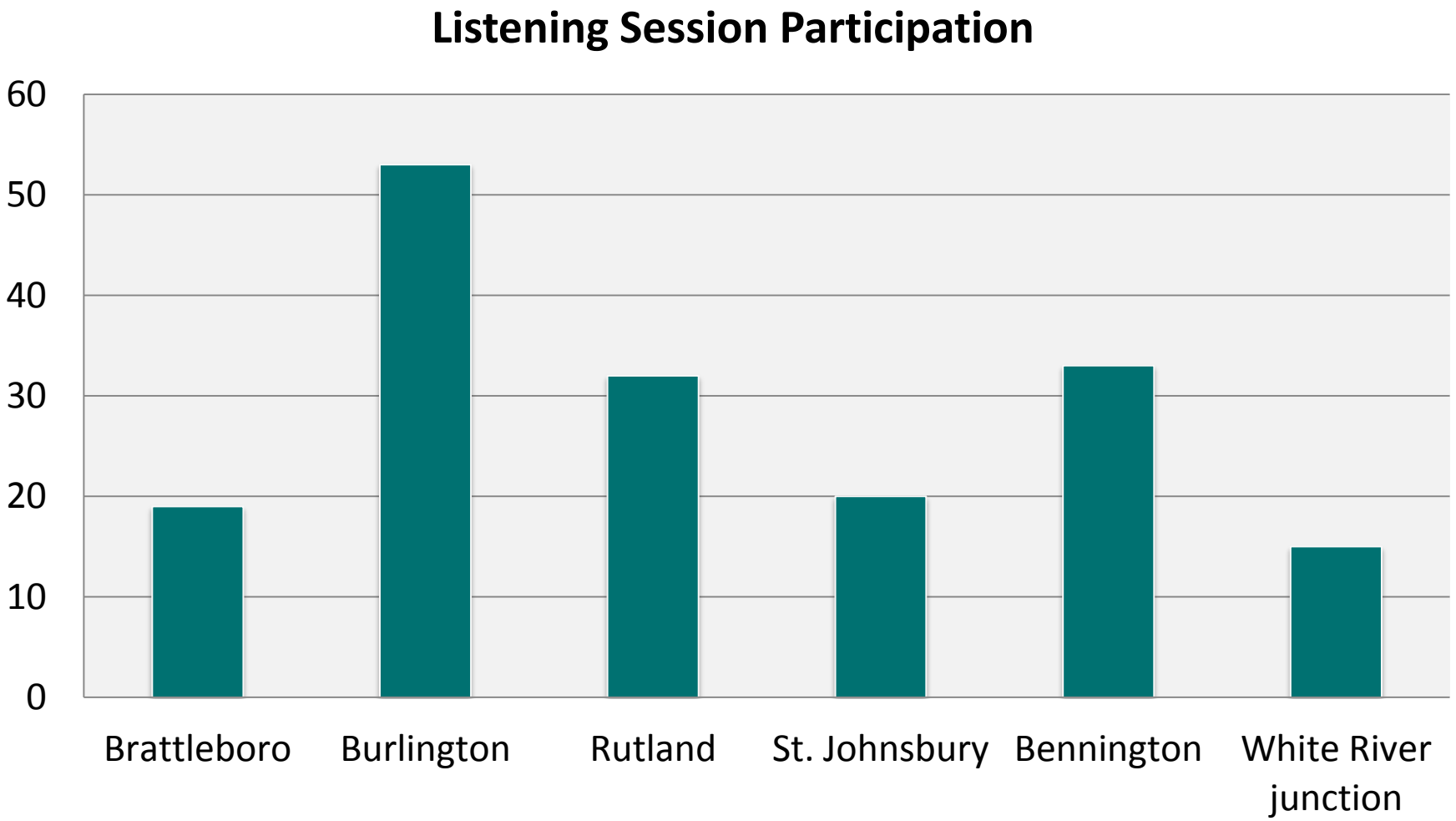
Source: OECD Health Statistics 2013, http://dx.doi.org/10.787/health-data-en; World Bank for non-OECD countries

PUBLIC INPUT

2012 Listening Sessions

- During the spring of 2012, AHS and AoA held a series of listening sessions around the state of Vermont to gather input on GMC's benefit design
  - April 25 – Brattleboro, Marlboro College Grad Center
  - May 2 – Burlington, City Hall Contois Auditorium
  - May 8 – Rutland Free Library, Fox Room
  - May 31 – Public Hearing with GMCB held at 11 VIT video-conferencing sites around the state
  - June 7 – St. Johnsbury, Catamount Arts
  - June 13- Bennington, Firehouse
  - June 20 – White River Junction, Hartford High School

2012 Listening Sessions



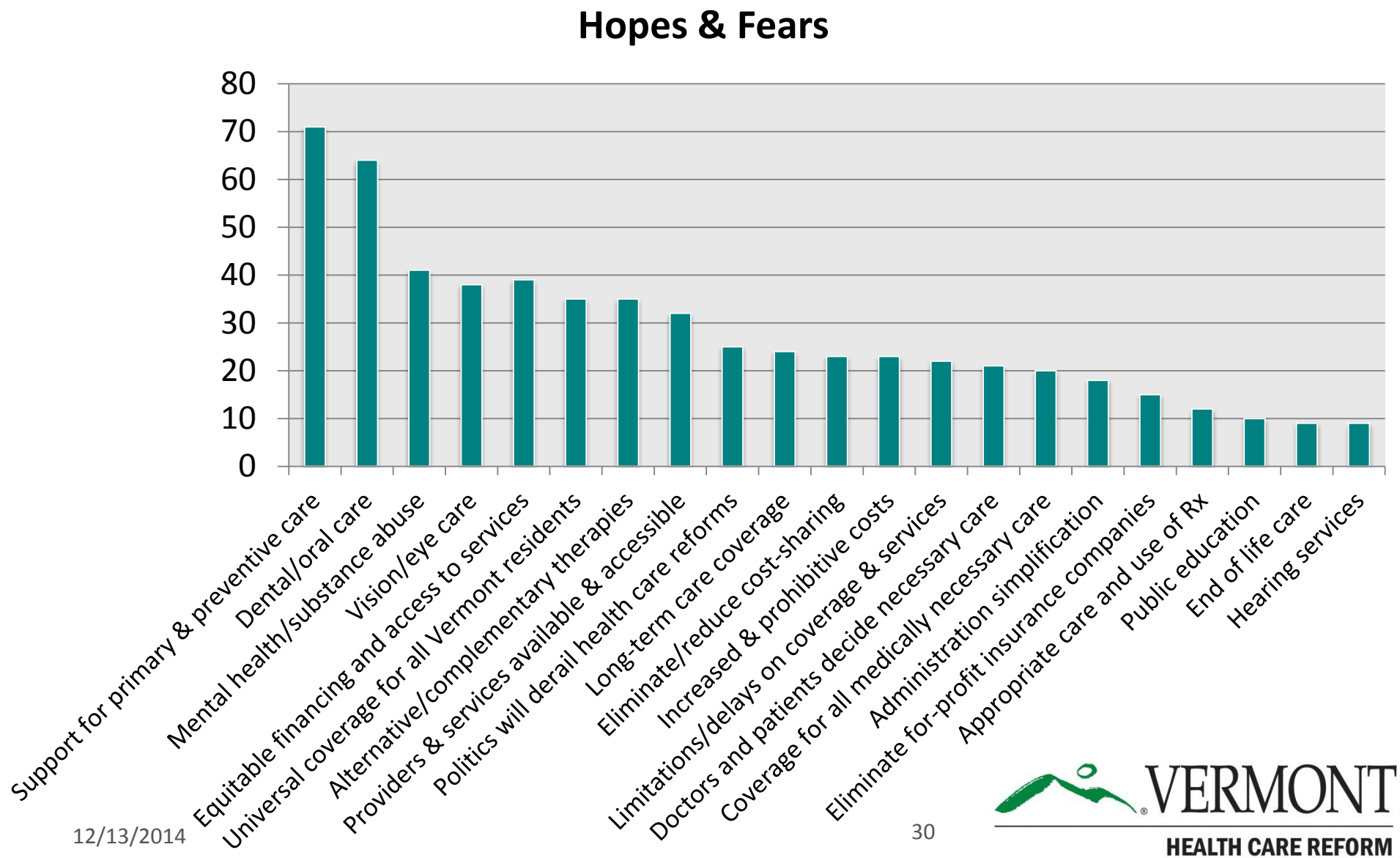
VERMONT HEALTH CARE REFORM

2012 Listening Sessions

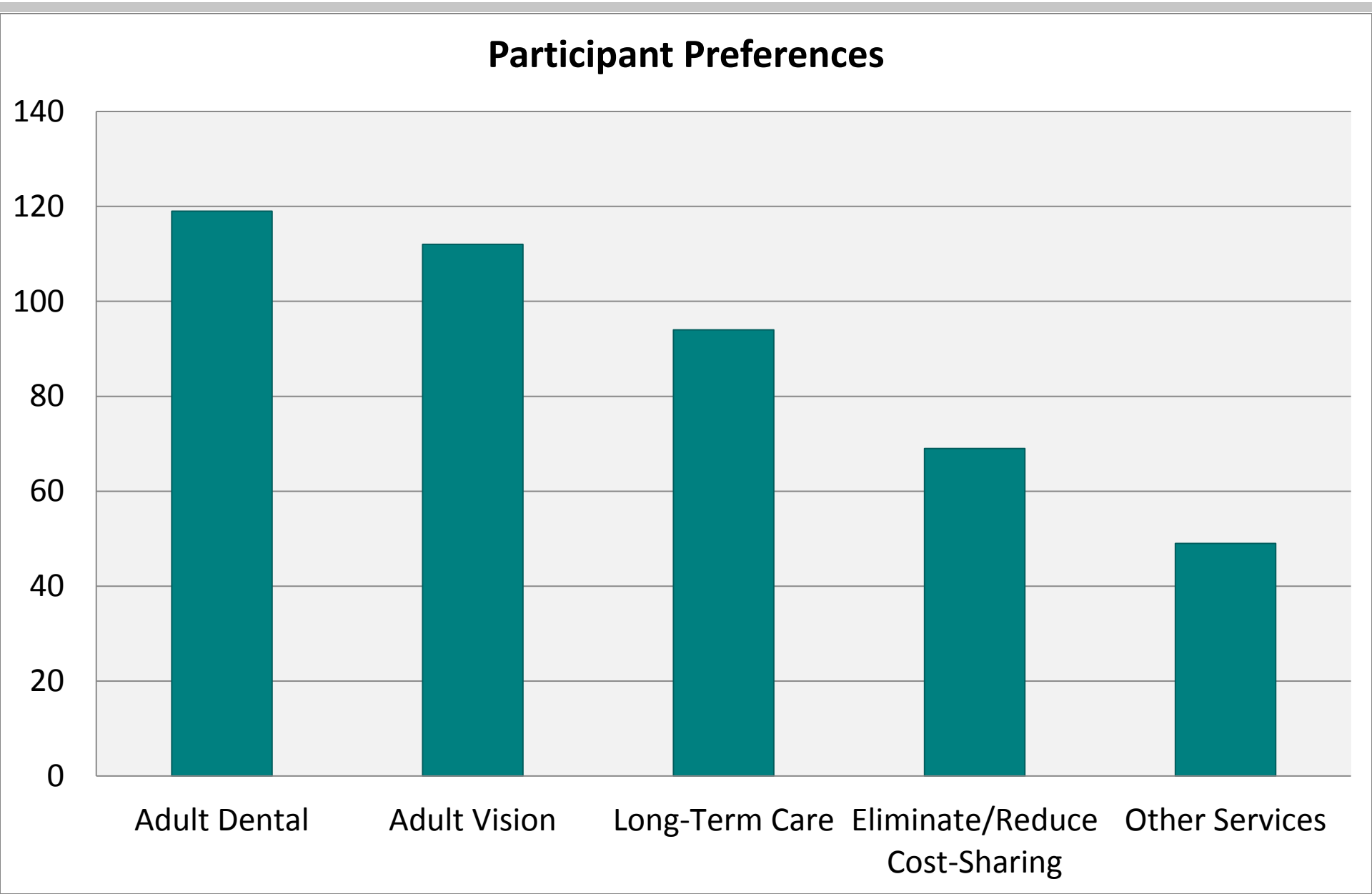
The listening sessions were divided into three components:

- Information- Health care reform implementation timeline and background information to frame discussion on benefit design.
- *Exercise #1* - Gathering open-ended feedback on hopes and fears from the public surrounding benefits and the single-payer system.
- *Exercise #2* - Setting priorities and examining the boundaries and limitations of a publicly financed system.

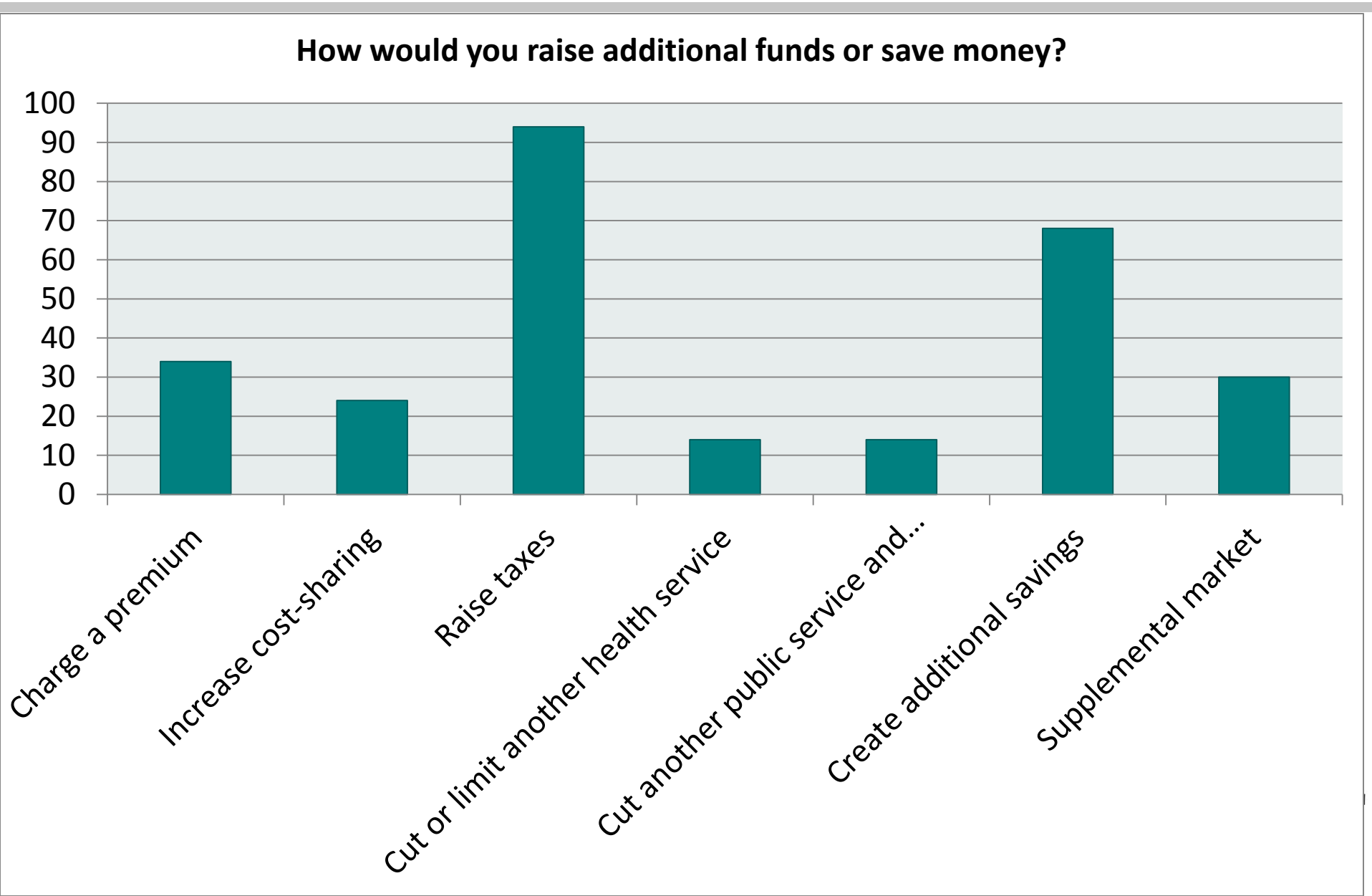
2012 Listening Sessions



2012 Listening Sessions



2012 Listening Sessions



Questions?

Appendix B-7. Presentation by Ellen Meara, Ph.D on Health Economics: Value Based Benefit Design

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Health Economics: Value-Based Benefits & Analytics

Vermont House Health Care Committee
Ellen Meara, PhD

MARCH 26, 2014

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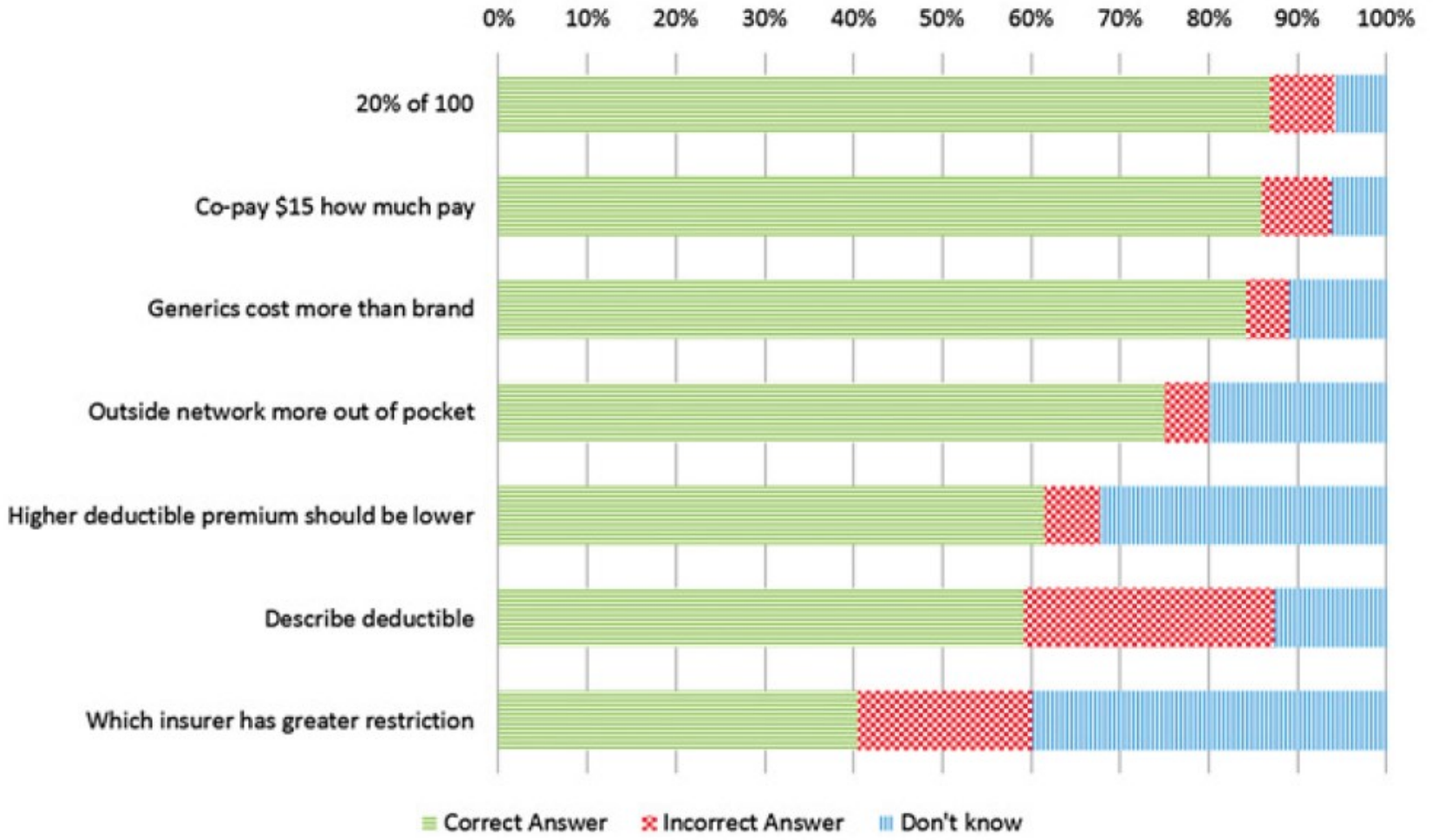
Context

Americans' (Lack of) Understanding of Health Insurance, 9/13



Source: Barcellos SH, Wuppermann AC, Carman KG, et al. Preparedness of Americans for the Affordable Care Act. *PNAS*. 2014.

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Goals

1. There is a tradeoff between insurance and costs
2. Cost-sharing lowers health care spending
3. Cost-sharing has unintended consequences

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Goals

1 **There is a tradeoff between insurance and costs**

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Tradeoff Between Insurance and Costs

Why do we want health insurance?	How is health insurance different?
Protection in case of (major) illness/injury	Not a one-time event like fires / accidents

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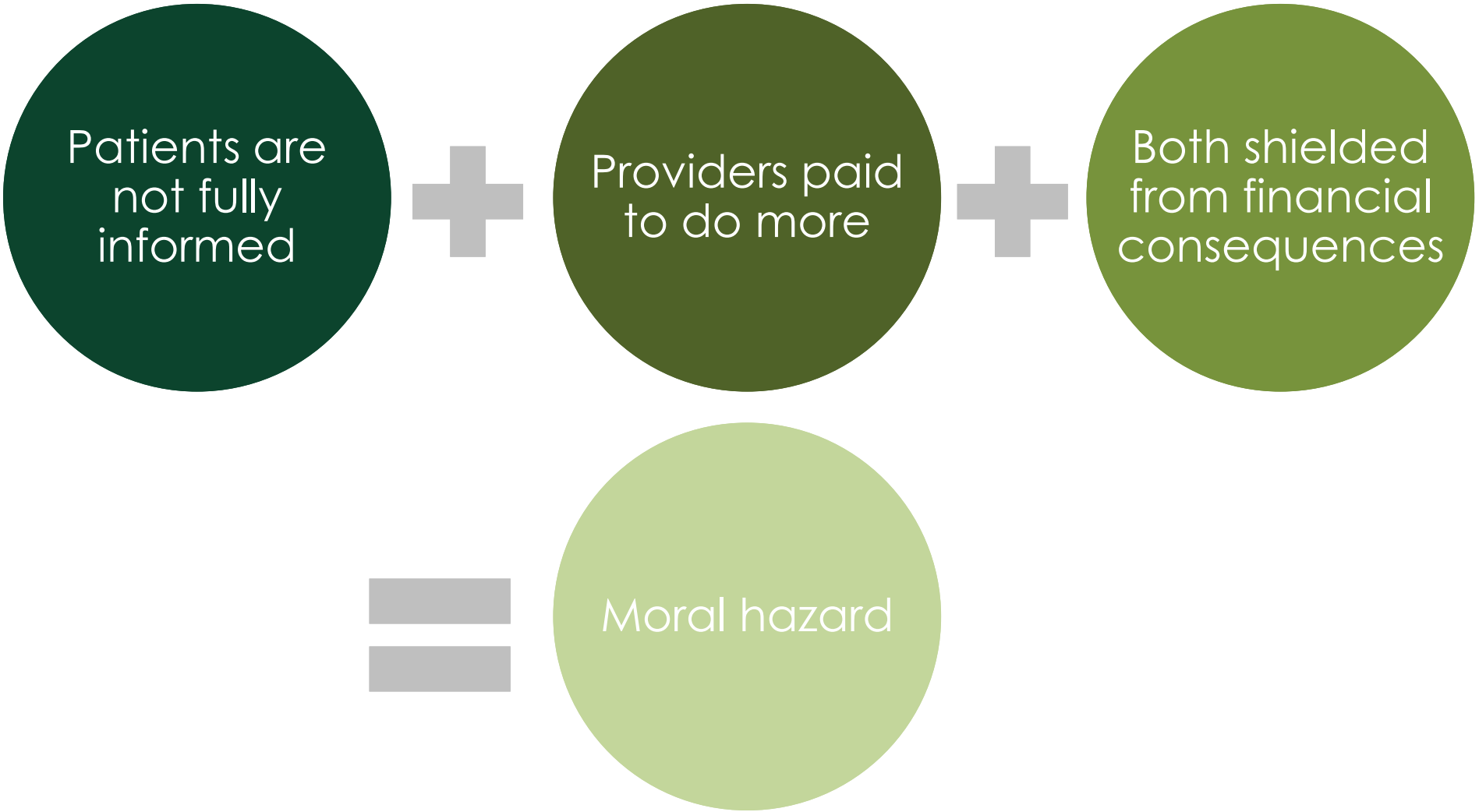
Tradeoff Between Insurance and Costs



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Goals

2 Cost-sharing lowers health care spending

3 Cost-sharing has unintended consequences

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Cost-Sharing Effects

How Has Cost-Sharing Been Used?

- **Deductible and Coinsurance**
- **Copayment**
- **Tiered Formularies**
- **Value-Based Insurance Design**
- **High Deductibles**

Cost-Sharing Effects

How Has Cost-Sharing Been Used?

Deductible and Coinsurance

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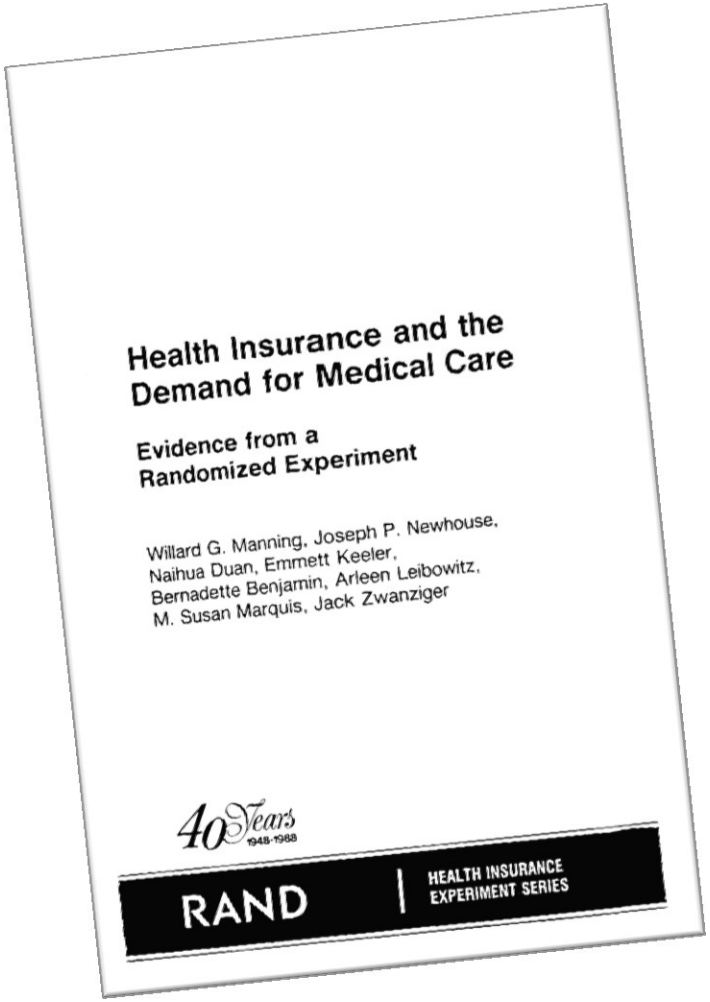
Cost-Sharing Effects: Deductible and Coinsurance



RAND Randomly Assigned 5,800 People

Plan (arm)	Coinsurance	Max Out-of-Pocket as % of Income	Deductible
Free Care	0%	NA	$0
25%	25%	5%	$0
50%	50%	10%	$0
95%	95%	15%	$0
Deductible	0%	NA	$150 – single $450 - family

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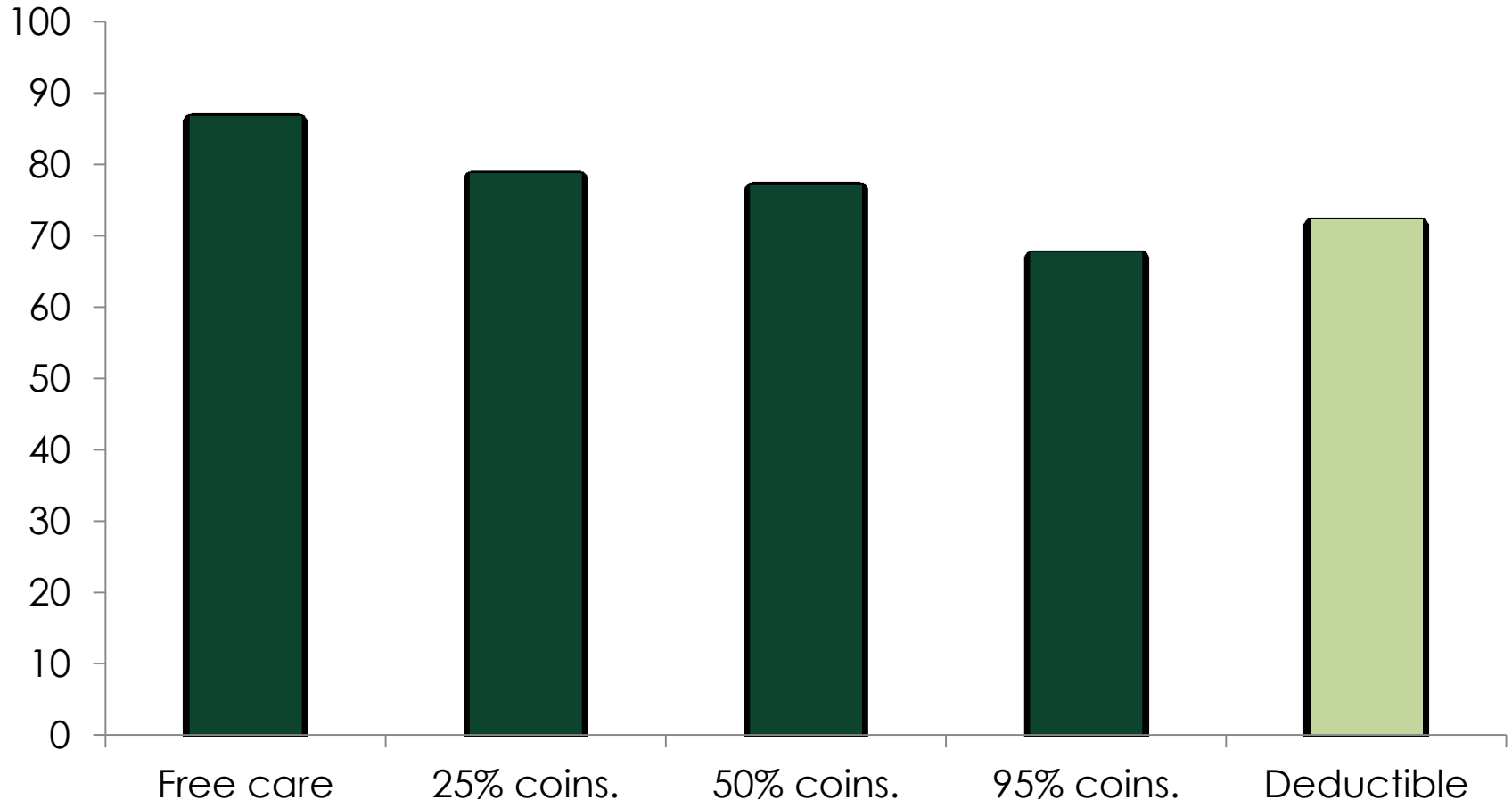
Cost-Sharing Effects: Deductible and Coinsurance

Percent of Beneficiaries Getting Any Medical Care



p-value<.0001 for difference across plans

Source: Manning et al. (1988). *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*.

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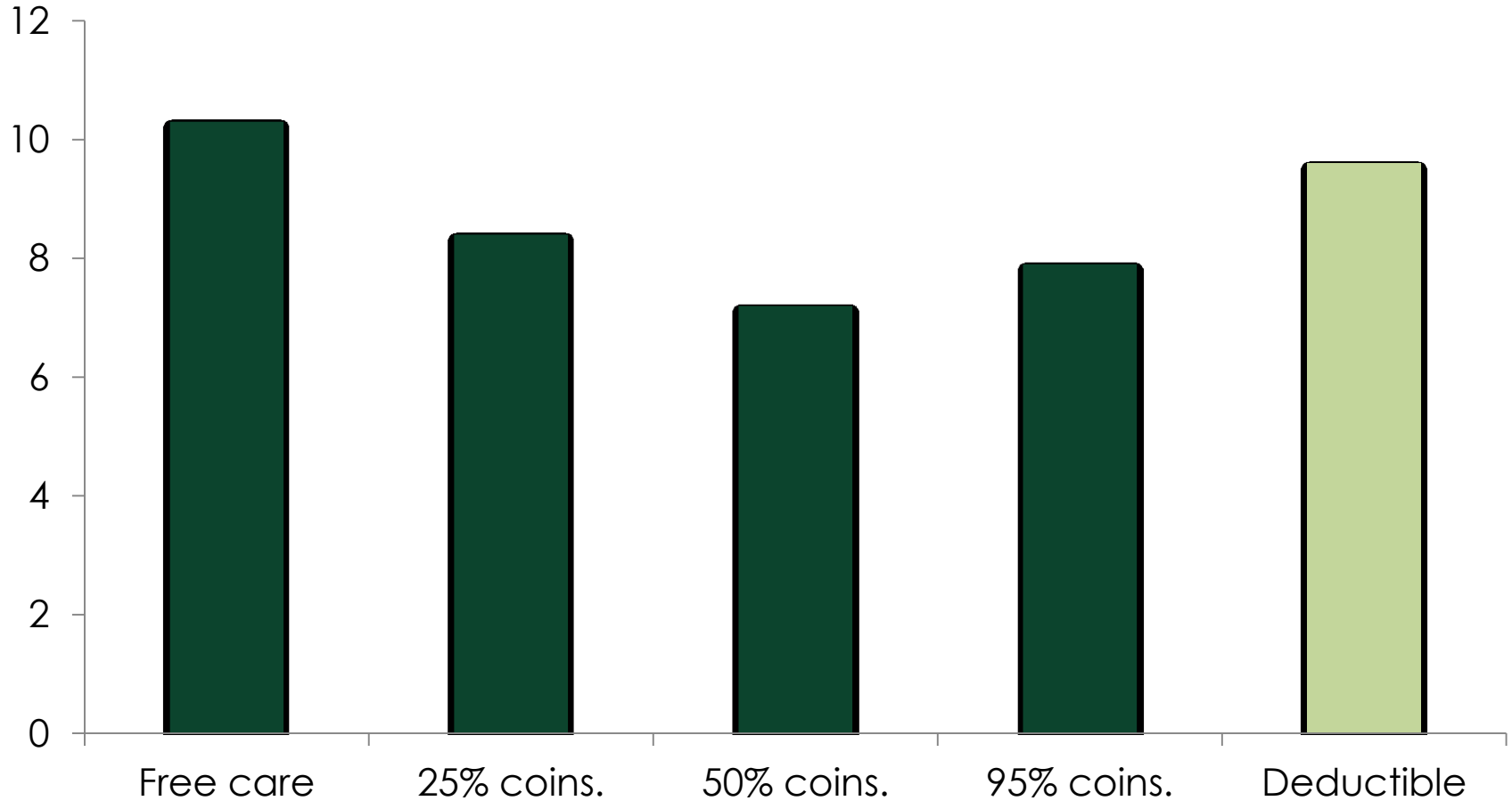
Cost-Sharing Effects: Deductible and Coinsurance

Percent of Beneficiaries with One or More Inpatient Admissions



p-value=.0006 for difference across plans

Source: Manning et al. (1988). *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*.

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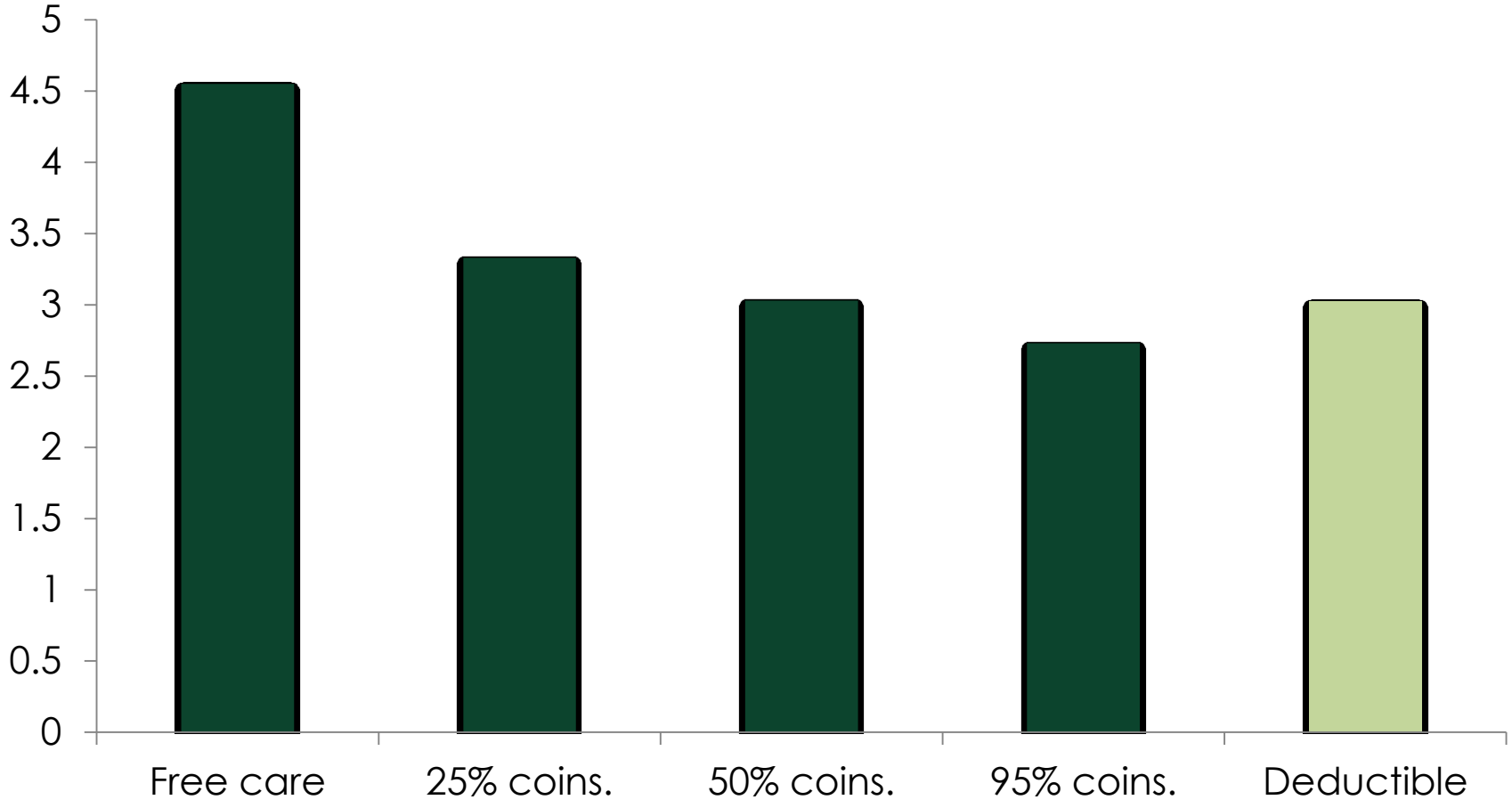
Cost-Sharing Effects: Deductible and Coinsurance

Annual Number of Face-to-Face Visits Per Beneficiary



p-value<.0001 for difference across plans

Source: Manning et al. (1988). *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*.

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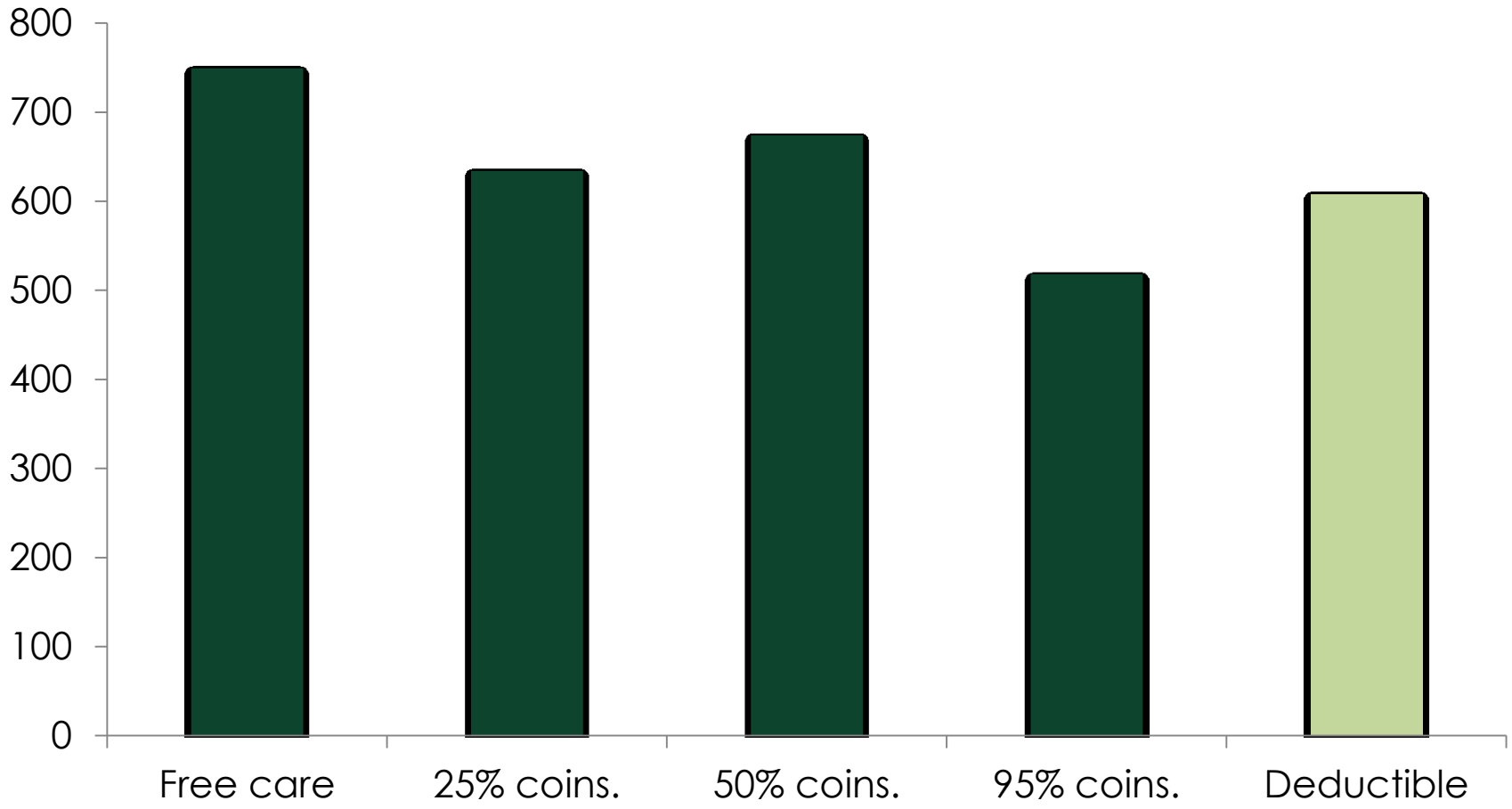
Cost-Sharing Effects: Deductible and Coinsurance

Total Annual Expenditures Per Beneficiary (1984 Dollars)



p-value=.003 for difference across plans

Source: Manning et al. (1988). *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*.

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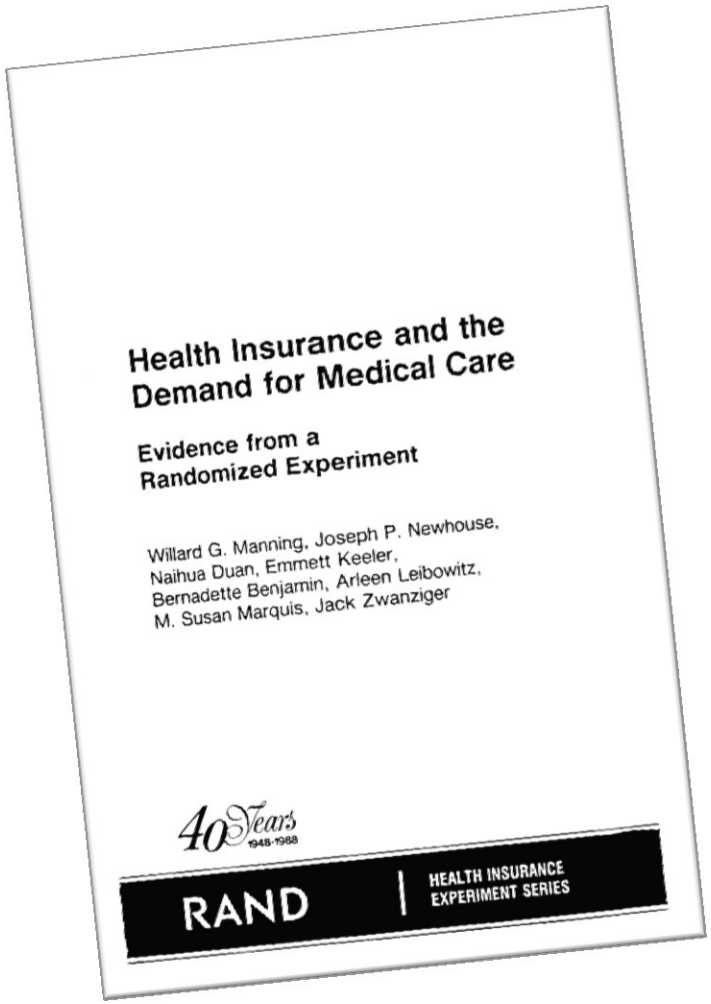
Cost-Sharing Effects: Deductible and Coinsurance



Utilization

Higher coinsurance **reduces effective and ineffective care** by same amount. A 10% rise in cost to patients led to 2% lower spending.

Outcomes

Higher coinsurance does not affect health outcomes for **healthy beneficiaries**.

Low-income groups at-risk of illness had adverse effects.

Cost-Sharing Effects

How Has Cost-Sharing Been Used?

Copayment

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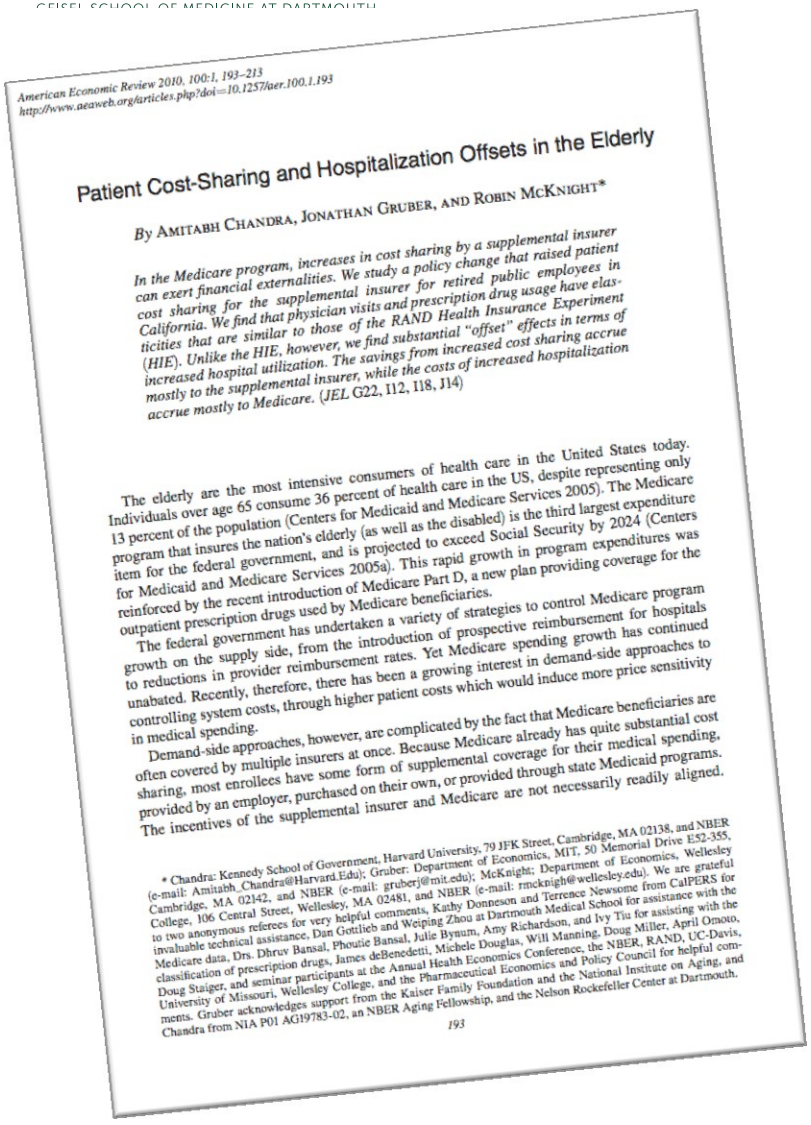
Cost-Sharing Effects: Copayment



American Economic Review 2010, 100:1, 193–213
http://www.aeaweb.org/articles.php?doi=10.1257/aer.100.1.193

Patient Cost-Sharing and Hospitalization Offsets in the Elderly

By Amitabh Chandra, Jonathan Gruber, and Robin McKnight*

In the Medicare program, increases in cost sharing by a supplemental insurer can exert financial externalities. We study a policy change that raised patient cost sharing for the supplemental insurer for retired public employees in California. We find that physician visits and prescription drug usage have elasticities that are similar to those of the RAND Health Insurance Experiment (HIE). Unlike the HIE, however, we find substantial "offset" effects in terms of increased hospital utilization. The savings from increased cost sharing accrue mostly to the supplemental insurer, while the costs of increased hospitalization accrue mostly to Medicare. (JEL G22, I12, I18, J14)

The elderly are the most intensive consumers of health care in the United States today. Individuals over age 65 consume 36 percent of health care in the US, despite representing only 13 percent of the population (Centers for Medicaid and Medicare Services 2005). The Medicare program that insures the nation's elderly (as well as the disabled) is the third largest expenditure item for the federal government, and is projected to exceed Social Security by 2024 (Centers for Medicaid and Medicare Services 2005a). This rapid growth in program expenditures was reinforced by the recent introduction of Medicare Part D, a new plan providing coverage for the outpatient prescription drugs used by Medicare beneficiaries.

The federal government has undertaken a variety of strategies to control Medicare program growth on the supply side, from the introduction of prospective reimbursement for hospitals to reductions in provider reimbursement rates. Yet Medicare spending growth has continued unabated. Recently, therefore, there has been a growing interest in demand-side approaches to controlling system costs, through higher patient costs which would induce more price sensitivity in medical spending.

Demand-side approaches, however, are complicated by the fact that Medicare beneficiaries are often covered by multiple insurers at once. Because Medicare already has quite substantial cost sharing, most enrollees have some form of supplemental coverage for their medical spending, provided by an employer, purchased on their own, or provided through state Medicaid programs. The incentives of the supplemental insurer and Medicare are not necessarily readily aligned.

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Utilization

10% rise in price leads to 1.5% **decline** in utilization.

Reductions occurred for acute, chronic, other drugs.

Outcomes

Hospitalizations went up (especially for sickest)

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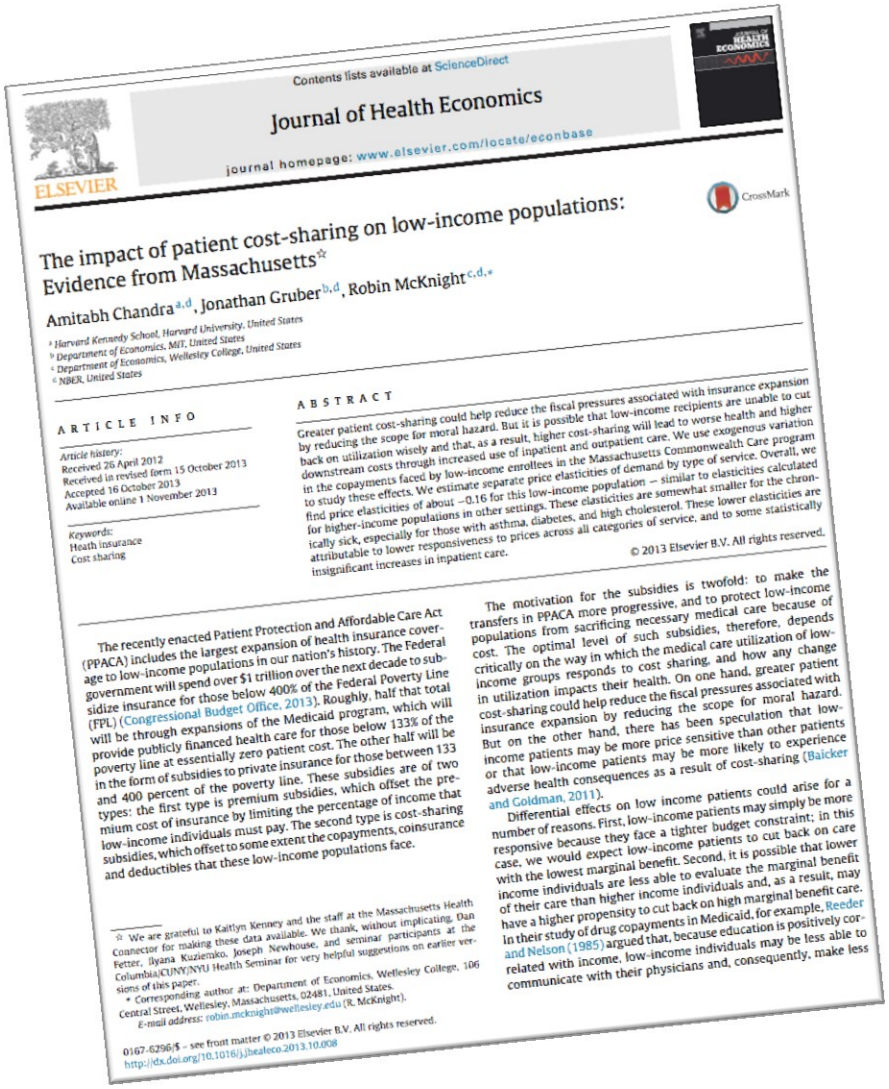
Cost-Sharing Effects: Copayment



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The impact of patient cost-sharing on low-income populations: Evidence from Massachusetts☆

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ABSTRACT

Greater patient cost-sharing could help reduce the fiscal pressures associated with insurance expansion by reducing the scope for moral hazard. But it is possible that low-income recipients are unable to cut back on utilization wisely and that, as a result, higher cost-sharing will lead to worse health and higher downstream costs through increased use of inpatient and outpatient care. We use exogenous variation in the copayments faced by low-income enrollees in the Massachusetts Commonwealth Care program to study these effects. We estimate separate price elasticities of demand by type of service. Overall, we find price elasticities of about −0.16 for this low-income population – similar to elasticities calculated for higher-income populations in other settings. These elasticities are somewhat smaller for the chronically sick, especially for those with asthma, diabetes, and high cholesterol. These lower elasticities are attributable to lower responsiveness to prices across all categories of service, and to some statistically insignificant increases in inpatient care.

The recently enacted Patient Protection and Affordable Care Act (PPACA) includes the largest expansion of health insurance coverage to low-income populations in our nation's history. The Federal government will spend over $1 trillion over the next decade to subsidize insurance for those below 400% of the Federal Poverty Line (FPL) (Congressional Budget Office, 2013). Roughly, half that total will be through expansions of the Medicaid program, which will provide publicly financed health care for those below 133% of the poverty line at essentially zero patient cost. The other half will be in the form of subsidies to private insurance for those between 133 and 400 percent of the poverty line. These subsidies are of two types: the first type is premium subsidies, which offset the premium cost of insurance by limiting the percentage of income that low-income individuals must pay. The second type is cost-sharing subsidies, which offset to some extent the copayments, coinsurance and deductibles that these low-income populations face.

The motivation for the subsidies is twofold: to make the transfers in PPACA more progressive, and to protect low-income populations from sacrificing necessary medical care because of cost. The optimal level of such subsidies, therefore, depends critically on the way in which the medical care utilization of low-income groups responds to cost sharing, and how any change in utilization impacts their health. On one hand, greater patient cost-sharing could help reduce the fiscal pressures associated with insurance expansion by reducing the scope for moral hazard. But on the other hand, there has been speculation that low-income patients may be more price sensitive than other patients or that low-income patients may be more likely to experience adverse health consequences as a result of cost-sharing (Baicker and Goldman, 2011).

Differential effects on low income patients could arise for a number of reasons. First, low-income patients may simply be more responsive because they face a tighter budget constraint; in this case, we would expect low-income patients to cut back on care with the lowest marginal benefit. Second, it is possible that lower income individuals are less able to evaluate the marginal benefit of their care than higher income individuals and, as a result, may have a higher propensity to cut back on high marginal benefit care. In their study of drug copayments in Medicaid, for example, Reeder and Nelson (1985) argued that, because education is positively correlated with income, low-income individuals may be less able to communicate with their physicians and, consequently, make less

☆ We are grateful to Kaitlyn Kenney and the staff at the Massachusetts Health Connector for making these data available. We thank, without implicating, Dan Fetter, Iyana Kuziemko, Joseph Newhouse, and seminar participants at the Columbia/CUNY/NYU Health Seminar for very helpful suggestions on earlier versions of this paper.

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Utilization

Higher copayments lead to decreased **utilization**.

Outcomes

Higher copayments **do not result** in a hospital offset.

Cost-Sharing Effects

How Has Cost-Sharing Been Used?

Tiered Formularies

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Cost-Sharing Effects: Tiered Formularies

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending

Haiden A. Huskamp, Ph.D., Patricia A. Deverka, M.D., Arnold M. Epstein, M.D., Robert S. Epstein, M.D., Kimberly A. McGuigan, Ph.D., and Richard G. Frank, Ph.D.

ABSTRACT

BACKGROUND
Many employers and health plans have adopted incentive-based formularies in an attempt to control prescription-drug costs.

METHODS
We used claims data to compare the utilization of and spending on drugs in two employer-sponsored health plans that implemented changes in formulary administration with those in comparison groups of enrollees covered by the same insurers. One plan simultaneously switched from a one-tier to a three-tier formulary and increased all enrollee copayments for medications. The second switched from a two-tier to a three-tier formulary, changing only the copayments for tier-3 drugs. We examined the utilization of angiotensin-converting–enzyme (ACE) inhibitors, proton-pump inhibitors, and 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins).

RESULTS
Enrollees covered by the employer that implemented more dramatic changes experienced slower growth than the comparison group in the probability of the use of a drug and a major shift in spending from the plan to the enrollee. Among the enrollees who were initially taking tier-3 statins, more enrollees in the intervention group than in the comparison group switched to tier-1 or tier-2 medications (49 percent vs. 17 percent, $P<0.001$) or stopped taking statins entirely (21 percent vs. 11 percent, $P=0.04$). Patterns were similar for ACE inhibitors and proton-pump inhibitors. The enrollees covered by the employer that implemented more moderate changes were more likely than the comparison enrollees to switch to tier-1 or tier-2 medications but not to stop taking a given class of medications altogether.

CONCLUSIONS
Different changes in formulary administration may have dramatically different effects on utilization and spending and may in some instances lead enrollees to discontinue therapy. The associated changes in copayments can substantially alter out-of-pocket spending by enrollees, the continuation of the use of medications, and possibly the quality of care.

From the Department of Health Care Policy, Harvard Medical School (H.A.H., R.G.F.); the Department of Health Policy and Management, Harvard School of Public Health (A.M.E.); and the Section on Health Services and Policy Research, Department of Medicine, Brigham and Women's Hospital (A.M.E.) — all in Boston; and Medco Health Solutions, Franklin Lakes, N.J. (P.A.D., R.S.E., K.A.M.). Address reprint requests to Dr. Huskamp at the Department of Health Care Policy, Harvard Medical School, 180 Longwood Ave., Boston, MA 02115, or at huskamp@hcp.med.harvard.edu.

N Engl J Med 2003;349:2224-32.

Utilization

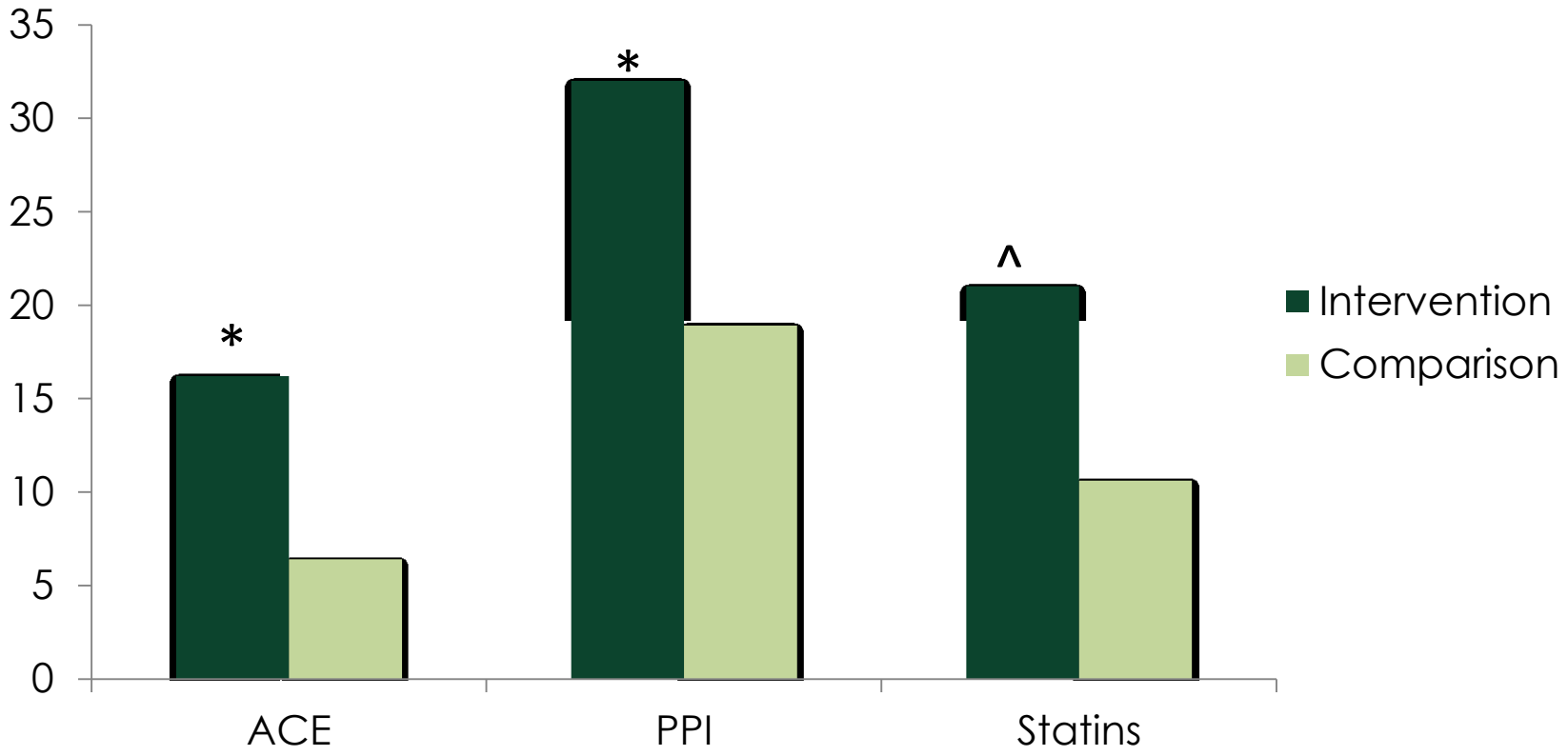
Drug spending **declined**, regardless of drug class.

Outcomes

Some patients **stopped** altogether.

Cost-Sharing Effects: Tiered Formularies

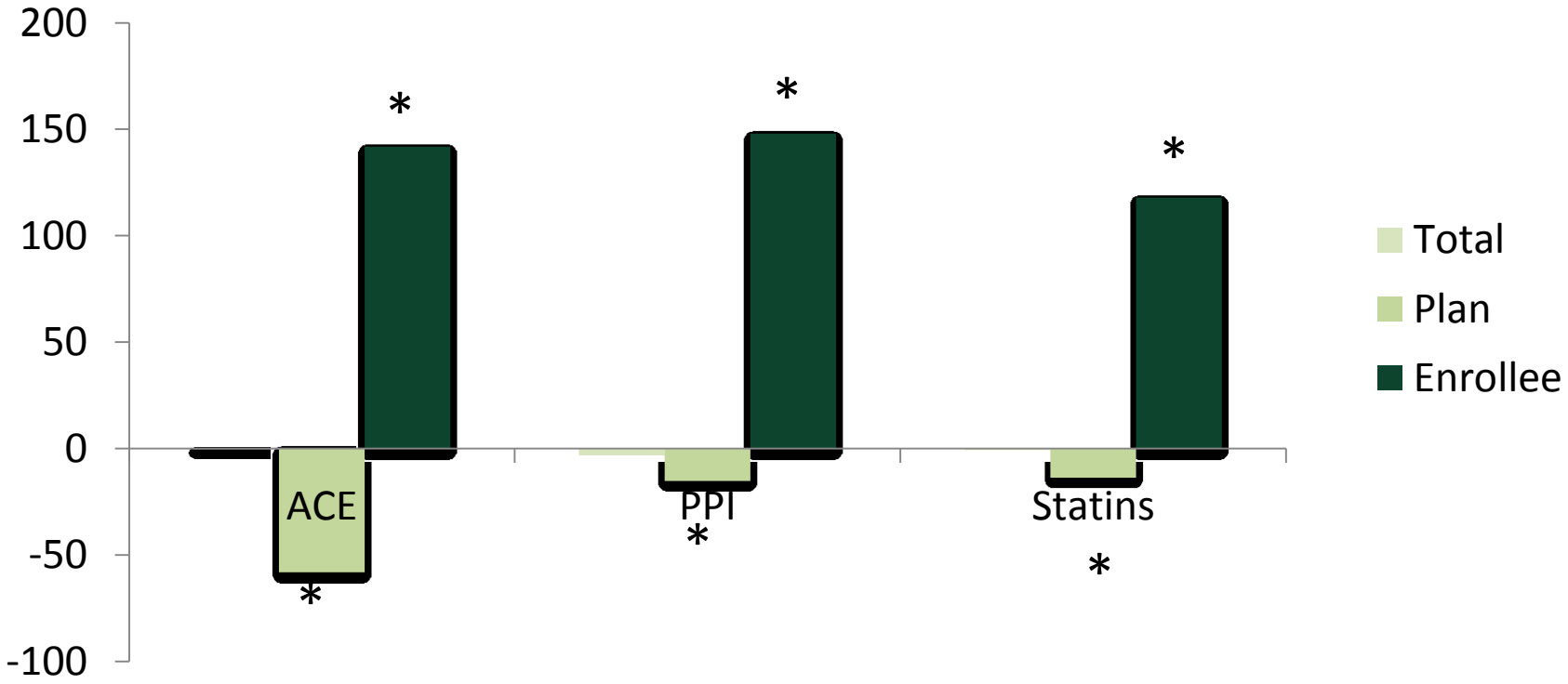
Percent Discontinuing Use in Drug Class



* P <.0001 for difference between intervention & comparison groups
^ P =.04 for difference between intervention & comparison

Cost-Sharing Effects: Tiered Formularies

Percentage Point Change In Spending, Intervention – Control Group



*P <.0001 for difference between intervention & comparison groups

Cost-Sharing Effects

How Has Cost-Sharing Been Used?

Value-Based Insurance Design

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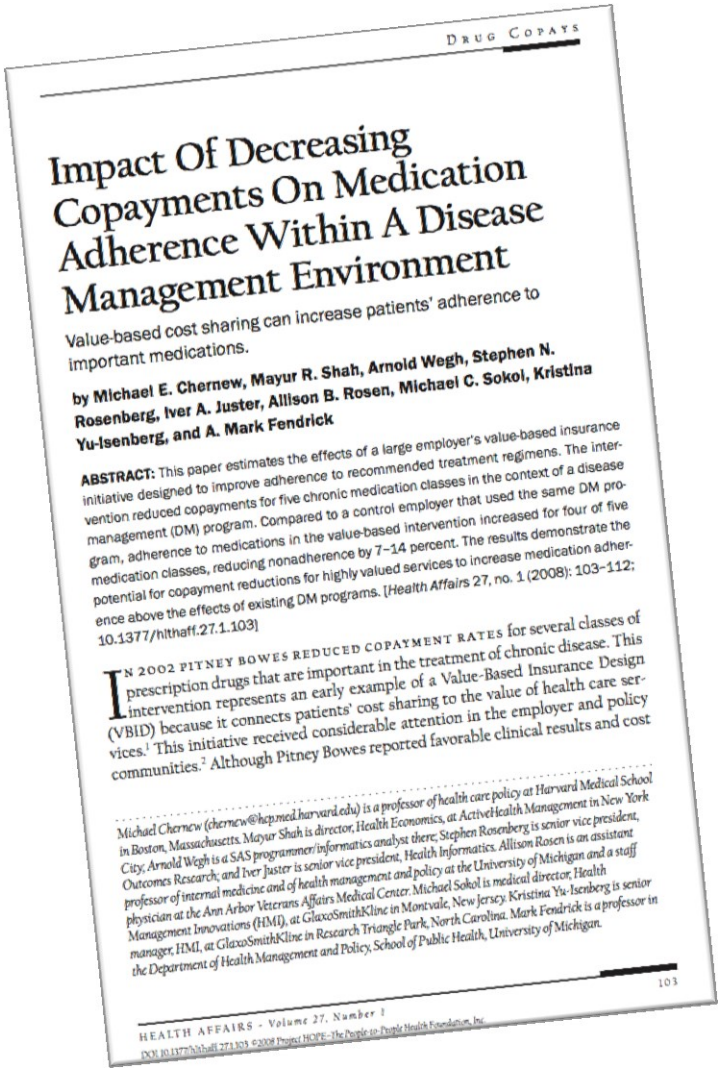
Cost-Sharing Effects: Value-Based Insurance Design



DRUG COPAYS

Impact Of Decreasing Copayments On Medication Adherence Within A Disease Management Environment

Value-based cost sharing can increase patients' adherence to important medications.

by Michael E. Chernew, Mayur R. Shah, Arnold Wegh, Stephen N. Rosenberg, Iver A. Juster, Allison B. Rosen, Michael C. Sokol, Kristina Yu-Isenberg, and A. Mark Fendrick

ABSTRACT: This paper estimates the effects of a large employer's value-based insurance initiative designed to improve adherence to recommended treatment regimens. The intervention reduced copayments for five chronic medication classes in the context of a disease management (DM) program. Compared to a control employer that used the same DM program, adherence to medications in the value-based intervention increased for four of five medication classes, reducing nonadherence by 7–14 percent. The results demonstrate the potential for copayment reductions for highly valued services to increase medication adherence above the effects of existing DM programs. [*Health Affairs* 27, no. 1 (2008): 103–112; 10.1377/hlthaff.27.1.103]

IN 2002 PITNEY BOWES REDUCED COPAYMENT RATES for several classes of prescription drugs that are important in the treatment of chronic disease. This intervention represents an early example of a Value-Based Insurance Design (VBID) because it connects patients' cost sharing to the value of health care services.[1] This initiative received considerable attention in the employer and policy communities.[2] Although Pitney Bowes reported favorable clinical results and cost

Michael Chernew (chernew@hcpmed.harvard.edu) is a professor of health care policy at Harvard Medical School in Boston, Massachusetts. Mayur Shah is director, Health Economics, at ActiveHealth Management in New York City. Arnold Wegh is a SAS programmer/informatics analyst there; Stephen Rosenberg is senior vice president, Outcomes Research; and Iver Juster is senior vice president, Health Informatics. Allison Rosen is an assistant professor of internal medicine and of health management and policy at the University of Michigan and a staff physician at the Ann Arbor Veterans Affairs Medical Center. Michael Sokol is medical director, Health Management Innovations (HMI), at GlaxoSmithKline in Montvale, New Jersey. Kristina Yu-Isenberg is senior manager, HMI, at GlaxoSmithKline in Research Triangle Park, North Carolina. Mark Fendrick is a professor in the Department of Health Management and Policy, School of Public Health, University of Michigan.

DOI 10.1377/hlthaff.27.1.103

Utilization

10% drop in price leads **to 1-4% rise** in Rx use

Cost-Sharing Effects

How Has Cost-Sharing Been Used?

High Deductibles

Cost-Sharing Effects: High Deductibles

POLICY

Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans

Melinda Beeuwkes Buntin, PhD; Amelia M. Haviland, PhD; Roland McDevitt, PhD; and Neeraj Sood, PhD

Objective: To investigate the effects of high-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs) on healthcare spending and on the use of recommended preventive care.

Study Design: Retrospective study.

Methods: We analyzed claims and enrollment data for 808,707 households from 53 large US employers, 28 of which offered HDHPs or CDHPs. We estimated the effects of HDHP or CDHP enrollment on healthcare cost growth between 2004 and 2005 using a difference-in-difference method that compared cost growth for families who were enrolled in HDHPs or CDHPs for the first time in 2005 with cost growth for families who were not offered HDHPs or CDHPs. Control families were weighted using propensity score weights to match the treatment families. Using similar methods, we examined the effects of HDHP or CDHP enrollment on the use of preventive care and the effects of HDHP or CDHP offering by employers on the mean cost growth.

Results: Families enrolling in HDHPs or CDHPs for the first time spent 14% less than similar families enrolled in conventional plans. Families in firms offering an HDHP or a CDHP spent less than those in other firms. Significant savings for enrollees were realized only for plans with deductibles of at least $1000, and savings decreased with generous employer contributions to healthcare accounts. Enrollment in HDHPs or CDHPs was also associated with moderate reductions in the use of preventive care.

Conclusions: The HDHPs or CDHPs with at least a $1000 deductible significantly reduced healthcare spending, but they also reduced the use of preventive care in the first year. This merits additional study because of concerns about enrollee health.

(*Am J Manag Care.* 2011;17(3):222-230)

For author information and disclosures, see end of text.

Curbing increases in healthcare costs is a top priority for policy makers and for employers. Many believe that high-deductible health plans (HDHPs), also known as consumer-directed health plans (CDHPs), when coupled with personal savings accounts, might be one way to hold down costs. These plans, intended to make patients more cost conscious, are becoming increasingly popular, and healthcare reform may foster further growth in enrollment. As of 2009, 20% of Americans with employer coverage were enrolled in a plan with a deductible high enough to be eligible for a health savings account. Among those purchasing coverage directly, 47% had a deductible at least this high.[1] A survey of large employers at the beginning of 2010 found that more than 54% offered at least 1 CDHP option, and another 7% were planning in 2011 to adopt one.[2] Growth is expected from 2 sources, mainly, CDHPs with low premiums offered through health insurance exchanges and more CDHP offerings in the employer market because of taxes placed on generous "Cadillac" plans.

Despite growing enrollment, little is known about the effects of HDHPs or CDHPs on healthcare costs and on the use of necessary care. Even less is known about the influence of specific HDHP or CDHP provisions, including deductible levels and account offerings.[3] Both questions are of key importance for those who are newly insured through exchanges and for those who are selecting plans in the employer or individual market. Part of the problem is the lack of good pre-post data for persons enrolling in diverse HDHP or CDHP and conventional plans. Most evidence is limited to studies with data from a single carrier, a single employer, or a single year; therefore, the findings may not apply outside of those settings. A review of these studies concluded that moving consumers from traditional plans to high-deductible plans could result in significant savings; however, coupling these plans with funded personal accounts could reduce this effect.[4] More recent work suggests that some CDHP plan designs might lead to higher spending over time, to discontinuation of chronic disease medications by patients, and to decreased use of office visits, hospitalizations, and emergency department care.[5,6] Other peer-reviewed studies[8-11] have found instances in which CDHP enrollment has no discernible effect on the use of preventive care. Reviewing a set of industry studies, the American

In this article
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eAppendices 1 to 5

Utilization

Reduction in utilization overall, even for free preventive care

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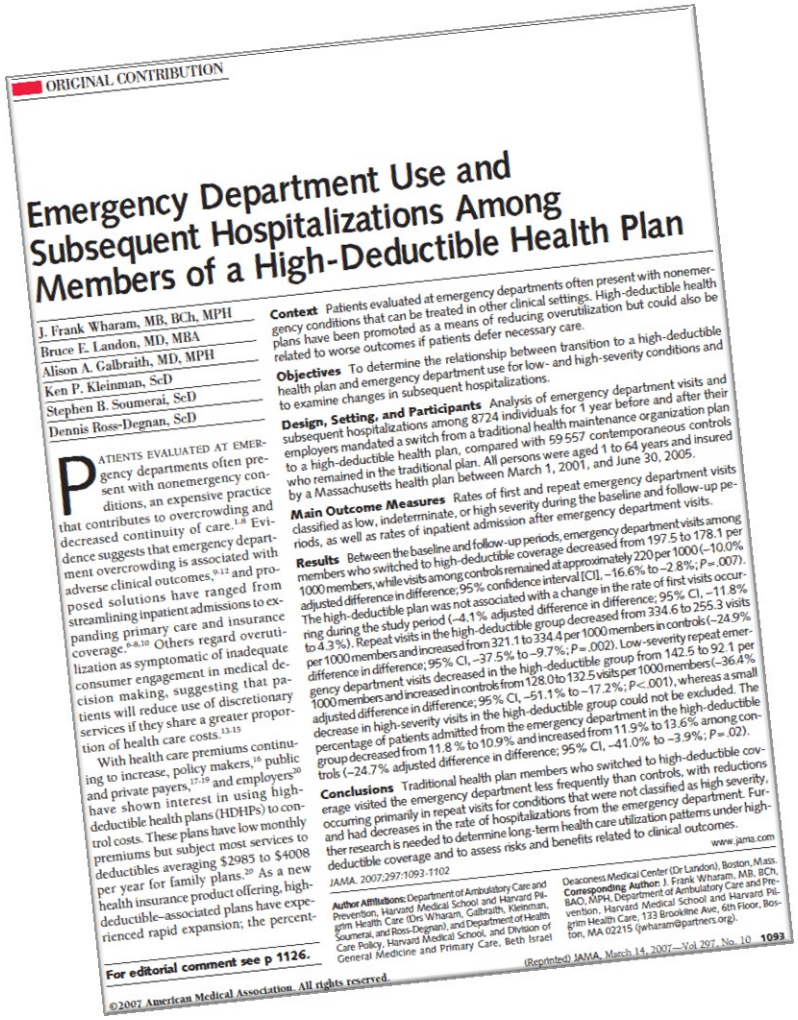
Cost-Sharing Effects: High Deductibles



ORIGINAL CONTRIBUTION

Emergency Department Use and Subsequent Hospitalizations Among Members of a High-Deductible Health Plan

J. Frank Wharam, MB, BCh, MPH
Bruce E. Landon, MD, MBA
Alison A. Galbraith, MD, MPH
Ken P. Kleinman, ScD
Stephen B. Soumerai, ScD
Dennis Ross-Degnan, ScD

Context Patients evaluated at emergency departments often present with nonemergency conditions that can be treated in other clinical settings. High-deductible health plans have been promoted as a means of reducing overutilization but could also be related to worse outcomes if patients defer necessary care.

Objectives To determine the relationship between transition to a high-deductible health plan and emergency department use for low- and high-severity conditions and to examine changes in subsequent hospitalizations.

Design, Setting, and Participants Analysis of emergency department visits and subsequent hospitalizations among 8724 individuals for 1 year before and after their employers mandated a switch from a traditional health maintenance organization plan to a high-deductible health plan, compared with 59 557 contemporaneous controls who remained in the traditional plan. All persons were aged 1 to 64 years and insured by a Massachusetts health plan between March 1, 2001, and June 30, 2005.

Main Outcome Measures Rates of first and repeat emergency department visits classified as low, indeterminate, or high severity during the baseline and follow-up periods, as well as rates of inpatient admission after emergency department visits.

Results Between the baseline and follow-up periods, emergency department visits among members who switched to high-deductible coverage decreased from 197.5 to 178.1 per 1000 members, while visits among controls remained at approximately 220 per 1000 (−10.0% adjusted difference in difference; 95% confidence interval [CI], −16.6% to −2.8%; $P = .007$). The high-deductible plan was not associated with a change in the rate of first visits occurring during the study period (−4.1% adjusted difference in difference; 95% CI, −11.8% to 4.3%). Repeat visits in the high-deductible group decreased from 334.6 to 255.3 visits per 1000 members and increased from 321.1 to 334.4 per 1000 members in controls (−24.9% difference in difference; 95% CI, −37.5% to −9.7%; $P = .002$). Low-severity repeat emergency department visits decreased in the high-deductible group from 142.5 to 92.1 per 1000 members and increased in controls from 128.0 to 132.5 visits per 1000 members (−36.4% adjusted difference in difference; 95% CI, −51.1% to −17.2%; $P < .001$), whereas a small decrease in high-severity visits in the high-deductible group could not be excluded. The percentage of patients admitted from the emergency department in the high-deductible group decreased from 11.8 % to 10.9% and increased from 11.9% to 13.6% among controls (−24.7% adjusted difference in difference; 95% CI, −41.0% to −3.9%; $P = .02$).

Conclusions Traditional health plan members who switched to high-deductible coverage visited the emergency department less frequently than controls, with reductions occurring primarily in repeat visits for conditions that were not classified as high severity, and had decreases in the rate of hospitalizations from the emergency department. Further research is needed to determine long-term health care utilization patterns under high-deductible coverage and to assess risks and benefits related to clinical outcomes.

www.jama.com
JAMA. 2007;297:1093-1102

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For editorial comment see p 1126.

Utilization

Reduction in Emergency Room use even for severe emergencies

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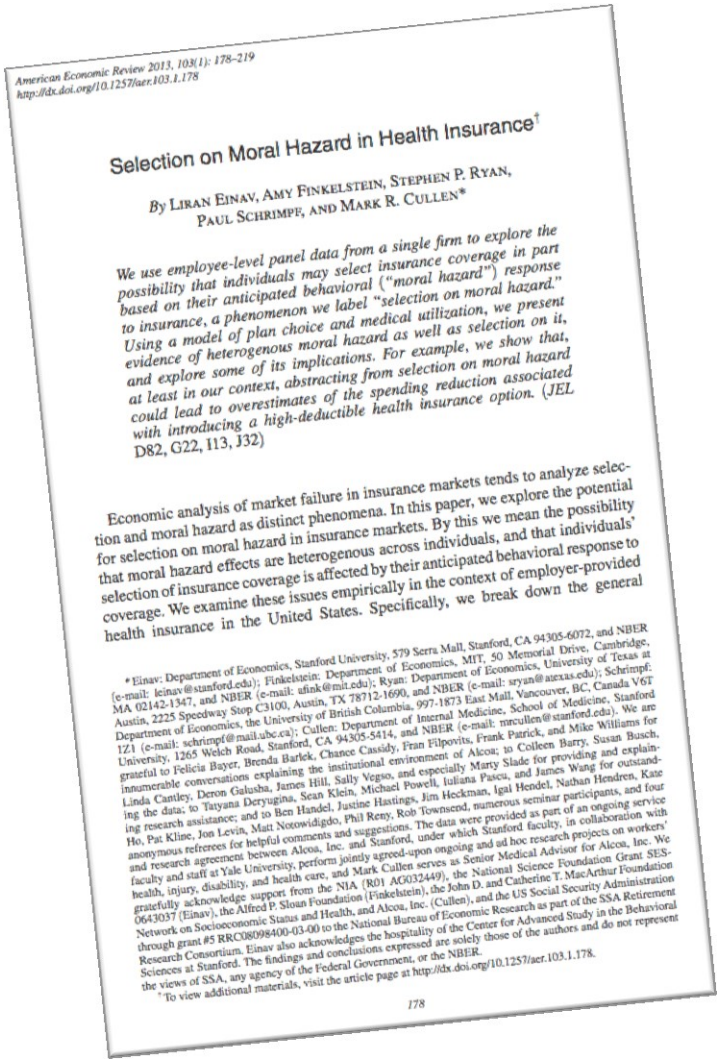
Cost-Sharing Effects: High Deductibles



American Economic Review 2013, 103(1): 178–219
http://dx.doi.org/10.1257/aer.103.1.178

Selection on Moral Hazard in Health Insurance†

By Liran Einav, Amy Finkelstein, Stephen P. Ryan, Paul Schrimpf, and Mark R. Cullen*

We use employee-level panel data from a single firm to explore the possibility that individuals may select insurance coverage in part based on their anticipated behavioral ("moral hazard") response to insurance, a phenomenon we label "selection on moral hazard." Using a model of plan choice and medical utilization, we present evidence of heterogenous moral hazard as well as selection on it, and explore some of its implications. For example, we show that, at least in our context, abstracting from selection on moral hazard could lead to overestimates of the spending reduction associated with introducing a high-deductible health insurance option. (JEL D82, G22, I13, J32)

Economic analysis of market failure in insurance markets tends to analyze selection and moral hazard as distinct phenomena. In this paper, we explore the potential for selection on moral hazard in insurance markets. By this we mean the possibility that moral hazard effects are heterogenous across individuals, and that individuals' selection of insurance coverage is affected by their anticipated behavioral response to coverage. We examine these issues empirically in the context of employer-provided health insurance in the United States. Specifically, we break down the general

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Outcomes

Distorts timing of care

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Cost-Sharing Effects

Type of cost sharing	Utilization fell as price rose?	Adverse events vs. better health care?
Deductible Coinsurance Copay	Yes – indiscriminately by service & population	Perhaps for low income, sickest patients
Tiered formularies	Yes – all drugs	Some evidence in asthma patients over age 5
Value-based design	Yes -	Increased medication compliance
High deductibles	Yes – even for "exempt" services	Not studied

Things to keep in mind

Estimated effects of cost-sharing are remarkably consistent across settings:

- Every 10% rise in price causes fall in use/spending that is 4% or less (most are around 2.0%)

Health effects hard to demonstrate

- Average, healthy patient not affected
- Adverse events possible for sicker, poorer patients

Cost-Sharing Effects

Will cost-sharing contain medical spending?

- YES, by about 20% if cost-sharing doubles

Will cost-sharing contribute to Act 48 goals of high-quality care & sustainable costs?

- Not nearly as likely for sickest, most vulnerable Vermonters
- Should be exercised strategically

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Goals

1. There is a tradeoff between insurance and costs
2. Cost-sharing lowers health care spending
3. Cost-sharing has unintended consequences

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Health Economics: Value-Based Benefits & Analytics

Vermont House Health Care Committee
Ellen Meara, PhD

MARCH 26, 2014

Appendix B-8. Department of Human Resources Benefit Summary SELECTCARE 2014

The SelectCare POS Plan

Summary of Benefits for the Employees and Retirees of the State of Vermont

What Does "POS" Mean?

- The "SelectCare POS Plan" is a "Point-of-Service" (POS) plan. In this plan, you decide whether or not to use a network doctor or hospital at the **"point of service"**, meaning, each time you use a medical service. When you use a network provider, the plan is similar to an HMO, with no annual deductible and small copay per visit.

It's Your Choice

- You get access to quality care at the lowest out-of-pocket costs available under your plan by having your care coordinated through your Primary Care Physician and by seeing network providers. You also get the **freedom to choose** providers who aren't part of the network. Your copays are lowest when you see participating providers, but you're still covered for visits to non-network providers at a higher cost share.

Important Medical Plan Features

- You may choose a Primary Care Physician (PCP) – your personal doctor -- to coordinate your care. As your needs change, you may change your Primary Care Physician for any reason.
- **Preventive care services** for every covered family member and paid at 100%.
- See a participating OB/GYN – **no referral** required.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**.

Drug Plan

- The program is administered by Express Scripts, Inc. The annual deductible is $25 per covered person per year. The plan covers 90% of the cost of generic drugs, 80% of the cost of preferred brand drugs and 60% of the cost for non-preferred brand drugs. For the 2014 Plan Year, the maximum out-of-pocket cost per individual per year is $775 (which includes the deductible). **40% copay drugs do not contribute to the maximum out of pocket limit.** At the local pharmacy, you show you drug plan card and pay your copay; the State is automatically billed for the balance of the cost. The drug plan also features a mail order option, with the convenience of direct home delivery for long-term maintenance drugs.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician (PCP) Office Visit such as:	**YOUR COST IS THE COPAY – WITH NO ANNUAL MEDICAL DEDUCTIBLE.**	**THE PLAN PAYS 70% AFTER THE ANNUAL MEDICAL DEDUCTIBLE.**
Preventive Care/Well Care:		
Periodic Physical Exams (Children and Adults)	Paid at 100%	70%
Routine Immunizations and Injections	Paid at 100%.	70%
Adult/Child Medical Care for Illness or Injury	$20 Copay per office visit	70%
Procedures performed in a Physician's Office	$20 Copay	70%
Routine Mammograms	Paid at 100%	Paid at 100%
Specialist Office Visits such as:		
Consultations and Referral Physician Services	$20 Copay per office visit	70%
Well Care (Includes Pap Test and PSAs)	Paid at 100%	70%
Procedures performed in Physician's office	$20 Copay per office visit	70%
Inpatient Hospital Services:		
Semi-Private Room and Board	$250 Copay per admission	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-ray		***All inpatient hospital admissions require Precertification. Call the toll-free number on your ID Card.***
Drugs and Medication		
Operating and Recovery Room		
Radiation Therapy and Chemotherapy		
Anesthesia and Inhalation Therapy		
Inpatient Surgeon's Charges	Paid at 100%.	70%
Second Surgical Opinion	$20 Copay per office visit.	70%
Outpatient Facility Services including:		
Operating Room, Recovery Room, Procedure Room and Treatment Room including:	Paid at 100%.	70%
Physician Services		
Diagnostic/Therapeutic Lab and X-rays		
Anesthesia and Inhalation Therapy		
Outpatient Preadmission Testing		
Office Visit	Paid at 100%.	70%
Outpatient Facility	Paid at 100%.	70%
Laboratory and Radiology Services such as:		
MRIs, MRAs, CAT Scans and PET Scans	Paid at 100%.	70%
Other Laboratory and Radiology Services		
Short-Term Rehabilitative Therapy including Physical, Speech, Occupational and Chiropractic Therapies.	$20 Copay per office visit – **Maximum of 60 visits per year in aggregate.***	70% **Maximum of 60 visits per year in aggregate.***
Prescription Drugs		
For both Retail and Mail Order Drugs Combined:		
Annual Deductible (Separate from your medical deductible)	$25 per individual/$75 per family	Not Covered
Plan Pays	90% for generic drugs, 80% for preferred brand drugs, and 60% for non-preferred brand drugs	
Your 2013 Annual Maximum Copay, excluding deductible	$750 per person	
2013 Maximum Out-Of-Pocket expense per year	$775 per person ($750 maximum copays plus $25 annual deductible.) , then the plan pays 100% for the rest of the calendar year	
Emergency and Urgent Care Services at:		
Physician's Office	$20 Copay	If true emergency, benefits are the same as the in-network benefits. If not a true emergency, benefits are paid at 70%.
Emergency Room, Urgent Care or Outpatient Facility	$50 Copay per visit, (waived if admitted)	
Ambulance	Paid at 100%.	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	$20 Copay	70%
All other office visits	Paid at 100%.	70%
Delivery		
Hospital Charges	$250 Copay per admission	70%
Physician Charges	Paid at 100%.	70%
Inpatient Services at Other Health Care Facilities including: Skilled Nursing, Rehabilitation and Sub-Acute Facilities	Paid at 100%.**60 days maximum per calendar year**	70%. **Precertification applies. 60 days maximum per calendar year**
Home Health Services	Paid at 100%.	70% ; **40 visits per calendar yr.**
Family Planning Services		
Office Visits (tests, counseling)	$20 Copay	70%
X-ray/lab if billed by separate facility	Paid at 100%.	70%
Vasectomy/Tubal Ligation (excludes reversals)		70% **Precertification applies**
Inpatient Facility	$250 per admission	70%
Outpatient Facility	Paid at 100%.	70%
Surgery in Physician's Office	$20 Copay	
Infertility Treatment – Up to $50,000/lifetime		
Office Visits (tests, counseling)	$20 Copay	Covered in-network only
X-ray/lab if billed by separate facility	Paid at 100%.	
Treatment/Surgery (includes In-vitro Fertilization, Artificial Insemination, GIFT and ZIFT) done at an inpatient or outpatient facility or physician's office.	Paid at 100%.	Covered in-network only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse Precertification Required		
Inpatient Mental Health	100%	70%
Inpatient Substance Abuse	100%	70%
Inpatient Substance Abuse Detoxification	100%	70%
Inpatient Substance Abuse Rehab Facility	100%	70%
Outpatient Mental Health	100%	70%
Marital/Family Counseling	100%	Not Covered
Outpatient Substance Abuse	100%	70%
Durable Medical Equipment	Paid at 100%.	70% **$700 Calendar year maximum**
External Prosthetic Appliances	Paid at 100%.	70% **$1,000 Calendar year maximum**
Vision Care	$100 every two calendar years, no deductible or coinsurance, routine exams and lenses.	
OTHER BENEFIT INFORMATION		
Annual Deductible Individual Family	None None	$500 $1,000
Annual Out-of-Pocket (OOP) Maximum Individual Family	None None	$2,000 plus deductible $6,000 plus deductible
Coinsurance	None	The plan pays 70% of eligible charges after the annual deductible is met. You pay 30% of the charges after the annual deductible is met.
Precertification (Inpatient, Outpatient, and MRI's)	Handled by your physician	Member must obtain approval
Lifetime Maximum	Unlimited	Unlimited

* Out-of-network treatment maximums are reduced by in-network services used.

If you use an In-NetworkProvider (In-Network Services):

- All services must be provided by or referred by your Primary Care Physician (PCP) in order to be covered except for: emergency services, routine care provided by a participating OB/GYN, and mental health and substance abuse services..

If you use a Out-of-Network Provider (Out-of-Network Services):

- All out-of-network hospital admissions, outpatient surgeries and MRI's must be precertified by the member. Precertification **is not required** for emergency admissions. To precertify, call the telephone number on the back of your ID card.
- Benefits which are not covered out-of-network are: Organ Transplants, Infertility Treatment and Prescription Drugs.
- Once the out-of-pocket maximum for Out-of-Network services is reached, the plan pays 100% of eligible charges for the remainder of the calendar year.

Appendix B-9. Scenarios Illustrating Benefit Designs

State of Vermont **APPENDIX B-9. SCENARIOS**

Estimated Out of Pocket Costs For illustrative purposes only

Based on Plan Designs as of December 16, 2014

Scenario	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
Pregnancy	$872	$1,705	$695	$2,100
Mental Health	$620	$900	$520	$1,445
COPD	$1,122	$2,140	$850	$2,100
Multiple Sclerosis	$2,155	$1,713	$850	$2,100
Family of Four	$515	$984	$544	$2,790

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

State of Vermont
Estimated Out of Pocket Costs - Pregnancy Scenario
Based on Plan Designs as of December 16, 2014

APPENDIX B-9. SCENARIOS
For illustrative purposes only

Scenario:
27 year old female on Single insurance. Pregnant. ER visit/delivery/surgery due to Ectopic pregnancy.

Pregnancy Services	# Units	Allowed Cost per Service	Allowed Costs	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
OB/GYN exams	8	$98	$781	$280	$160	$160	$620
Ambulance	1	$1,081	$1,081	$0	$616	$296	$15
Drug - preferred brand	3	$237	$710	$217	$105	$45	$710
ER services	1	$5,220	$5,220	$75	$1,044	$1,044	$75
Surgery	1	$16,820	$16,820	$0	$3,364	$3,364	$1,550
Hospitalization	1	$5,406	$5,406	$300	$1,081	$1,081	$250
Total Potential Member Costs			$30,018	$872	$6,370	$5,990	$3,220
Total Potential Member Costs - Medical			$29,308	$655	$6,265	$5,945	$2,510
Total Potential Member Costs - Drug			$710	$217	$105	$45	$710
Maximum Out of Pocket - Combined			N/A	N/A	N/A	N/A	$2,100
Maximum Out of Pocket - Medical			$5,000	$1,600	$650	N/A	
Maximum Out of Pocket - Drug			$1,300	$1,250	$200	N/A	
Total Paid by Member			**$872**	**$1,705**	**$695**	**$2,100**	

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

State of Vermont
Estimated Out of Pocket Costs - Mental Health Scenario
Based on Plan Designs as of December 16, 2014

APPENDIX B-9. SCENARIOS
For illustrative purposes only

Scenario:
35 year old male with bipolar disease. Lithium maintenance meds. PCP visits twice per year for testing. Also sees psychiatrist 18 times per year.

Mental Health Services	# Units	Allowed Cost per Service	Allowed Costs	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
PCP visit	2	$102	$204	$50	$20	$20	$107
Drugs - maintenance (generic)	12	$46	$557	$120	$120	$60	$101
Lab tests	1	$901	$901	$0	$580	$260	$901
Psychiatrist visits	18	$240	$4,325	$450	$180	$180	$335

Total Potential Member Costs	$5,987	$620	$900	$520	$1,445
Total Potential Member Costs - Medical	$5,430	$500	$780	$460	$1,344
Total Potential Member Costs - Drug	$557	$120	$120	$60	$101

Maximum Out of Pocket - Combined	N/A	N/A	N/A	$2,100
Maximum Out of Pocket - Medical	$5,000	$1,600	$650	N/A
Maximum Out of Pocket - Drug	$1,300	$1,250	$200	N/A

Total Paid by Member	**$620**	**$900**	**$520**	**$1,445**

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

State of Vermont
Estimated Out of Pocket Costs - COPD Scenario
Based on Plan Designs as of December 16, 2014

APPENDIX B-9. SCENARIOS
For illustrative purposes only

COPD Services	# Units	Allowed Cost per Service	Allowed Costs	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
PCP	2	$108	$216	$50	$20	$20	$113
Hospitalized twice	2	$7,208	$14,417	$600	$3,283	$2,963	$1,800
Drugs (generic)	12	$23	$278	$120	$120	$60	$96
Drugs (brand)	12	$122	$1,460	$352	$420	$180	$393
Home oxygen and equipment	1	$3,364	$3,364	$0	$673	$673	$917
Total Potential Member Costs			$19,735	$1,122	$4,516	$3,896	$3,320
Total Potential Member Costs - Medical			$17,997	$650	$3,976	$3,656	$2,830
Total Potential Member Costs - Drug			$1,738	$472	$540	$240	$490
Maximum Out of Pocket - Combined			N/A	N/A	N/A	$2,100	
Maximum Out of Pocket - Medical			$5,000	$1,600	$650	N/A	
Maximum Out of Pocket - Drug			$1,300	$1,250	$200	N/A	
Total Paid by Member			**$1,122**	**$2,140**	**$850**	**$2,100**	

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

State of Vermont
Estimated Out of Pocket Costs - Multiple Sclerosis Scenario
Based on Plan Designs as of December 16, 2014

APPENDIX B-9. SCENARIOS
For illustrative purposes only

Multiple Sclerosis Services	# Units	Allowed Cost per Service	Allowed Costs	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
PCP visits	6	$96	$577	$150	$60	$60	$121
Neurologist	3	$360	$1,081	$105	$60	$60	$390
Rehab visits	24	$60	$1,442	$600	$673	$368	$405
Durable medical equipment	1	$6,007	$6,007	$0	$260	$240	$15
Drugs - Specialty	12	$1,201	$14,417	$5,812	$660	$360	$1,263
Total Potential Member Costs			$23,524	$6,667	$1,713	$1,089	$2,195
Total Potential Member Costs - Medical			$9,107	$855	$1,053	$729	$932
Total Potential Member Costs - Drug			$14,417	$5,812	$660	$360	$1,263
Maximum Out of Pocket - Combined			N/A	N/A	N/A	$2,100	
Maximum Out of Pocket - Medical			$5,000	$1,600	$650	N/A	
Maximum Out of Pocket - Drug			$1,300	$1,250	$200	N/A	
Total Paid by Member			**$2,155**	**$1,713**	**$850**	**$2,100**	

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

State of Vermont
Estimated Out of Pocket Costs - Family of Four Scenario
Based on Plan Designs as of December 16, 2014

APPENDIX B-9. SCENARIOS
For illustrative purposes only

Scenario:
Family of four. One child with diabetes. Dad with cholesterol and high blood pressure meds. Mother to receive colonoscopy. Other child breaks arm in ski accident.

Family of Four Services	# Units	Allowed Cost per Service	Allowed Costs	Copay 93.5% (State Adj)	Deductible 87.0% (Catamount Adj)	Deductible Subsidy 93.5%	HDHP 80%
PCP visits	8	$100	$961	$200	$80	$80	$389
Drug - Diabetes (generic)	12	$173	$2,072	$120	$120	$60	$1,066
Drug - Cholesterol, BP (generic)	12	$95	$1,141	$120	$120	$60	$60
ER services	1	$1,322	$1,322	$75	$664	$344	$1,275
Colonoscopy (preventive)	1	$5,166	$5,166	$0	$0	$0	$0
Total Potential Family Costs			$10,662	$515	$984	$544	$2,790
Total Potential Family Costs - Medical			$7,449	$275	$744	$424	$1,664
Total Potential Family Costs - Drug			$3,214	$240	$240	$120	$1,126
Maximum Out of Pocket - Combined			N/A	N/A	N/A	$4,200	
Maximum Out of Pocket - Medical			$10,000	$3,200	$1,300	N/A	
Maximum Out of Pocket - Drug			$2,600	$2,500	$400	N/A	
Total Paid by Family			**$515**	**$984**	**$544**	**$2,790**	

Illustrative purposes only. Based on estimated provider payment rates and a set number, type and order of services.

Appendix B-10. GMC Secondary: Adding an Out of Pocket Limit to Medicare

Appendix B-10

Calculation of Medicare FFS AV at Various MOOP levels

		Catamount Subsidy (93.5%) = $650 (medical only)		Catamount (87%) = $1,600 (medical only)		HDHP 80% = $2,100 (includes Rx)							State 93.5% = $5,000 (medical only)				
MOOP	**$250**	**$500**	**$1,000**	**$1,250**	**$1,800**	**$2,100**	**$2,400**	**$2,500**	**$3,000**	**$3,600**	**$4,000**	**$4,800**	**$5,100**	**$5,750**	**$6,600**	**$6,750**	**$999,999,999**
Results with LDS Dual/Non Dual Mix																	
Allowed PMPM - 2012	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770	$770
Allowed PMPM - 2017	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888	$888
Implied Annual Trend	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%
Cost Share PMPM	$17	$32	$52	$60	$74	$79	$84	$86	$92	$99	$102	$108	$110	$113	$117	$118	$132
Impact of MOOP	$115	$101	$80	$72	$59	$53	$48	$47	$40	$34	$30	$24	$22	$19	$15	$15	$0
Paid PMPM	$870	$856	$835	$828	$814	$808	$803	$802	$795	$789	$785	$779	$778	$774	$771	$770	$755
Resulting AV w/MOOP	**98.0%**	**96.4%**	**94.1%**	**93.2%**	**91.7%**	**91.1%**	**90.5%**	**90.3%**	**89.6%**	**88.9%**	**88.5%**	**87.8%**	**87.6%**	**87.2%**	**86.8%**	**86.8%**	**85.1%**
Medicare FFS AV (no MOOP)	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**	**85.1%**

For discussion and illustrative purposes only. Uses Medicare limited data set to estimate the impact of various maximum out of pocket levels on the Medicare FFS population. Parts A and B only.

Appendix C-1: The Gruber Microsimulation Model

Microsimulation is a method of analysis that uses a computer program to model ("simulate") the effects of policy changes on individual ("micro") units such as people, households and businesses. The approach used here is the type of "microsimulation" modeling used by the Treasury Department, CBO, and other government entities. This approach draws on the best evidence available in the health economics literature to model how individuals will respond to the changes in the insurance environment induced by changes in government policy.

The Gruber Microsimulation Model (GMSIM) computes the effects of health insurance policies on the distribution of health care spending and private and public sector health care costs. This model has been used over the past 15 years by a wide variety of state and federal policy makers to analyze the impacts of health insurance reforms. This model was first developed in 1999 for use in estimating the impact of tax credits on health insurance coverage, with funding from the Kaiser Family Foundation. Over the subsequent 15 years, the model's capability has been expanded to consider the full variety of possible health interventions, including public insurance expansions, employer or individual mandates, purchasing pools for insurance, single payer systems, and more.

GMSIM was the basis for the empirical modeling in the well-known February 2011 report by Professor William Hsaio. The 2011 report attempted to provide a comprehensive overview of the factors involved in transitioning to a unified and universal health care system. Central to that report was a careful modeling of the Vermont health care economy, and how it would be affected by that transition. The 2011 report is now somewhat out of date; in particular, recent survey data of Vermont households on their insurance status is now available to update the model. But the basic structure provides an excellent starting point for modeling the incidence of current health care spending.

Microsimulation Model Construction

Structure of GMSIM

The GMSIM is a complex model that has grown over 15 years to address a wide variety of health policy questions. In this section, we provide a brief overview of the model. The assumptions included in the modeled are detailed in Appendix C-2.

The GMSIM builds upon micro-data on individuals, including data available for Vermont residents in the Vermont Household Health Insurance Survey (VHHIS) and in national datasets such as the Current Population Survey (CPS).

This data on individuals is then carefully supplemented by data on employers. GMSIM builds "synthetic firms," assigning each individual worker in the dataset a set of co-workers selected to represent the likely true set of co-workers in that firm. The model uses data from the Vermont Department of Labor and the Vermont Department of Taxes to show, for workers of any given earnings level, the earnings distribution of their co-workers. Using these data, other sample individuals are randomly selected in order to statistically replicate the earnings distribution for that worker's earnings level. These workers then become the co-workers in a worker's synthetic firm.

Assigning Incidence

A starting point for any analysis of financing reform is a rich understanding of the incidence of existing health care spending. "Incidence" refers to entities that are ultimately responsible for certain costs. Only by first understanding who bears the burden of health care costs in Vermont today can we paint a rich picture of how financing alters that burden.

Addressing questions such as the incidence of health care spending requires assigning the incidence of different types of health care spending to different entities. In this section we discuss each element of health care spending and to whom it is assigned for incidence purposes, drawing on economic theory and evidence for making such assignments.

***Medicaid Expenditures*:** The incidence of Medicaid expenditures is allocated between the federal government and the state government, using future projections of the Vermont Federal Matching Assistance Percentages (FMAPs) for the base Medicaid population, the ACA expansion population, and the CHIP program. We applied these percentages to Medicaid expenditure data provided by the Vermont Agency of Human Services.

Other Government Insurance: For those covered by other government insurance (primarily military coverage) the incidence is fully on the Federal government.

***Family Premiums and Out of Pocket Medical Spending*:** The incidence of family spending on health insurance and medical spending is directly on the family, with one important exception: federal tax breaks to insurance spending. The most significant of these federal tax breaks are the deduction from federal income taxation for health insurance premiums for the self-employed and the deduction of employee premiums from state and federal taxable income for the vast majority of employees. We use aggregated data provided by the Vermont Tax Department to estimate each of these items for Vermont residents in order to assign the relative incidence between the family and the state and federal government.

***Private Employer Health Insurance Premiums*:** Employer-sponsored health insurance premiums are the single largest element of health care spending in the state. There is a large literature in economics showing that the incidence of employer premium payments is on employee wages.

We begin with the typical economics assumption that health insurance premiums were fully shifted to workers' wages in a lump sum (constant dollar) fashion across all employees. We then augment that modeling with a minimum wage constraint – wages cannot be reduced below the minimum wage, so any extra costs induced by this constraint are borne by the employer. We assume that wages are "sticky," that is, that employers do not redirect costs or savings from health care coverage immediately to wages, but rather redirect these funds over several years.

***State Health Care Spending*:** The state of Vermont and its localities spend a large share of their budgets on health care, ranging from employee health insurance spending, to the state share of Medicaid spending, to other state public health programs. For state and local health insurance spending, we assume lower incidence on wages relative to private employers.

The share of state taxes that are collected on businesses are assigned to employers as part of their incidence.

The various elements of incidence described above can have multiple impacts on any family, through their own health care spending, health insurance premiums, and state taxes. We integrate of all these changes into one total incidence measure for each family.

Modeling Green Mountain Care

The GMSIM takes as its starting point the situation in Vermont post-ACA. The model incorporates the latest available information on the impacts of the ACA in Vermont in setting the baseline for any analysis. This information includes the most recent available data on exchange enrollment across plans; plan prices and characteristics; enrollment in Medicaid; and other insurance coverage information. The GMSIM fully incorporates all aspects of the ACA.

We then model the transition to Green Mountain Care in 2017. We model the "steady state" situation in Vermont after full transition, and then consider various scenarios for transition paths to that steady state.

Modeling the impact of GMC involves several steps. First, individuals are enrolled in GMC as a default. The impacts of this default enrollment vary by type of individual:

- Uninsured individuals are directly enrolled into GMC.
- Those who currently purchase individual insurance are directly enrolled into GMC.
- Those who are on public insurance will also be directly enrolled. However, for those low income individuals who have benefits packages more generous than GMC, we also model the "wrap-around" benefits to which they are entitled.

The most difficult case is those who have employer-sponsored insurance, since employers can choose to continue to offer ESI. It also is important to differentiate multi-state employers who may be slower to change their benefits offering in response to GMC. As well, existing employers and employees will move to GMC as a function of the generosity of the program relative to their employer sponsored insurance. We use data provided by Wakely Consulting Group to measure the share of large firm employees who are employed in multi-state firms.

We then apply assumptions regarding the percentage of individuals who will remain on ESI under certain conditions. Next, we apply assumptions as to which employers will purchase supplemental insurance above GMC for their employees, and to what actuarial value. Finally, we apply assumptions as to which individuals will purchase supplemental insurance above GMC, and to what actuarial value. These assumptions are detailed in Appendix C-2.

Incorporating Actuarial Analysis

Moving to Green Mountain Care is a major reform to the insurance system which goes well beyond the types of reforms that have been studied in the past. As such, it is critical to have a sophisticated insurance pricing model which accounts for the impact of population flows and insurance design on insurance markets. The microsimulation team worked iteratively with actuaries from Wakely Consulting Group to consider the effect of insurance market change on population movements (the focus of GMSIM) and pricing (the focus of actuarial analysis).

Incorporating actuarial analysis is critical for understanding several aspects of the GMC reform.

The first is changes in health care utilization due to the changes in the nature of the health insurance package. Next, the actuarial analysis models the ultimate cost of care within the GMC pool based on the health mix and utilization decisions of those who enroll in GMC.

In particular, the integration between actuarial and economic modeling worked as follows:

- Initial insurance market prices and conditions were integrated into the model as described above
- Based on these initial conditions, as well as the policy change and form of financing, GMSIM was used to model population and income flows
- The resulting relative morbidity of populations in GMC, relative to the pre-GMC market, was then passed to Wakely.
- These morbidity changes were then incorporated into an actuarial model to capture the impact on pricing. This accounts for the potential changes in GMC population pools arising from the transition to GMC.
- This information is passed back to GMSIM by the actuary

GMSIM incorporates this information in the form of new prices in GMC populations.

Data Sources

Our modeling of the incidence of health care spending in Vermont draws upon a wide variety of rich data sources that are available for the state.

The 2012 Vermont Household Health Insurance Survey (VHHIS)

In 2012, the state of Vermont under took a detailed collection of data on households and their insurance coverage through the VHHIS. This survey gathered data from more than 4,600 Vermont households, with data on almost 11,000 state residents. This is a very large sample for a state of this size; in contrast, the three year pooled sample from the Current Population Survey that was used in the Hsaio report was only about two-thirds as large. The VHHIS data collection was cutting edge, including collection both from landlines and cell phone only households. And there was an oversample of the uninsured which allows for more comprehensive modeling of the behavior of this group.

The data include a rich battery of information for each household member, including but not limited to:

- Type of insurance coverage
- Source of insurance coverage
- Duration of insurance coverage/uninsured
- Medical expenditures
- Medical utilization and location of care
- Health Insurance premiums

- Barriers to health care receipt
- Health status
- Demographics (age, gender, education, etc.)
- Employment
- Job characteristics, including firm size and provision of health insurance
- Family income

As described above, these data provide the ideal basis for the type of microsimulation modeling that is required for a rich incidence analysis in Vermont.

Augmenting the VHHIS

While the VHHIS is the most comprehensive data source available for this analysis, it has three limitations. First, it is two years out of date. Second, there is well known under/misreporting of key measures in survey data, such as coverage by public insurance or medical expenditures. Such measurement problems could lead to important misstatements of the incidence of health care spending and the subsequent effects of reform. Finally, a number of important expenditure items are not collected by the VHHIS but are central to understanding the incidence of health care spending in Vermont.

We therefore carefully augment the VHHIS in a number of ways to produce the best possible estimates:

Medicaid coverage. Underreporting of public insurance coverage is a well-known problem in survey data. We therefore recalibrate to state and federal reports of enrollment by type of enrollee (e.g. child, disabled & blind, elderly, etc).

Public insurance spending**.** The VHHIS has no data on the insured spending of those who are enrolled in public insurance. We use data from state and federal sources to impute per capita spending by type of enrollee. Specifically, we used Medicaid expenditure data provided by the Vermont Agency of Human Services (AHS) and Department of Vermont Health Access (DVHA). These expenditures include both DVHA Medicaid expenditures as well as expenditures for mental health services and long term care services and supports provided through other departments within AHS. Estimates of managed care investments were also included in public insurance spending.

Employer-sponsored insurance premiums**.** The survey includes data on the employee portion of employer-sponsored insurance premiums, but not on the employer portion. Three Vermont insurers, Blue Cross Blue Shield of Vermont, Cigna and MVP, provided data on enrollment and premiums by firm size (both total premiums and the employer/employee shares) for their Vermont book of business.

***Individual market insurance premiums*.** Blue Cross Blue Shield of Vermont, Cigna and MVP provided data on enrollment and premiums for their individual policies.

***Income*.** The VHHIS is not designed to focus on income collection in the same way as Census data sets such as the Current Population Survey or the American Community Survey. We therefore recalibrate the income distribution in the VHHIS to match the distribution from these more precise Census data sets, as well as income data provided by the Vermont Department of Taxes.

Appendix C-2: Microsimulation Assumptions

This Appendix describes the assumptions provided by the State of Vermont to be used for the microsimulation analysis. It also describes the type of output provided to the State as an output from the model. It is important to remember that the numbers presented throughout this report are **estimates** despite the precise dollar amounts. Readers should avoid drawing strong conclusions from small differences, which result due to rounding.

Populations

A. Population counts: Population counts by type of insurance for the 94% AV Best Policies run can be found in Appendix A-1.
   1. *Non-group*: those holding individual insurance policies (no longer exists under GMC)
   2. *Medicaid primary*: those who are Medicaid eligible and have no other insurance (incorporated fully into GMC)
   3. *Employer sponsored insurance*: this is divided into private, state, local and municipal employees
   4. *Federal government insurance*: Federal Employee Health Benefits
   5. *Uninsured*
   6. *Medicare*: overall Medicare enrollment, as well as supplementation by individuals (medi-gap), by Medicaid (duals), and by employers
   7. *Military insurance*
   8. *GMC enrollment*: overall GMC enrollment, and separately present those who are receiving employer supplementation to GMC and those who are purchasing GMC supplements on their own
   9. *Commuters in*: We assume that residents of other states who work in Vermont for a Vermont firm are able to enroll in GMC. These non-residents would pay the public premium in the same manner and amount as a Vermont resident with the same income and family size.

B. Key assumptions relating to these population counts include:
   1. We assume the number of uninsured is zero under GMC due to the operational planning by the State.
   2. We assume all employees of small firms (with fewer than 100 employees) drop ESI and go onto GMC, under the state's Affordable Care Act Section 1332 waiver.
   3. We assume a three year phase down of ESI for large firms. We break down large group ESI down into four groups – those in national firms and those not in national firms, and then within those we distinguish between those who have an ESI AV higher than they are offered on GMC and those that have a lower ESI AV. Our assumptions for the percentage of employees of large firms who remain on ESI are laid out in the following table:

Large Group ESI Assumptions	National firms	Vermont only firms
Firm offers ESI with AV *Greater* than GMC's AV	Year 1: 60% remain on ESI Year 2: 40% remain on ESI Year 3 & thereafter: 12.5% remain on ESI	Year 1: 25% remain on ESI Year 2: 12.5% remain on ESI Year 3 & thereafter: 0% remain on ESI
Firm offers ESI with AV *Lower* than GMC's AV	Year 1: 30% remain on ESI Year 2: 15% remain on ESI Year 3 & thereafter: 0% remain on ESI	0% remain on ESI in any year

4. We assume that all employees of state, local, and municipal employers drop ESI in the first year and go onto GMC.
5. For federal employees, we assume that virtually all federal employees move on to GMC rather than pay for both ESI and GMC. We assume no impact on military.
6. We assume no impact on Medicare.

C. Data sources for populations include the Vermont Household Health Insurance Survey (VHHIS), enrollment in public insurance programs provided by the Vermont Agency of Human Services and Department of Vermont Health Access, and data reported by Vermont health insurers for this project.

Private Insurance Coverage and Spending

Spending is in millions, while enrollment is in thousands of persons.

A. Key assumptions relating to private coverage and spending include:

1. *Trend*: We assume private insurance spending increases based on the trends projected in Table 17 of the National Health Expenditure accounts.[1]

2. *Non-group* premium spending is spending on individual insurance without GMC

3. *Individual supplementation of GMC*: We measure spending on individual supplementation of GMC by allowing individuals to supplement in either of two cases:

[1] See Table 17 of the National Health Expenditure Data, found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

a. If the individual's ex-ante AV is above their GMC AV, and their ex-ante premium is above their individual contribution to GMC, then they buy-up to their ex-ante AV, and
b. If the individual's ex-ante AV is above their GMC AV, but their ex-ante premium is below their individual contribution to GMC, then they buy-up 50% of the difference between their ex-ante AV and GMC AV.

4. *Individual supplementation of Medicare*: We assume no change due to GMC.

5. *Private employer spending:* We show base coverage for active workers (those remaining on ESI), as well as supplementation of active workers who move to GMC. We also show supplemental spending for retirees.
   a. *Supplemental coverage*: To model private employer supplementation of GMC, we consider the firm's spending on the employees' ex-ante premium before GMC, and the ex-ante AV of the plan the employer provided before GMC. Our assumptions are summarized as follows:
      (1) If the firm spent *more* on the employee's ex-ante premium than GMC AND the ex-ante AV of the plan the employer provided is higher than the employee is receiving on GMC, then the employer supplements the employee up to the ex-ante AV, with similar cost sharing arrangements (e.g. 80/20 cost sharing).
      (2) If the firm spent *less* on the employee's ex-ante premium than before GMC, but the ex-ante AV of the plan the employer provided is higher than the employee is receiving on GMC, then the employer supplements up to 50% of the AV difference.

   b. *Employer savings re-directed to employee wages*: To the extent that an employer's spending on health insurance without GMC exceeds the employer's spending under GMC on the GMC payroll tax, plus any supplemental coverage for its employees to maintain previous coverage levels, we assume that the employer will re-direct some of its savings to employee wages.
      1. *Total amount shifted to wages*: We assume that private employers redirect 60% of savings to wages the first year, 80% the second year, and 100% each year after that.
      2. *Total remaining un-shifted*: This represents extra costs to wages that employers are unable to shift to due minimum and nominal wage restrictions.
      3. *Total withheld:* This represents savings to wages that firms choose not to shift (this is a wage stickiness assumption). We assume that employers re-direct any remaining savings to uses other than wages, for example, investing in capital equipment, paying down debt, or new hiring.

6. *Federal Employee Spending:* We assume no change in insurance coverage for federal employees. We assume no federal supplementation.

7. *Military Spending*: We assume no change in military health insurance coverage. We assume no supplementation.

8. *State/local/municipal employees:*
   a. *Coverage for active workers*: We assume all public employees move to GMC
   b. *Supplemental coverage*: This category includes active employees and retirees; samples are too small to split them out. We make the same assumptions regarding public employer supplementation of GMC as we made for private employer supplementation in paragraph 5.a.
   c. *Employer savings re-directed to employee wages*: We assume that state, local and municipal employers savings after paying the GMC payroll tax and any supplemental coverage as follows. State, local and municipal employers redirect 50% of savings to wages in the first year, 60% in the second year, 80% in the third year, 90% in the fourth year, and 100% in all remaining years.

B. Data Sources: Private coverage and spending projections were based on data reported by Vermont health insurers for this project.

GMC Enrollment & Spending

GMC spending per member per month by category of enrollee was calculated by actuaries at Wakely Consulting Group. (See methodology in Appendix D.) This includes:

1. GMC spending, and enrollment on GMC, for each type of employer
2. GMC spending for Medicaid primary
3. We are assuming no GMC effect on Medicare
4. GMC spending for individuals not in the labor force

GMC enrollment and spending was modeled based on the behavior of synthetic firms and individuals created for this model.

Data sources for GMC enrollment and spending include data reported by Vermont health insurers for this project, the Vermont Household Health Insurance Survey (VHHIS), the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), data provided by the Vermont Department of Labor, data provided by the Vermont Tax Department, and public program enrollment and spending reports.

State and Local Budget Implications

We looked at state and local budget implications by breaking down GMC spending across categories and adding in state spending on Medicaid & GMC supplementation of Medicare.

This shows revenues to the state, under both ACA & GMC scenarios, from traditional taxes, as well as the new GMC payroll tax, the GMC individual contributions, and the dollar transfer from the federal government to cover Medicaid costs and 1332 waiver pass-through funding.

A. Key assumptions

1. *Wage effects on taxes:* As noted above, we assume that employers that experience savings under GMC will re-direct some savings to employee wages. Employees who receive higher wages will pay a portion of those wages in higher state income tax. We assume that these employees will spend some of their higher wages on goods and services, resulting in small increases to revenues from the state's sales tax, meals tax, gas tax, etc.

2. *State spending*:
   a. *Provider payment rates:* GMC and Medicaid spending assumes GMC pays standard payment rates to health care providers for all GMC enrollees. These standard provider payment rates are a blend of commercial and Medicaid rates.
   b. *Medicaid fixed costs:* Medicaid spending assumes some spending will not vary with enrollment, utilization and GMC payment rates (e.g. graduate medical education costs, investment in Managed Care Organizations, Long-Term Care costs).

3. *State Revenue:*
   a. *GMC payroll tax:* The employer payroll tax would be levied at a rate of 11.5% on all Vermont businesses on their qualifying Vermont payroll. Qualifying payroll is all payroll except wages for any individual employee in excess of $200,000 with that amount adjusted annually for inflation.
   b. *GMC individual contributions:* we use a percent of income contribution in the same format as the ACA. 0% of income up to 138% FPL, 2.5% of income from 138-150% FPL, 2.5% - 9.5% of income from 150-400% FPL, and 9.5% of income at 400% + FPL, capped at $27,500.
   c. *Federal funding for Medicaid:* Federal Financial Participation (FFP) on Medicaid expenditures assumes that Vermont's base and CHIP Federal Matching Assistance Percentages (FMAPs) continue to decrease by 2% per year until the base FMAP reaches the federal minimum of 50.00% in 2020. The FMAP for the federal expansion population (childless adults <138% FPL) is calculated according to the ACA formula. The FMAP projections are displayed in the following table.

Projections of the Federal Matching Assistance Percentage (FMAP) for Vermont Medicaid

FMAP by Calendar Year	SCHIP: Children 237% - 312% FPL	Expansion population: Childless Adults <138% FPL	Base FMAP: All other Medicaid-eligible populations, including Dual eligibles
2014	69.93%	78.52%	57.04%
2015	74.95%	82.47%	56.18%
2016	90.18%	86.09%	53.64%

Projections of the Federal Matching Assistance Percentage (FMAP) for Vermont Medicaid			
2017	89.45%	86.52%	52.58%
2018	88.73%	89.76%	51.55%
2019	88.14%	93.00%	50.59%
2020+	88.00%	90.00%	50.00%

d. *Federal ACA Pass-Through Funding:* uses conservative assumptions and assumes that the federal government will forward to Vermont the funds that it would otherwise provide to individuals in Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) under the ACA, less funds it would collect from the Cadillac Tax, individual mandate, and equity assessment (large employer penalty). Federal ACA pass-through funding decreases from 2018 forward because it is offset by federal Cadillac tax revenue. The state uses a slightly less conservative assumption in its balance sheet and does not reduce the pass-through funding by the Cadillac Tax, individual mandate, and equity assessment (large employer penalty). The calculation methodology that will be used by the federal government for pass-through funding has not yet been published by the federal government and thus is uncertain.
e. *Provider taxes*: We assume that under GMC the existing provider taxes will be repealed, including the taxes on nursing home beds and acute hospital, psychiatric hospital, ICF/MR, home health and outpatient pharmacy revenues.
f. *Other state revenue sources*: We assume the employer assessment will be repealed and that revenue from the claims tax and premium tax will be substantially reduced under GMC.

Federal Budget Implications

Federal spending includes the Federal Medicaid payments to Vermont, as well as spending on ACA individual and firm tax credits.

Key assumptions:

1. *Federal spending*:
   a. *Federal transfer to Vermont for Medicaid primary:* Federal Financial Participation (FFP) for Medicaid Primary increases under GMC because total state Medicaid expenditures increase.
   b. *Federal ACA Tax Credit Spending* is the same without GMC and with GMC. We assume that the federal government will pass-through funding for APTCs and CSRs on behalf of individuals who, without GMC, would have received these subsidies through the Exchange in the relevant year between 2017-2021. Under the ACA, the federal government pays these funds to individuals in the form of tax credits. Under GMC, the federal government pays the funds to the state and the state directs the funds to pay for GMC.

2. *Federal revenue:*
    a. *ACA revenues* (Cadillac tax, mandate & equity assessment) are the same with and without GMC. While Vermont firms and individuals would not be paying these taxes and assessment after the State receives an ACA waiver of these requirements, it is important to include the calculation in the event the federal government determines these projections must be subtracted in the pass-through calculation.
    b. *Federal income tax revenue:* Federal income tax revenue is expected to *increase* as a result of higher wages and not paying health care premiums pre-tax. Federal income tax revenue is expected to *decrease* as a result of deducting the GMC tax on Schedule A. The net result of these three effects is a small *decrease* in federal income tax revenue.
    c. *Payroll tax revenue* is expected to increase as a result of higher wages.

Family Spending

Spending at the family level is in actual dollars (rounded to nearest $10) and includes both earned and unearned income.

We also looked at family spending, *on average* across all families in the state. A family that spends $0 on a particular category, for example a family that pays $0 in property tax, is included as a $0 in the average.

Family spending includes:

1. *Out of pocket medical expenditures:* this line does not include premium contributions
2. *Non-group*: Individual market premium spending
3. *ESI premium spending:* Employee contribution to employer sponsored insurance premium
4. *ESI supplementation to GMC*: Employee contribution to employer sponsored supplemental insurance. We assume cost-sharing between employer and employee for supplemental insurance is similar to cost-sharing for ESI premiums (e.g. 80/20).
5. *Individual contributions for GMC*
6. *Individual supplementation of GMC*
7. *Tax payments:* Federal payroll tax includes only the individual portion of payroll taxes, not the employer portion.

Appendix D-1: Actuarial Cost Analysis and Assumptions

This Appendix describes the assumptions and analyses provided by Wakely Consulting Group (Wakely). Wakely's key analyses include 2017 cost projections, plan designs, and additional benefit modeling. The cost projections and analyses used information from multiple sources, including but not limited to health plans, micro-simulation results and the State of Vermont. For complementary information on data sources and assumptions, see Appendix C-2 on micro-simulation assumptions.

2017 Cost Projections

A. Data Sources: Many different sources of data were considered as the basis for the cost projections. The Expenditure Analysis and VHCUREs data were used as reasonability checks for the data but were not otherwise used. The data used was total cost of care (or allowed claims), including member cost sharing.

   1. *Commercial*: To project the 2017 commercial costs, Wakely relied on data provided by the health plans that included 2013 premium, allowed and paid claim costs for each of the individual, small and large group markets. This data represented a large portion of the commercial market but did not include all of the large group market. Based on reasonability checks with other data sources, the Per Member Per Month (PMPM) costs appeared reasonable to use for the entire large group market.

   2. *Medicaid*: Given the significant changes in Medicaid due to the Affordable Care Act (ACA), it was preferable to use 2014 data. The State of Vermont provided all Medicaid costs for the 2015 State Fiscal Year, split but primary, secondary, and other/fixed costs (which included items such as GME, DSH, long term supports and services and administrative costs).

B. Key assumptions relating to the projection of costs to 2017 include:

   1. *Benefit changes (Commercial only):* Under GMC, pediatric dental and vision are required to be covered benefits. Since the starting data for commercial was pre-ACA, these costs would not yet be included in the base data. An adjustment for these benefits was estimated using publicly available rate filings in Vermont, prior benefit analyses specific to Vermont, and information provided from the micro-simulation on the percent of covered lives who would receive these benefits.

   2. *Trend:* As discussed in other sections of the report, trends were developed for both the commercial and Medicaid markets. The first set of trends was to bring the base data to 2017 without GMC. These trends were developed in conjunction with Rand. The following information was used to estimate the trends (the list is not all inclusive):
      - Publicly available rate filings in Vermont
      - Emerging commercial experience in VHCUREs
      - Green Mountain Care Board hospital budgets

- Any expected SIM savings, if applicable
- Medicaid historical trends, based on data supplied by the State of Vermont
- CMS/NHE national trends

The following table shows the final allowed PMPM claim cost trends by year that were mutually agreed upon by Wakely and Rand. Given the base data was 2013 for commercial and state fiscal year 2015 for Medicaid, some of the earlier trend years were not ultimately used. Based on guidance from the State, some Medicaid "Other" costs were not trended (for example, GME payments are a fixed amount per year). Additionally, LTSS costs were trended at an annual rate of 3 percent based on information provided by the State.

Year of Trend	Medicaid	Commercial
2012-2013	3.8%	6.5%
2013-2014	4.9%	6.5%
2014-2015	1.1%	6.2%
2015-2016	2.9%	6.1%
2016-2017	3.9%	7.7%

3. *Morbidity (Commercial only):* Under GMC the covered population will be different compared to the base data. The health status difference of the population, or the morbidity change, was an output from the micro-simulation and varied based on the scenario and number of people estimated to be covered under GMC. For commercial, the two key population differences under GMC were employees who will not have coverage under GMC but are in the base data and the uninsured who will be eligible for GMC but are not in the base data. The impact of the population differences results in a significant decrease to PMPM costs, driven by the assumption that the uninsured are significantly healthier than the current population. For the commercial 94 percent actuarial value plan, including commuters and federal employees, the morbidity adjustment was estimated to be -6.4 percent based on the micro-simulation results. For Medicaid it was assumed that the uninsured who are eligible for Medicaid enrolled as part of the ACA in 2014. Thus, no additional morbidity adjustment was made for Medicaid.

4. *Provider Payments:* Under GMC, the state provided the assumption that provider payment rates would be based on the current Medicaid and commercial reimbursement rate, combined to alleviate any cost shift due to today's Medicaid rates, and then trended forward to the applicable year. These payments are expected to be neutral in total due to the elimination of the cost shift, but the changes have implications on the separate commercial and Medicaid markets. The University of Massachusetts provided provider payment rates for each market by inpatient, outpatient and professional, split by providers that will be impacted by GMC and those that will not. In general, it was

assumed any provider in Vermont as well as select providers in neighboring states, would be impacted by GMC provider payment changes. Wakely also estimated the portion of commercial and Medicaid costs that would be impacted. Many costs were excluded, including but not limited to, prescription drugs, dental, and long term services and supports (Medicaid). It was also assumed that Medicare secondary covered costs under Medicaid would not be impacted. Based on the current payment rates, the percent of costs impacted, and projected membership in each market, an estimate was made to the impact of both markets on having the same, but overall neutral, provider payment rates. This results in a large increase to the overall Medicaid costs and a notable decrease to the overall commercial costs once combined within GMC.

5. *Induced Demand (Commercial only):* Based on the current data from the health plans as well as VHCUREs, the average actuarial value (or percent of costs that are paid for through health care coverage) is around 86%. If more generous coverage is offered, it is expected that the utilization of services will increase, all else equal. Similarly, if less generous coverage is provided, utilization would be expected to decrease, all else equal. As part of the ACA, HHS released proposed induced utilization factors[1]. These factors were used to estimate the change in utilization based on the various actuarial values, interpolating where necessary. Since one GMC scenario is an actuarial value of 100%, an induced utilization assumption was developed for this scenario.

6. *Actuarial Value (Commercial only):* The actuarial value of a plan is based on the expected average claim costs covered under GMC. Various plan designs were considered with the target actuarial value used to reduce the allowed claims. For plan designs with less than a 94 percent actuarial value, a weighted average of actuarial values was completed to account for the population eligible for 94 and 87 percent cost sharing subsidies, as applicable. The distribution of the population eligible for subsidies, based on FPL, was an output of the micro-simulation and varied by scenario.

7. *Payer Administrative Expenses:* Administrative expenses for the commercial market were assumed to be 7% under GMC. This is less than the current non-benefit expense loads in health plan premiums, resulting in some savings under GMC. For Medicaid, the current administrative costs were assumed to continue under GMC.

C. Methodology: To arrive at the 2017 cost projections, the base data was used in conjunction with the above assumptions, all of which are multiplicative except administrative expenses. The result was a "premium equivalent" for both commercial and Medicaid under GMC. These premium equivalents were incorporated into the micro-simulation. If the output using the premium equivalents changed the above assumptions (e.g. morbidity), the process was re-iterated to achieve a steady state.

[1] https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014#h-42

D. Results: The following tables show the premium equivalents developed for both commercial and Medicaid using the above data, assumptions and methodology. The "Other Costs" are shown in total dollars since these costs are mostly unaffected by enrollment changes. The other values are PMPM amounts.

	Commercial
2013 Allowed PMPM	$419.07
Benefit Change Factor	1.012
Trend Factor (4 years of Trend)	1.292
Morbidity	0.936
Provider Payment Change	0.880
Induced Demand	1.056
2017 GMC Allowed PMPM	$476.60
Actuarial Value	0.935
2017 GMC Paid PMPM	$445.62
Administrative Load	7%
2017 GMC Premium Equivalent	$479.16

	Medicaid		
	Primary	**Secondary**	**Other Costs**
SFY15 Allowed PMPM	$466.99	$545.13	$648,418,583
Benefit Change Factor	1.000	1.000	1.000
Trend Factor (2.5 years of Trend)	1.075	1.075	1.049
Morbidity	1.000	1.000	1.000
Provider Payment Change	1.338	1.000	1.000
Induced Demand	1.000	1.000	1.000
2017 GMC Allowed PMPM	$671.76	$586.01	$679,979,377
Actuarial Value	1.000	1.000	1.000
2017 GMC Paid PMPM	$671.76	$586.01	$679,979,377
Administrative Load			Included in Other Costs
2017 GMC Premium Equivalent	$671.76	$586.01	$679,979,377

Plan Designs

As part of GMC, several plan design options were considered at various actuarial value levels. These plan designs are described and provided in Appendix B and incorporate three actuarial value levels: 80, 87, and 94 percent. The development of these plan designs was based on the following process.

A. Gather input:

1. *Current Plan Designs* for key plans, such as state employee plan, VEHI plans, and Catamount Health were provided as the starting point for plans at the 94 and 87 percent actuarial value levels.

2. *Input* from the State of Vermont, consultants and other key stakeholders were provided that shaped some of the plan design options. This input was iterative as Wakely developed and refined various plan options.

B. Development of plan designs:

1. *The Truven Health Benefit Modeler,* developed in conjunction with Wakely, was used to develop the plan designs that would meet the target actuarial value levels. Underlying the modeler is detailed claim and enrollment data for over 42 million commercially-insured lives. Since allowed costs can have a significant impact on the actuarial value of a plan, the model was first normalized to the estimated 2017 allowed costs, which varied depending on the targeted actuarial value of the plan, largely due to induced demand but also because of differences such as morbidity. Once the model was normalized for the estimated 2017 allowed costs, the cost sharing was adjusted until the targeted actuarial value was achieved. While the model has many cost sharing inputs for various service categories, only a subset have a significant impact on the resulting actuarial value.

2. *The Federal Actuarial Value Calculator (AVC)* was used as a check of the Truven Health Benefit Modeler. This was only a high level reasonability check and the Federal AVC is expected to be less precise for several reasons. First the model is not normalized to 2017 GMC estimated allowed costs. Second, the model has less inputs which results in less precision. Lastly, the primary goal of the Federal AVC is to bucket similarly generous plans rather than be an accurate pricing tool. However, since it is critical that the plan design be reasonably accurate and pricing models will all produce different results, the Federal AVC was used to ensure the reasonability of the plan design results. In order to produce the most relevant comparison, the Draft 2016 AVC was used. Additionally, the metal level chosen in the AVC was based on the allowed costs in the Federal AVC continuance table compared to the GMC plan rather than matching the metal tier to the approximate actuarial value of the GMC plan.

3. *The 80 percent high deductible health plan* required additional modeling. This plan design has two separate deductibles, one that applies to inpatient services and another that applies to all other categories of services (the deductibles do not apply to preventive services). Neither the Truven Health Benefit Modeler nor the Federal AVC can accommodate this plan design. To approximate the actuarial value and resulting cost sharing levels for this plan, Wakely developed a combined deductible that would be similar in actuarial value to the two separate deductibles. However, this is a less precise method and the cost sharing for this plan should be considered illustrative only. If this plan is considered in the future, Wakely recommends using separate inpatient and "all other" continuance tables to model this plan design. Another alternative would be to use a claim re-adjudication process on the VHCUREs commercial data to more accurately reflect the actuarial value of this plan design. In both cases, the underlying data would need to be adjusted to reflect the expected GMC population and expected costs.

   In addition to the cost sharing, the 80 percent high deductible plans also included an account feature for the subsidy eligible population. The subsidies were more generous than the current federal ACA cost sharing subsidies with additional, higher FPLs receiving some subsidies. Wakely used the Federal AVC to estimate the impact of these accounts. No rollover of accounts was assumed although the State may consider partial rollovers in the future, particularly to encourage certain behaviors, such as receiving annual preventive care. A few federal AVC results for the accounts were not intuitive. If this plan is considered in the future, the impact of these accounts should be re-evaluated using the same proposed methods to evaluate the actuarial value and cost sharing of the plans (separate continuance tables or claim re-adjudication).
4. *Results* are based on the various scenarios and assumptions used to produce the allowed cost estimates. To the extent any of these assumptions are updated or allowed costs are refined, the plan designs would need to be updated as well. Additionally and as noted, neither the Truven Benefit Modeler nor the Federal AVC could accommodate the cost sharing structure for some of the plans (particularly select 80 percent plans). These plan designs would require further refinement and scrutiny should there be future interest in these plan options.

Additional Benefit Modeling

As required under Act 48, the estimated cost of covering hearing, adult dental, adult vision and long term care were calculated. The following is a high level summary of the assumptions that went into each of these cost estimates. The cost estimates are shown in Appendix B-1. Wakely also estimated the impact of Medicare secondary coverage where the commercial MOOP was applied to the Medicare fee for service benefits.

A. Hearing: Vermont's current Essential Health Benefits (EHB) do not cover annual hearing exams or hearing aids so would not automatically be covered services under GMC. Medicaid currently covers this benefit.

   1. *Data*: VHCUREs data was used as a basis for the cost projections. It was assumed that if an individual had a hearing aid covered that their entire employer group

had hearing coverage. Using this methodology, data for only those assumed to cover hearing benefits were used as the base data. Both utilization and cost per service or device were calculated for these members.

2. *Assumptions:*
    i. Trend: The trends used for medical costs (and listed in the above table) from 2012 to 2017 were also used for hearing.
    ii. Benefits and Cost Sharing: The benefits were set to closely align with the Medicaid benefits. One annual exam per year is covered with a $20 copay and hearing aids were covered with no member cost sharing every three years. If the State of Vermont decides in the future to pursue a deductible plan, the cost sharing should be reviewed to ensure it is appropriate considering the medical coverage.
    iii. Administrative Expenses: An assumption of 7% was used which is likely reasonable since this benefit would be incorporated into the medical coverage.
    iv. Enrollment: The scenario used in the cost estimation excluded commuters and federal employees as well as wrap coverage for employees who remain on employer sponsored coverage. If the hearing benefit is considered in the future the cost estimates should be updated to reflect the current enrollment estimates.

B. Adult Vision: Vermont's current Essential Health Benefits do not cover annual vision exams or hardware except for pediatric coverage and would therefore not be automatically covered for adults under GMC. Medicaid currently covers an exam but does not cover hardware.

1. *Data*: VHCUREs data was used as a basis for the cost projections. It was assumed that if an individual had vision hardware covered that their entire employer group had vision coverage. Using this methodology, data for only those assumed to cover vision benefits were used as the base data. Both utilization and cost per service were calculated for these members although the utilization results did not appear reasonable. The Federal vision premiums were also used to check for reasonability of the resulting cost estimates.

2. *Assumptions:*
    i. Trend: The trends used were 3 percent annual. This considers that vision typically trends lower and also that the benefit maximum would limit the impact of trend unless adjusted for inflation.
    ii. Benefits and Cost Sharing: The benefits were set to closely align with the Federal vision benefits, since these benefits are the basis for the pediatric vision benefits under Vermont's EHB. One annual exam and hardware per year are covered (frames and contacts have annual benefits maximums although the pediatric benefit does not). Since Medicaid already covers

an exam, only the cost of hardware is included as an additional cost under GMC.

iii. Administrative Expenses: An assumption of 7% was used to match the commercial medical assumption but this is likely aggressive since this benefit historically has administrative costs that are a higher percent of overall costs.

iv. Enrollment: The scenario used in the cost estimation excluded commuters and federal employees as well as wrap coverage for employees who remain on employer sponsored coverage. If the adult vision benefit is considered in the future the cost estimates should be updated to reflect the current enrollment estimates.

v. Percent of Adults: The percent of GMC enrollees that this benefit would apply based on age was an output of the micro-simulation. Adults are expected to be approximately 84% of the commercial population and 58% of the Medicaid population.

C. Adult Dental: Vermont's current Essential Health Benefits do not cover dental except for pediatric coverage and would therefore not be automatically covered for adults under GMC. Medicaid currently covers dental up to an annual maximum of $510.

1. *Data:* The primary source of dental data was 2010-2012 Vermont specific data from Truven's MarketScan Dental Data, including data only for those aged 19 and older. Given most current dental benefits include annual benefit maximums, dental data is typically missing claims once the member reaches the maximum. As a result, dental data needs to be used with caution. As a result, we also used several other sources of data or premiums to check for reasonability. These include the State employee dental premiums, Delta Dental rate filings and Delta Dental adult only Vermont Health Connect premiums.

2. *Assumptions:*

i. Trend: The trends used were 6% annual. Dental trends have been lower recently but given the longer trending period, a more conservative trend assumption was used.

ii. Benefits and Cost Sharing: Cost estimates were calculated for three different benefit and cost sharing scenarios. These are shown in Appendix B-1.

iii. An adjustment was made to estimate the impact of missing claims due to current plans having an annual benefit maximum. This adjustment was made primarily to Restorative and Major services since these services are most likely to be impacted by the benefit maximum.

iv. Administrative Expenses: An assumption of 7% was used to match the commercial medical assumption but this is likely aggressive since this benefit historically has administrative costs that are a higher percent of overall costs.

v. Enrollment: The scenario used in the cost estimation excluded commuters and federal employees as well as wrap coverage for employees who remain on employer sponsored coverage. If the adult dental benefit is considered in the future the cost estimates should be updated to reflect the current enrollment estimates.
vi. Percent of Adults: The percent of GMC enrollees that this benefit would apply based on age was an output of the micro-simulation. Adults are expected to be approximately 84% of the commercial population and 58% of the Medicaid population.

3. *Results*: Based on our analysis and the various data points reviewed, if adult dental is considered under GMC, refining these estimates and underlying data is critical to more accurately estimating the cost of adult dental. There is also likely to be increased utilization in the early years of coverage as those without prior coverage have pent up demand.

D. Long Term Services and Supports: Currently, Long Term Services and Supports (LTSS) is provided to the Vermont Medicaid population. A cost estimate was developed assuming full LTSS coverage would be extended to the non-Medicaid population in 2017.

1. *Data:* The cost estimate was based on the 2012 Vermont Health Care Expenditure data. The 2012 non-Medicaid and non-Medicare covered costs associated with home health and nursing home care were used as a starting point for the projection.

2. *Assumptions:*
   i. Trend: Costs were trended from 2012 to 2017 based on the historical LTSS 2009-2012 trend, adjusted for enrollment increases, from the Expenditure Analysis. An additional trend adjustment was made to account for the aging population in Vermont. The total average trend used varied from 4.0 to 5.0 percent annually.
   ii. Induced Demand: Based on several LTSS studies, a significant amount of LTSS is either provided by unpaid caregivers or the need goes unmet. Cost estimates for the unpaid cost ranges vary significantly. The studies we reviewed included the following:
      • A November 2010 study produced by UMass Medical School's Center for Health Law and Economics and Office of Long-Term Support Studies on behalf of the Massachusetts Long-Term Care Financing Advisory Committee. This study indicated that $8.6 billion was paid for LTSS costs in Massachusetts and that an additional $9.6 billion in cost was either unpaid or came from needs that went unmet. Applying this additional cost to the

relative non-Medicaid and non-Medicare costs results in an induced utilization factor of about 5.0.[2]

• An AARP study titled "Valuing the Invaluable: 2011 Update" estimated that in 2009, $203 billion was paid for LTSS costs nationally and an additional $405 billion was provided by unpaid care givers. Applying this additional cost to the relative non-Medicaid and non-Medicare costs results in an induced utilization factor of about 8.0.[3]

• An additional AARP study from September 2011 indicated that in 2004, 72% of older people living in the community received assistance exclusively from unpaid caregivers. This study further supports the above indication that the cost of unpaid care-giving is about two to three times the amount of total paid caregiving.[4]

iii. Cost Sharing: The analysis assumes there would be no cost sharing by the member. Costs would be significantly reduced if there were cost sharing. Additionally, implementing a waiting period of 30 to 90 days could reduce the total cost estimate by 10% to 20%.

E. Medicare Secondary Coverage: Medicare remains primary after implementation of GMC. GMC could provide secondary coverage for those with Medicare as their primary insurance. When considering the 80% AV plan, which included an income sensitive out of pocket maximum, an analysis was done of applying these maximums as secondary coverage for those on Medicare. The results of this analysis are in Appendix B-10.

1. *Data:* CMS 2012 Limited Data Set (LDS) was used as the base data for the analysis. Vermont specific data, including both dual and non-dual members, was used. Allowed PMPMs and continuance tables were developed using this data. Only Part A and B data was included. Part D (prescription drug) was not included as part of the analysis since secondary coverage with the drug benefit would be complicated.

2. *Assumptions:*
   i. Trend: The allowed costs were trended at an average of 2.9 percent annually from 2012 to 2017 based on projected Medicare fee for service costs.
   ii. Cost Sharing: The secondary coverage would apply only to Medicare fee for service (FFS) members since the Medicare Advantage population already incorporates a MOOP. The FFS cost sharing was applied to the

[2] http://www.mass.gov/eohhs/docs/eohhs/ltc/ma-ltcf-full.pdf
[3] http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf
[4] http://www.longtermscorecard.org/~/media/Microsite/Files/Reinhard_raising_expectations_LTSS_scorecard_REPORT_WEB_v5.pdf

2017 estimated data, with a resulting 85 percent actuarial value for Parts A and B (the actuarial value varies by duals and non-duals).

3. *Results:* The impact to the actuarial value was estimated for each of the plan designs considered for the current commercial market under GMC. Wakely's Medicare bid model was used with the data and assumptions above for each MOOP amount. Given the higher expected costs of Medicare beneficiaries, the resulting actuarial value increases significantly for the lower MOOP levels. There is a more modest increase in actuarial value for MOOPs that align with the maximum allowable under the ACA for the commercial market.

Reliances and Caveats

1. Wakely relied on data and projections that were provided by the health plans, the State, Rand and Jonathan Gruber. We performed reasonability checks, but did not audit the data we received. If the underlying data or information is inaccurate or incomplete, the results of our analysis may need to be modified accordingly.

2. It is impossible to project costs several years into the future with accuracy, and it is particularly difficult to project the effects of untested reforms. We made assumptions and estimates in order to develop these projections. To the extent that actual results differ from these assumptions, our results could be materially affected.

3. This document is intended for use by the State of Vermont for discussion purposes only. The report may not be appropriate for other purposes. Wakely does not intend to benefit and assumes no duty or liability to other parties who receive this work. The report should only be reviewed in its entirety and then only by qualified individuals.

Michael Costa
Deputy Director of Health Care Reform - Finance
Agency of Administration
State of Vermont

December 26, 2014

Subject: Risk Mitigation for Green Mountain Care

Dear Michael,

Wakely was retained by the State of Vermont (State) to develop considerations in two specific approaches towards risk mitigation for Green Mountain Care (GMC): reinsurance with specific stop loss and reserve for adverse deviation of claim costs. We do not recommend the State purchase stop loss reinsurance given the anticipated size of GMC. We also estimated that an insurance company with the size and risk characteristics similar to those of GMC would need to hold between 4.4% and 13.0% of annual claims.

Specific Stop Loss to Mitigate High Cost Claimants

Specific stop loss insurance is typically purchased from reinsurers and protects a self-funded employer group or insurer from the financial impact of high cost individuals. It does not provide much protection against overall adverse experience. The cost of specific stop loss insurance is typically high relative to the coverage afforded. On average, reinsurers expect to pay out about 60% of the premiums they collect for the coverage meaning the cost of the coverage is approximately 40% of the premiums. Self-funded employers with a couple of hundred to thousands of covered employees typically purchase reinsurance to protect against catastrophic costs for a single individual or multiple high cost claimants in a given year – outside of what would be expected based on historic experience. For these employers, a single million dollar claim could represent a large proportion of their overall medical expenditures and cash reserves. For Green Mountain Care, with roughly $3.6 billion in estimated annual claim costs (excludes long term support and services and other Medicaid fixed costs), individual large claims are very unlikely to materially affect overall expenditures. In addition, such a large block of business is very stable and past experience is credible for predicting future large claims incidence. The most significant risk to the financial health of a large cohort like the proposed Vermont system include inappropriate provider contracts, mispricing, pandemic type events and fraud. While the impact of some of these may be partially mitigated by the presence of stop loss insurance, it is an inefficient and expensive way of addressing these risks.

Capital to Support GMC Program

GMC is considering retaining capital for purposes of addressing potential adverse deviations in medical expenditures and tax revenue underlying a potential change to a state run healthcare program. One approach to considering appropriate capital levels to address such adverse deviations is the NAIC's Risk-Based Capital (RBC) formula.

From http://www.naic.org/cipr_topics/topic_risk_based_capital.htm:

Risk-Based Capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. RBC limits the amount of risk a company can take. It requires a company with a higher amount of risk to hold a higher amount of capital. Capital provides a cushion to a company against insolvency. RBC is intended to be a minimum regulatory capital standard called the Authorized Control Level (ACL) and not necessarily the full amount of capital that an insurer would want to hold to meet its safety and competitive objectives. In addition, RBC is not designed to be used as

a stand-alone tool in determining financial solvency of an insurance company; rather it is one of the tools that give regulators legal authority to take control of an insurance company if reserves fall below the ACL.

Insurance companies must hold at least 200% of the ACL to avoid any actions and typically hold 250% to 350%. Therefore, an insurance company with the size and characteristics of the Vermont system would have to hold somewhere between 4.4% and 13% of annual claims to meet typical insurance company RBC targets under the assumptions modeled.

We would recommend that a full Enterprise Risk Management (ERM) analysis be performed as key options for funding, provider payment, benefits and administration are selected and refined. This type of analysis may consider RBC fundamentals rather than applying the NAIC's formula from the RBC Calculator.

Wakely used the NAIC's 2014 RBC model and entered key values into the model. The inputs included "premium equivalents" and claims for enrollees currently in commercial and Medicaid lines. Medicare members were not considered in this analysis. The claims and premiums were developed in a separate analysis and any assumptions/limitations described in that analysis apply but may not be described here.

We assumed that GMC would offer coverage at the 94% actuarial value to all members. The scenario incorporates the higher enrollment estimate, including but not limited to coverage for commuters and federal employees.

We did not consider that many government programs operate on a "pay as you go" basis. This means that liabilities are not considered when determining if there is sufficient cash to cover operations. We assume funding would take place in advance of claims being incurred each month and that payments to providers would follow typical insurance company payment patterns, meaning there would be approximately one to three months' worth of incurred claims in cash available over and above any capital retained to address adverse experience. Our RBC modeling estimates RBC levels required over and above this cash, on the assumption that this cash could not or should not be used to address adverse deviations.

We assumed some portion of the claims are capitated to reflect the fact that the Green Mountain Care Board sets hospital budgets and that Vermont is moving away from fee for service toward capitation. For RBC calculations, hospital budgets may effectively be modeled as capitations. Under a scenario of all providers being paid under capitated arrangements, we estimate the ACL of the program at approximately 2.2% of annual incurred claims (approximately $81M assuming $3.6B in annual incurred claims). Under a scenario of 30% of provider payments being capitated and 70% being contractual arrangements or fee for service, we estimate the Authorized Control Level at approximately 3.8% of annual incurred claims (approximately $136M).

The RBC formula was not developed to specifically inform state capital levels under a system such as that being considered in Vermont. However, it does provide one useful, industry-accepted construct for considering capital levels to support insurance operations.

The RBC formula was not set up to handle certain unique characteristics of potential state run health programs, including the following proposed, high level mechanisms:

1. Premiums are actually comprised of tax revenue and amounts paid by covered state residents.
2. Provider reimbursement rates in Vermont are partially set using state budgeting mechanisms.
3. Provider reimbursement rates can be adjusted prospectively if tax revenues are insufficient.

Many details were not available nor could be reflected in the model, including but not limited to covered and excluded populations, taxing mechanisms and timing, the political environment, economic environment, required administrative functions and costs, specific provider contracting levels and mechanisms, and medical management programs.

A state run healthcare insurance system, with unilateral taxing and provider contracting authority is a very different entity than the typical health insurance company. Therefore, the modeling discussed above should be considered only as one viewpoint related to this question, rather than the only viewpoint. In addition, emerging details up for debate may materially affect estimates produced as part of this modeling.

Caveats

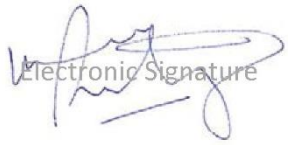
Wakely relied on data and projections that were developed jointly by Wakely, the State, and Jonathan Gruber. We performed reasonability checks, but did not audit the data we received from non-Wakely entities. If the underlying data or information is inaccurate or incomplete, the results of our analysis may need to be modified accordingly.

It is impossible to project costs and capital needs several years into the future with accuracy, and it is particularly difficult to project the effects of untested reforms. We made assumptions and estimates in order to develop these projections. To the extent that actual results differ from these assumptions, our results could be materially affected.

This document is intended for use by the State of Vermont for discussion purposes only. The report may not be appropriate for other purposes. Wakely does not intend to benefit and assumes no duty or liability to other parties who receive this work. The report should only be reviewed in its entirety and then only by qualified individuals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Julie Peper, FSA, MAAA
Director and Senior Consulting Actuary
Wakely Consulting Group



Karan Rustagi, ASA, MAAA
Consulting Actuary
Wakely Consulting Group

Appendix E-1: All-Payer Health Care Payment System Background

The purpose of this concept paper is to describe the general approach Vermont is proposing for all-payer health care payment reform. This paper can serve as a starting point for discussion among internal and external stakeholders, including the federal Centers for Medicare and Medicaid Services (CMS), about the proposed approach.

Vermont is developing a payment reform strategy that is consistent with federal policy and builds on the public/private partnership that has been established in the state. Our proposed approach allows for appropriate provider autonomy and consumer protection under the umbrella of a transparent, effective regulatory system.

Vermont has undertaken a multi-year effort to implement universal, comprehensive health care coverage for all of the state's residents that is equitably financed and made affordable well into the future. The state plans to seek a federal all-payer waiver that would permit Medicare and Medicaid participation in payment and delivery system reforms that are central to the plan. These reforms build on the innovative models supported by CMS and on the progress made within Vermont to implement those models. Specific Vermont achievements in payment and delivery system reform, made with CMS support, include:

- Vermont has used its long-standing section 1115 waivers (the Global Commitment and Choices for Care) to fund Medicaid managed care investments and to shift services away from institutional care to community-based services;
- More than 80 percent of Vermonters are served by an Advanced Primary Care Medical Home that is part of the MACPAC all-payer demonstration;
- The vast majority of Vermont providers, including all of our hospitals and New Hampshire-based Dartmouth Hitchcock Medical Center (DHMC, a major provider of health care to Vermonters) are in one of three Vermont ACOs participating in the Medicare Shared Savings Program;
- DHMC also is in the Pioneer ACO program for New Hampshire;
- The majority of Vermont's federally-qualified health centers have formed a primary care-based ACO;
- Vermont received a State Innovation Model (SIM) grant, which has supported expansion of the shared savings program to Medicaid and commercial insurers. Three of our ACOs are participating in the commercial ACO program, while two are participating in the Medicaid program;
- The SIM grant also is supporting development of all-payer bundled payments and full build-out of Vermont's health information exchange infrastructure.

Building on this active participation in CMS initiatives, and CMS support of Vermont's innovation efforts, Vermont is proposing a statewide, all-payer system of provider payment. Governor Shumlin has proposed covering the bulk of Vermonters through one payer under a system of public financing. We believe this proposal could work

equally well with that model or with our existing, limited multi-payer private insurance market (two carriers do business in Vermont's merged individual and small group market and only three sell in the large group market).

Vermont's proposal has two strengths, in addition to the strong foundation described above:

1. An explicit commitment from the Governor, backed by Vermont law passed in 2011, to constrain health care cost growth to a level that is affordable, relative to the state's overall economic growth, and to move away from volume-based provider payment;
2. A mature regulatory system under the authority of the Green Mountain Care Board (GMCB). The GMCB was created in 2011 as an independent, full-time, professional board that reviews and approves health insurer rates, annual hospital budgets and major capital expenditures by health care providers.
    - The GMCB also is the overseer of payments to ACOs and other key aspects of the commercial and Medicaid shared savings programs, including calculation of shared savings, risk adjustment, risk corridors and quality measurement.
    - The GMCB has broad (as yet unused) statutory authority to implement broader provider rate-setting, beyond the hospital sector.
    - The GMCB set a limit of 3 percent growth in hospital budgets for current year. Actual budgets approved by the board are slated to grow at 2.7 percent, year-over-year. These budgets include not only expenditures for hospital services, but also the majority of physician payments, as a high and growing percentage of physicians in the state are employed by hospitals.
    - In setting the limit on hospital budget growth, the board looked to indicators of economic growth in the state and made clear that their goal was to link health care cost growth and economic growth over the long term.

Building on these strengths, Vermont proposes a system of health care provider payment oversight with three central elements:

1. Continued regulatory oversight of the parameters of ACO/payer relationships, including payment levels, rates of increase in payment year-to-year and quality measurement;
2. Oversight of insurer payments to non-ACO providers, and a requirement for a fair, transparent and standardized fee schedule for those providers;
3. Continued oversight of health insurance premiums and premium growth.

The state is currently assessing the interface between these regulatory schemes and regulation of hospital budgets (which has existed since the 1980s), and the extent to which the hospital budget review process is necessary, and/or whether it should be redesigned, under a fully-developed system of broader provider payment regulation.

With these three elements in place (at a minimum), Vermont would propose that we commit to:

- Control of the rate of growth in total health care costs at a rate that is consistent with growth in the economy;
- Deliberate movement further away from fee-for-service provider payment by transitioning ACO payments from shared savings to a model involving two sided risk and increased provider accountability for total costs and quality;
- Obtaining a commitment from all commercial payers in the individual and small group market, plus Medicaid, to participate in the models of payment to both ACOs and non-ACO providers;
- Adoption by the GMCB of parameters for all-payer payments to ACOs;
- Adoption by the GMCB of rules for all-payer payments to providers outside of ACOs;
- Continued payments by Medicaid and commercial payers to Blueprint Advanced Primary Care Medical Homes and Community Health Teams.

We would be asking CMS for:

- Approval for Medicare participation in the Vermont provider payment model – for both ACO payments and non-ACO payments;
- Necessary approval from CMS for Medicaid participation in this model;
- Continued participation in payments to Advanced Primary Care Medical Homes and Community Health Teams.

Medicare participation in this model is critical, as will make our policies universal, consistent and substantially more efficient and effective. This approach has the potential to reduce administrative costs for payers, providers and government and maximize positive delivery system change through consistent payment rules and monitoring. The end result will be lower costs for all payers.

Further details of the ACO and non-ACO provider payment models will be developed by GMCB board members, staff and contractors over the next 12 months, with input from the Governor's Office, key stakeholders, the Agency of Human Services and the Department of Vermont Health Access. Elements of the proposal that require further development include:

- The specific methodology for the ACO payment system;
- The specific methodology for the non-ACO payment system;
- Whether and how to incorporate in payment models services beyond the normal scope of ACOs, including long term services and supports;
- The extent to which per capita payments or payment levels for specific services from payers to providers will vary across payers;
- The extent to which, across all payers, per capita payments or payment levels for specific services will vary by provider;
- The specific levels of the limits to be applied to health care cost growth;
- The specific methodology for attributing Vermont's population to providers;
- Membership rules and roles for participating providers;
- Appropriate consumer protections in a statewide, all-payer system of health care cost and quality regulation.

Vermont is a relatively low-cost state for the Medicare program, but per-capita Medicare growth rates exceeded the national average in recent years (see data below). We believe this program would offer CMS a compelling example of how a low-cost, rural state, through a deliberate commitment to low rates of cost growth, could reduce expected Medicare expenditures, reduce pressure on Medicaid and private premiums and improve outcomes for all residents of the state.

VT total (all payers) per capita health care costs, 2009	$7,635 (above national average)
VT total rate of growth 1991–2009	6.7% (above national average)
National per capita all payers, 2009	$6,815
National all-payer trend, 1991–2009	5.3%
VT Medicare per capita	$8,719 (below national average)
VT Medicare rate of growth 1991–2009	6.8% (above national average)
National Medicare per capita, 2009	$10,365
National Medicare rate of growth, 1991–2009	6.3%

Appendix E-2: Affordable Care Act Waiver Background

Before Vermont can fully implement Green Mountain Care, it needs the federal government to waive certain parts of the Affordable Care Act. The Affordable Care Act is a federal law that requires states to have Health Benefit Exchanges offering health insurance plans[1] and administering federal subsidies to individuals to make the plans more affordable.[2] Individuals pay a penalty if they do not have health care coverage.[3] Large employers pay a penalty if they do not offer affordable and adequate health care coverage.[4] Starting in 2017, the federal government can waive a state's obligation to any or all of the above provisions and allow the state to implement its own innovative health care coverage programs as long as its program maintains the following parameters:

- Coverage of the same amount or more people than under the ACA[5]
    - Green Mountain Care will cover more people than the ACA because it will cover all Vermont residents.
- Coverage that is as comprehensive or more comprehensive than coverage under the ACA[6]
    - Green Mountain Care will offer the same covered services as ACA plans.
- Coverage that is as affordable or more affordable than coverage under the ACA[7]
    - At a minimum, Green Mountain Care will apply the ACA's premium tax credit and cost-sharing reduction sliding scale to a gold-level plan.
- A health care system that is deficit neutral for the federal government[8]
    - Green Mountain Care will maintain reciprocal deficit neutrality for the federal government and the State of Vermont.

To reach universal coverage, Vermont would request waivers of the Health Benefits Exchange, the individual mandate, and the large employer penalty through Section 1332 of the Affordable Care Act.

The ACA expanded health care coverage, but was never designed to provide universal coverage. Green Mountain Care will achieve universal coverage by having residency as its only eligibility requirement and eliminating barriers such as premium due dates and enrollment deadlines. In order to achieve this, Vermont would request a waiver from the Affordable Care Act's requirements around:

- Health Benefits Exchange
- Individual mandate
- Large employer penalty

[1] ACA, Subtitle D, Parts I & II.
[2] I.R.C. § 36B.
[3] I.R.C. § 5000A.
[4] I.R.C. § 4980.
[5] ACA, Section 1332(b)(1)(C); 42 U.S.C. 18052(b)(1)(C).
[6] ACA, Section 1332(b)(1)(A); 42 U.S.C. 18052(b)(1)(A).
[7] ACA, Section 1332(b)(1)(B); 42 U.S.C. 18052(b)(1)(B).
[8] ACA, Section 1332(b)(1)(D); 42 U.S.C. 18052(b)(1)(D).

Waiver of Health Benefits Exchange

The Affordable Care Act requires each state to have at least one Health Benefit Exchange through which individuals and small businesses can purchase qualified health plans from insurance companies or can access public coverage through Medicaid. Vermont, in compliance with the Affordable Care Act, started operating its Health Benefits Exchange, called Vermont Health Connect, on October 1, 2014. Vermont, like all other state-based exchanges, has had operational challenges in its start-up phase, but continues to work towards full and better operations for both individuals and small businesses.

Although Vermont's Health Benefit Exchange, once fully operational, will afford greater access to health care coverage and financial help to make coverage more affordable, it does not prevent loss of coverage. In a 2012 statewide survey, Vermonters most commonly cited the following reasons for losing coverage: affordability, job loss, waiting periods for coverage, eligibility issues, and problems with paperwork or late payments.[9] Many of these barriers continue to exist for Vermonters despite implementation of a Health Benefits Exchange. In order to provide coverage to all Vermonters, Vermont must move away from a complicated system of insurance-based health care and public coverage to a system based solely on residency. Accordingly, Vermont would ask CCIIO to waive the Affordable Care Act's requirement to have a state or federal Health Benefit Exchange.[10]

Waiver of Large Employer Penalty

The Affordable Care Act furthers the traditional employer-sponsored health insurance model by instituting a penalty on large employers who do not offer health care coverage or who offer health care coverage that is unaffordable or inadequate. In Vermont, the traditional employer-based health insurance model has not led to universal coverage, with job loss being the most cited reason for loss of coverage.[11] Although health insurance is available under the Health Benefit Exchange, individuals may experience gaps in coverage due to a misalignment of the qualified health plan start date or failure to sign up within the special enrollment period. As a result, the current employer-based health insurance model will not lead to universal coverage in Vermont.

By basing eligibility for Green Mountain Care solely on residency rather than the complicated mix of eligibility criteria based on income and employment, Vermont would ensure that its entire population receives continuous coverage. Because all Vermont residents would have Green Mountain Care, an employer penalty will be superfluous. Accordingly, Vermont would request that the Affordable Care Act's large employer penalty be waived.

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[9] Vermont Department of Financial Regulation Insurance Division, 2012 Vermont Household Health Insurance Survey, Pg. 77, http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf.

[10] Parts I & II of subtitle D in Title I of the Affordable Care Act.

[11] Vermont Department of Financial Regulation Insurance Division, 2012 Vermont Household Health Insurance Survey, Pg. 77, http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf.

Waiver of Individual Mandate

As with the large employer penalty provision, Vermont would also request that the individual mandate be waived. All residents of Vermont would have Green Mountain Care, so all residents of Vermont will meet the Affordable Care Act's requirement of minimum essential coverage, making the individual penalty unnecessary.

The Health Benefits Exchange, large employer penalty, and individual mandate requirements under the Affordable Care Act bind individuals and small businesses to insurance-based coverage. Waiving these provisions would provide Vermont with the flexibility to achieve universal health care coverage through providing Green Mountain Care to all residents.

To achieve comprehensive coverage, Vermont would request a waiver of the qualified health insurance plan.

Vermont would ask CCIIO to waive the Affordable Care Act's requirements for qualified health benefits plans. The Affordable Care Act requires that qualified health insurance plans be offered at the bronze, silver, gold, and platinum levels.[12] This leaves some individuals at the silver or bronze level with higher out of pocket costs. Green Mountain Care would provide individuals with one plan that compares to a gold level or better, ensuring greater coverage for all Vermonters than is provided today.

In addition to better out of pocket coverage, Green Mountain Care would provide the same or more covered services than what is offered today. Green Mountain Care would have all of the Essential Health Benefits under the Affordable Care Act.[13] Additionally, Act 48 requires Vermont to design Green Mountain Care to address chronic care in the most effective way possible. Other benefits such as adult dental or adult vision must also be considered in designing Green Mountain Care's benefit plan. Vermonters who qualify for Medicaid coverage will continue to receive coverage through Green Mountain Care, including Medicaid benefits. Vermont would seek to integrate its current Section 1115 Global Commitment to Health waiver with the new permissions through Section 1332 of the ACA to ensure that Green Mountain Care operates as a seamless, single system.

Waiving the Affordable Care Act's requirements around qualified health insurance plans would allow Green Mountain Care to provide the same or more covered services as well as greater coverage of out of pocket costs than many current qualified health insurance plans.

[12] Sec. 1332(c) of the Affordable Care Act.

[13] Sec. 1332(b) of the Affordable Care Act. Vermont's Essential Health Benefits are listed at https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/vermont-ehb-benchmark-plan.pdf.

To achieve greater affordability, Vermont would request a waiver of the premium tax credit and cost sharing reductions.

In order to increase access to private insurance plans, the Affordable Care Act provides premium tax credits and cost-sharing reductions to eligible individuals.[14] The cost sharing reductions and the advance payment of the premium tax credits are paid directly to the insurers. The premium tax credits and the cost sharing reductions are not available to individuals with other sources of affordable, adequate coverage, such as employer-sponsored insurance or Medicare.

Before the Affordable Care Act was passed, Vermont had affordable health care programs for individuals up to 300% FPL. These programs had premiums and coverage that were more affordable to many Vermonters than subsidized insurance under the ACA. Vermont is trying to maintain the affordability standard it had before the ACA,[15] but despite these efforts, one of the most-cited barriers to individuals maintaining health care coverage is cost.[16] Green Mountain Care would eliminate cost as a barrier by breaking the direct link between monthly payment and health care coverage. The coverage under Green Mountain Care would be publicly financed in an income-sensitized manner that maintains or improves upon Vermont's current subsidized structure for plans at an 80% actuarial value (AV) or greater, which equates to a gold level plan, ensuring that all Vermonters contribute in a way that maintains or surpasses the ACA's affordability standards.

To achieve public financing of Green Mountain Care, Vermont would request that CCIIO waive the Affordable Care Act's premium tax credit and cost sharing reductions as they are currently administered. Instead of going to health insurance companies, these funds will go directly to the state for purposes of equitably financing and administering Green Mountain Care.

ACA Waiver Federal Funding Calculation

Under the ACA waiver, Vermont may receive the premium tax credit, cost sharing reductions, and small business tax credit payments that would have been paid had the ACA's requirement to have an Exchange selling health insurance not been waived.[17]

Premium Tax Credits and Cost Sharing Reductions

Currently, the federal government provides advanced payment of the premium tax credit and cost sharing reduction payments directly to insurers on behalf of eligible individuals. Under the ACA waiver, Vermont would waive this requirement because residents would move from paying premiums for insurance plans through Vermont Health Connect to having publicly-

[14] Parts I of subtitle E in Title I of the Affordable Care Act; Section 36B of the Internal Revenue Code of 1986.
[15] Vermont currently reduces premiums through subsidies that reduce the federal advanced premium tax credit's applicable percentage by 1.5% for Vermonters up to 300% FPL and subsidizes cost sharing reductions from 73% AV to 77% AV for Vermonters from 200-250% FPL and from 70% to 73% AV for Vermonters from 250-300% FPL.
[16] Vermont Department of Financial Regulation Insurance Division, 2012 Vermont Household Health Insurance Survey, Pg. 77, http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf.
[17] ACA § 1332(a)(3); 42 U.S.C. § 18052(a)(3).

financed health care coverage under Green Mountain Care.[18] Under the ACA waiver, the federal government would pay Vermont the aggregate amount of the premium tax credits and cost sharing reduction payments that would have otherwise been paid under the ACA.[19]

The ACA does not define how the premium tax credits and cost sharing reductions payments will be calculated. After analyzing various options, Vermont proposed that the federal government calculate the aggregate amount of the premium tax credits and cost sharing reduction payments by using a modified formula that the federal government is already using with the Basic Health Program (BHP).

With the BHP, the ACA gives states the flexibility to establish health coverage for low-income individuals not eligible for Medicaid.[20] Like the ACA waiver, a state's BHP must maintain the affordability and coverage requirements set out in the ACA.[21] In return, the federal government will transfer to the state 95% of the amount in premium tax credit and cost sharing reduction payments that would have otherwise been available under the ACA. The ACA and its attendant rules set out several requirements around these calculations, including the fact that the calculation must be made on a per enrollee basis where age, income, coverage tier, geographic area, and health status are taken into account.[22]

Because the principles behind the BHP program and the ACA waiver are similar, Vermont proposed using the BHP formulas modified by Vermont-specific factors to calculate the federal share for the premium tax credits and cost sharing reduction payments under the ACA waiver. For instance, Vermont uses community rating, so any factors based on age or tobacco rating would be omitted from the formula. Vermont is also comprised of one geographic area for insurance rates, so that factor may be omitted as well. Also, the ACA requires BHP funding to be 95% of the total estimated funding, whereas the ACA waiver has no such factor. After taking these adjustments into account, Vermont created formulas to calculate the premium tax credit and cost sharing payment amounts.

Premium Tax Credit Formula

Vermont created the following formula to calculate the premium tax credit:

$$PTC_{c,h,i} = [ARP_c - (\Sigma_j I_{h,i,j} \times PTCF_{h,i,j})/n] \times IRF \times E_{c,h,i}$$

$PTC_{c,h,i}$= Premium tax credit portion of ACA waiver payment rate
c= Coverage status (self-only or applicable category of family coverage)
h= Household size
i= Income range (as percentage of FPL)

[18] ACA § 1332(a)(2); 42 U.S.C. § 18052(a)(2).
[19] ACA § 1332(a)(3); 42 U.S.C. § 18052(a)(3).
[20] ACA § 1331; 42 U.S.C. § 18051.
[21] ACA § 1331(a)(2); 42 U.S.C. § 18051(a)(2) (with the exception of the cost sharing reduction standard where individuals from 150% FPL to 200% FPL may be covered by an 80% AV plan rather than an 87% AV plan).
[22] ACA § 1331(d)(3); 42 U.S.C. § 18051(d)(3); 79 FR 14111 (March 12, 2014).

ARP_c= Adjusted reference premium
$I_{h,i,j}$= Income (in dollars per month) at each 1 percentage-point increment of FPL
j= j^{th} percentage-point increment FPL
n= Number of income increments used to calculate the mean PTC
$PTCF_{h,i,j}$= Premium Tax Credit Formula percentage
IRF= Income reconciliation factor
$E_{c,h,I}$ = Number of individuals enrolled

Premium tax credit portion of ACA waiver payment rate
Like the BHP, the premium tax credit estimate would be calculated by rate cells in which coverage status, such as single, couple, or family, is taken into account along with household size and income range. Vermont would use income ranges up to 400% FPL because income eligibility for the premium tax credit goes up to 400% FPL. Within each rate cell, the formula would estimate the average premium tax credit, which is the difference between the second lowest cost silver plan premium available and the amount of income that a household would be required to pay if the members of the household were enrolled in the second lowest cost silver plan in Vermont Health Connect.

Adjusted reference premium
Vermont would take the current second lowest cost silver plan premium and trend it out to 2017. For its trend going forward, Vermont proposes using the regional average change in the second lowest cost silver plan premium or the National Health Expenditures projection if the regional trend has large variations that would normally not apply to Vermont. Vermont does not use age rating, but proposes applying an age adjustment to the reference premium in order to reflect Vermont's rapidly aging population.[23] Without an age adjustment, Vermont's reference premium would be based on the health of a population that no longer exists. Vermont also suggests employing a population health factor to the reference premium similar to the BHP's population health factor. The BHP population health factor takes into account that the cost of providing care to individuals with income below 200% FPL is often greater than other individuals with health insurance.[24] Similarly, to the extent that Vermont's large insurance market has a different rate than the small and individual market, that difference would be reflected in the adjusted reference premium.

Calculation of the average premium tax credit
Once the adjusted reference premium is determined, the average premium tax credit for the rate cell would be calculated by subtracting from the adjusted reference premium the average amount that would have been paid for a second lowest cost silver plan after applying the premium tax credit.

[23] Vermont was one of three states with the largest increases in median age between 2000 and 2010. 2010 Census Briefs, *Age and Sex Composition: 2010,* May 2011, http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf.

[24] The BHP population health factor for 2015 and 2016 was 1.0. 79 FR 63363 (Oct. 23, 2014).

Income reconciliation factor
Next, Vermont suggests multiplying the average premium tax credit calculation with an income reconciliation factor. Like the BHP, Vermont proposes that individuals do not have to reconcile their premium tax credits at the end of the year. Accordingly, Vermont applies an income reconciliation factor based on previous experience with reconciliation of tax credits in order to take reconciliation into account without Vermonters having to do the calculation on their tax forms.

Number of individuals enrolled
For the number of individuals enrolled, Vermont estimated all of the individuals that would have been eligible for the premium tax credit under the ACA, absent the waiver.

Vermont Premium Subsidy
Under Act 50 of 2013 and in its 1115 Global Commitment waiver, Vermont further subsidizes the premium tax credits by decreasing the percentage of income applied to the second lowest silver plan by 1.5%. Vermont received federal match for this program and would request retention of the match going forward through its Section 1115 waiver renewal. The request would be based on the total number of eligible Vermonters in Green Mountain Care who are ineligible for Medicaid, Medicare, TRICARE, federal employees and a small number of individuals estimated to take up employer sponsored insurance, whose incomes are between 138-300% of federal poverty.

Cost sharing reduction formula
Vermont created the following formula to calculate the cost sharing reduction payments:

$$CSR_{c,h,i} = ARP_c \times FRAC / AV \times IUF_{h,i} \times \Delta AV_{h,i} \times E_{c,h,I}$$

$CSR_{c,h,i}$= Cost-sharing reduction subsidy portion of BHP payment rate
c= Coverage status (self-only or applicable category of family coverage) obtained through BHP
h= Household size
i= Income range (as percentage of FPL)
ARP_c= Adjusted reference premium
FRAC= Factor removing administrative costs
AV= Actuarial value of plan (as percentage of allowed benefits covered by the applicable QHP without a cost-sharing reduction subsidy)
$IUF_{h,i}$= Induced utilization factor
$\Delta AV_{h,i}$= Change in actuarial value (as percentage of allowed benefits)

Cost sharing reduction portion of ACA waiver payment rate
As with the BHP and the premium tax credit calculations, the cost sharing reduction estimate would be calculated by rate cells in which coverage status, such as single, couple, or family, is taken into account along with household size and income range. Vermont uses income ranges up to 250% FPL because income eligibility for the cost sharing reduction goes up to 250% FPL. Within each rate cell, the formula estimated the average advance cost-sharing reductions

payment that would have been provided to individuals had they enrolled through Vermont Health Connect.

Adjusted reference premium
Vermont would take the current second lowest cost silver plan premium and trend it out to 2017. For its trend going forward, Vermont used the regional average change in the second lowest cost silver plan premium or the National Health Expenditures projection if the regional trend has large variations that would normally not apply to Vermont. As with the premium tax credit calculation, Vermont would apply an age adjustment and a population health factor to ensure an accurate reference premium in the future.

Factor removing administrative costs
The BHP formula includes a factor removing administrative costs (FRAC) to ensure that the federal government is funding essential health benefits rather than taxes and other administrative costs. Under the EHB rules, the suggested FRAC is 80% because that is the factor currently used to calculate cost sharing reduction payments. Vermont would use 88.3% because that number reflected the administrative costs of the largest insurer in Vermont and Vermont Medicaid, and to the extent that Green Mountain Care would reduce administrative costs, that reduction should be reflected in the cost sharing reduction calculation.

Actuarial value of plan, induced utilization factor, and change in actuarial value
As with the BHP formula, the actuarial value of the plan is 70% AV because the reference premium is the second lowest cost silver plan.

Vermont would also incorporate the BHP's induced utilization factor, which is also used to calculate the cost sharing reductions. The induced utilization factor takes into account that individuals with lower out of pocket costs are more likely to use health care services. The induced utilization factor used by the federal government is 1.12 for individuals up to 200% FPL and 1.00 for individuals up to 250% FPL.

The change in actuarial value is the difference between the second lowest costs silver plan's AV of 70% and the subsidized cost sharing actuarial values of 94% AV for those up to 150% FPL, 87% AV for those up to 200% FPL and 73% AV for those up to 250% FPL.

Number of individuals enrolled
For the number of individuals enrolled, Vermont estimated all of the individuals who would have been eligible for cost sharing reductions under the ACA, absent the waiver.

<u>Vermont Cost Sharing Subsidy</u>
Although Vermont further subsidizes the federal government's cost sharing reductions up to 300% FPL, the funding is purely state funds, so there is no need to calculate a federal contribution.

The ACA Waiver Application

In order to comply with federal law,[25] Vermont's ACA waiver application would include actuarial analyses and actuarial certifications to support Vermont's estimates that Green Mountain Care would cover the same or more people as the ACA with health care coverage that is equally or more comprehensive and affordable than ACA coverage. Vermont would also submit:

- A comprehensive description of the Vermont legislation and program to implement waiver
- A copy of the enacted state legislation that provides the state with authority to implement the proposed waiver
- A list of the provisions the state is seeking to waive
- Actuarial analysis and actuarial certifications showing that Vermont has met:
    - Comprehensive coverage requirement
    - Affordability requirement
    - Scope of coverage requirement
- Economic analyses showing that Vermont has met:
    - Comprehensive coverage requirement
    - Affordability requirement
    - Scope of coverage requirement
    - Federal deficit requirement, including:
        - 10 year budget plan that is deficit neutral, including administrative costs
        - Analysis regarding the estimated impact of the waiver on health insurance coverage in Vermont
- Data and assumptions on comprehensive coverage requirement, affordability requirement, scope of coverage requirement and federal deficit requirement, including
    - Information on the age, income, health expenses and current health insurance status of the relevant population; the number of employers by number of employees and whether the employer offers insurance; cross- tabulations of these variables; and an explanation of data sources and quality;
    - An explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects, and other relevant factors.
- Implementation timeline
- Whether the waiver increases or decreases administrative burden on individuals, insurers and employers
- Explanation of how the waiver will affect the implementation of the provisions of the ACA that are not waived
- Explanation of how the waiver will affect residents seeking care outside of Vermont

[25] 31 CFR Part 33; 45 CFR Part 155.

- Explanation of how Vermont will provide federal agencies with the necessary information to administer waiver at federal level
- Explanation of how the proposal will address individual, employer, insurer, or provider compliance, waste, fraud, and abuse
- Reporting targets: quarterly, annual, and cumulative targets for:
    - Comprehensive coverage requirement
    - Affordability requirement
    - Scope of coverage requirement
    - Federal deficit requirement
- Written evidence that Vermont held at least two public hearings
- Any other information consistent with guidance provided by the Secretary of Health and Human Services (HHS) or the Secretary of the Treasury.

Public Notice and Timelines for the ACA Waiver Process

Under federal law, Vermont must ensure appropriate public comment on its ACA waiver application and follow the following timelines:

- Prior to submitting the application, the state would give public notice and provide a public comment period, including public hearings. The public notice would include:
    - A comprehensive description of the application for the waiver
    - Information on where copies of the application for the waiver are available for public review and comment
    - Information on where and how public comments may be submitted
    - The location, date, and time of state public hearings
- Vermont would then submit the application to HHS
- 45 days after submission, the HHS Secretary and Treasury Secretary would complete preliminary review of application
    - Federal agencies would then provide public notice of completed application
- No later than 180 days after preliminary review complete, HHS would provide a decision-making period and follow federal public notice process

Submissions to HHS

Vermont submitted a white paper to CCIIO and to the general assembly on November 1, 2014. This paper can be found here:
http://hcr.vermont.gov/sites/hcr/files/2014/1332%20Concept%20Paper%20FINAL.pdf

Meetings with Federal Partners

Collaboration with federal partners is critical for Vermont to implement a universal health care program. Vermont has been working closely with the federal government since the passage of Act 48 to ensure the state is in position to be granted a waiver at the earliest possible opportunity as required by Act 48.

Vermont was expected to be the first state to apply for the waiver and thus our collaboration with the U.S. Department of Health and Human Services (HHS) has included contributing to the

development of the waiver application process itself, as well as discussing Vermont's specific proposals for meeting the waiver requirements, including evidence and analysis showing that Vermont can meet those requirements.

Vermont's health care reform team has been engaging in ongoing conversations with multiple federal agencies and offices to further our analysis of the coverage, tax, and subsidy implications of our waiver proposal and to strengthen our application. The cross-cutting policy issues intrinsic in Vermont's waiver proposals requires collaboration with the White House Executive Offices, the Department of Health and Human Services (HHS), which has regulatory authority over the consolidated waiver process, and about a dozen other offices and departments including Centers for Medicaid and Medicare Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), Center for Medicaid and CHIP Services (CMCS), Center for Medicare and Medicaid Innovation (CMMI), CMS Office of the Actuary, the U.S. Department of Labor, U.S. Treasury, and the Office of Management and Budget.

Meetings with federal partners began in earnest in January of 2014. Vermont's Director of Health Care Reform, Deputy Director, and Special Counsel began regular teleconferences with CCIIO staff to discuss the waiver requirements and Vermont's proposals. Further analysis of the components of Vermont's proposals led to a meeting in April with Assistant Secretary Phyllis C. Borzi of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). In June Director Lunge traveled to Washington, D.C. to meet with the White House office of health reform policy director Jeanne Lambrew, who is Deputy Assistant to the President for Health Policy, and Christen Linke-Young, Senior Policy Advisor for Health. Director Lunge and Deputy Director Michael Costa also met with CMS staff in Bethesda in July.

The meetings in the first half of the year laid the groundwork for Governor Shumlin and his health policy advisors to travel to D.C. on September 24, 2014 to meet with HHS Secretary Sylvia Mathews Burwell, Assistant Secretary of the Treasury Mark Mazur, and the head of the health division for the Office of Budget and Management, Julian Harris. The objective of those meetings was to facilitate inter-agency collaboration from the top down and to establish the necessary lines of communication for Vermont to accomplish its goal of submitting a successful waiver application.

Following the Governor's meetings in September, Vermont's health care reform team organized a series of three interagency teleconferences/webinars. The teleconferences were held on October 24th, October 31st, and November 6th. Over 60 staffers from about a dozen offices, including the White House and the Vermont congressional delegation, were invited to participate in the calls. 20-30 people were on the line for each call. Vermont's health care reform team presented the information and our consultants from Wakely and UMass were on the line to provide back-up support.

During the October 24th teleconference Vermont presented an overview of Green Mountain Care for those who were new to Vermont's plan. We also presented proposed federal premium tax credit and cost-sharing reduction pass-through funding formulas. On October 31st Vermont

presented background information on the coverage and financing plan for Green Mountain Care including the approach to eligibility, benefit design, financing, operations, and delivery system reform. On November 6th Vermont walked through the assumptions the state was proposing to meet the remaining criteria for the ACA waiver. These include how we propose to show that we will cover at least as many people as under the ACA, with benefits that are at least as generous without increasing costs of coverage.

The federal staffers raised detailed questions during the multi-agency calls. The health care reform team engaged smaller groups from individual offices to drill down on issues within their areas of expertise. Multiple meetings were held with Treasury on tax implications for the financing plan. November 24th we held a call with Treasury, OMB, CMS and the Office of the Actuary to take a closer look at the issue of pass-through funding. November 25th we held a call with CMCS for a deeper dive on the interactions between Medicaid and Vermont's ACA waiver.

Governor Shumlin spoke with with HHS Secretary Burwell again on December 15, 2014.

In conclusion, we found that our partners in the federal agencies were excited about Vermont's plans and eager to help however they can. Staffers expressed enthusiasm for Vermont's strides toward obtaining the ACA waiver, which was included in the Affordable Care Act for the express purpose of allowing states to come up with innovative ways to cover more of their population and provide better benefits. Participating in Vermont's process toward applying for the waiver gave those federal agencies a first look at what may come to life under the ACA waiver provision.

The Table below provides a summary of meetings with the federal government.

Table E-2.1 Summary of Meetings with Vermont's Health Care Reform Team and Federal Partners

January 17, 2014	Initial teleconference with CCIIO staff responsible for the 1332 waiver process. Continued meeting most months through 2014.
April 7, 2014	Teleconference with Assistant Secretary Phyllis Borzi of U.S. DOL EBSA.
June 19, 2014	White House meeting with Deputy Director Jeanne Lambrew.
July 28-30, 2014	Director Lunge and Deputy Director Costa in D.C., met with CMS and the congressional delegation.
September 4, 2014	Teleconference with HHS staff to prep for Gov. Shumlin's meeting with Secretary Burwell.
September 24, 2014	Governor Shumlin in D.C. to meet with HHS Secretary Burwell, Treasury Assistant Secretary Mazur, and Julian Harris of OMB.

October 24, 2014	First interagency teleconference/webinar on Green Mountain Care and proposed federal PTC and CSR pass-through funding formulas.
October 31, 2014	Second interagency teleconference/webinar on background for the GMC coverage and financing plan.
October 27, 2014	Teleconference with Treasury.
November 6, 2014	Third interagency teleconference/webinar on the 1332 waiver criteria.
November 24, 2014	Teleconference on pass-through funding with OMB, Treasury, CMS, and OACT.
November 25, 2014	CMCS deep-dive on Vermont 1332 waiver and Medicaid interactions.
December 15, 2014	Conference call with Governor Shumlin and HHS Secretary Burwell.
Ongoing	Monthly calls with the Vermont congressional delegation.
Ongoing	Monthly calls with CCIIO on the 1332 waiver process.
Ongoing	Follow-up calls with all federal partners.

Appendix F-1: Medicaid

Federal Financial Participation in Medicaid

The federal government pays each state a certain share of its Medicaid program. The share that the federal government pays, called the Federal Matching Assistance Percentage (FMAP), is determined annually pursuant to a statutory formula based on each state's per capita income. In calendar year 2015, the base FMAP for Vermont is 56.18%.[1] Vermont's FMAP rate has declined annually since 2009, and we estimate that it will continue to do so in future years. Likewise, the federal government pays a share of the Children's Health Insurance Program (CHIP). This amount is higher than the FMAP rate used for the Medicaid population, and is called the Enhanced FMAP rate. In calendar year 2015, the enhanced FMAP rate for Vermont's CHIP program is 74.95%.[2]

Furthermore, the ACA significantly expanded Medicaid, making individuals with income up to 138% of the federal poverty level (FPL) eligible for Medicaid. For most states, this will be a substantial expansion in their Medicaid population. In calendar year 2015, the enhanced FMAP rate for Vermont's "expansion population" is 82.47%. The federal government will pay a higher FMAP for this expansion population, leveling off at 90% in 2019.

Vermont, under its 1115 Demonstration Waiver, had previously expanded its Medicaid eligibility to income levels greater than the ACA. For states like Vermont that had previously expanded Medicaid eligibility, the federal government will phase-in a higher FMAP rate for some populations in their state.

The FMAPs used in this analysis are contained in Appendix C-2 with the other microsimulation analysis assumptions. Note that the base and enhanced FMAP rates are subject to change annually. For the purposes of this analysis, we used the 2015 rates as a starting point and then used the economic model to estimate future FMAP rates.

Impacts on Existing Medicaid Funding Sources

Lost or reduced state Medicaid revenue add dollars to the required public financing. Lost Medicaid dollars would be replaced by fungible dollars within the Green Mountain Care Fund for the purposes of drawing down federal Medicaid match, as we would propose that the Green Mountain Care Fund absorb the State Health Care Resources Fund. The 2013 report estimated that the State would be able to apply $637 million in existing State Medicaid revenue to GMC in 2017. We estimate the actual number to be $341 million, a figure that increases the total amount to be publicly financed in 2017 by $296 million.

[1] See JFO website: www.leg.state.vt.us/jfo/healthcare/
[2] *Ibid.*

The reduction in Medicaid revenue from the original projection is due to two factors. First, the State has not increased Medicaid rates annually as assumed in the 2013 report due to economic headwinds and budget pressures. Second, some revenue sources used to support Medicaid today would not be viable under GMC. Specifically, GMC would feature repeal of provider taxes, the Claims Tax, and Employer Assessment once the State implemented GMC. Medicaid premiums would no longer be charged. Also, tobacco settlement funds are set to decline prior to 2017.

Table F-1.1 sets forth current state revenue streams that support Medicaid in FY 15 post rescission and estimate the availability of these revenue sources for Green Mountain Care for 2017 through 2021. Table F-1.2 sets forth the current state revenues that support the State Health Care Resources Fund in FY 15 post rescission and estimate the availability of these revenue sources for Green Mountain Care from 2017 through 2021.

Medicaid revenue estimates are typically done on a state fiscal year (SFY) basis. They are set forth by SFY here to ensure continuity with existing estimates. GMC would operate on a calendar year basis. Accordingly, state Medicaid revenue estimates would need to be converted to a calendar year basis once an implementation year is determined.

Table F-1.1: State Medicaid Funding Sources FY 2015 as Passed through 2021 under GMC[3]

State Medicaid Funding	FY 15 Post Rescission	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21
General Fund	185,233,145	190,790,139	196,513,844	202,409,259	208,481,537	214,735,983	221,178,062
Tobacco Funds	33,031,032	28,547,443	27,310,469	16,310,469	16,310,469	16,310,469	16,310,469
State Health Care Resources Fund	268,592,899	268,984,365	96,173,000	99,173,000	101,173,000	103,173,000	105,173,000
IDT	40,000	40,000	40,000	40,000	40,000	40,000	40,000
Insurance Fund	883,847	883,847	883,847	883,847	883,847	883,847	883,847
HIT	2,080,754	3,000,000	0	0	0	0	0
Agriculture Mosquito Control	56,272	56,272	56,272	56,272	56,272	56,272	56,272
Success Beyond Six	21,037,211	21,743,125	22,300,000	22,300,000	22,300,000	22,300,000	22,300,000
Next Generation	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Exchange Funding	-5,340,670	-8,400,000	0	0	0	0	0
Carry Forward	50,000	0	0	0	0	0	0
Fund Balance used	4,074,531	0	0	0	0	0	0
TOTAL STATE MEDICAID REVENUE	510,039,021	505,945,191	343,577,432	341,472,847	349,545,125	357,799,571	366,241,650

Source: Vermont Dept. of Finance and Management Prior to Completion of the FY 2016 Budget Recommendation

Assumptions and Notes

We assume three percent annual growth in General Fund support for Medicaid. Tobacco settlement funds are projected to decrease $11 million in SFY 18. State Health Care Resource Fund revenue would be diminished substantially due to repeal of provider taxes,

[3] This table includes revenue sources for Managed Care Entity Investments, as well as Medicaid coverage.

claims taxes, and various premiums. The Medicaid allocable cost of the Exchange is included in the general GMC Medicaid cost estimates. The non-Medicaid allocable Exchange cost is included in the non-payer operations cost estimate.

Table F-1.2: State Health Care Resources Fund FY 15 as Passed through 2021 under GMC

State Health Care Resources Fund	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21
Cig Tax[4]	64,900,000	61,900,000	76,000,000	79,000,000	81,000,000	83,000,000	85,000,000
Tobacco Products	7,700,000	6,800,000	6,800,000	6,800,000	6,800,000	6,800,000	6,800,000
Claims Assessment	14,000,000	14,280,000	0	0	0	0	0
Employer Assessment	15,738,631	16,800,000	0	0	0	0	0
GME	12,873,000	12,873,000	12,873,000	12,873,000	12,873,000	12,873,000	12,873,000
Provider Tax – Hospitals	127,639,915	131,150,013	0	0	0	0	0
Provider Tax NH	15,801,530	15,801,530	0	0	0	0	0
Provider Tax Home Health	4,233,302	4,233,302	0	0	0	0	0
Provider Tax ICF-MR	73,759	73,759	0	0	0	0	0
Pharmacy $0.10 Script	800,000	800,000	0	0	0	0	0
Premium Dr. D	50,607	50,607	0	0	0	0	0
Premiums SCHIP	623,382	623,382	0	0	0	0	0
Premiums Rx Programs	3,045,450	3,045,450	0	0	0	0	0
Recoveries	500,000	500,000	500,000	500,000	500,000	500,000	500,000
Other	13,323	53,323	0	0	0	0	0
TOTAL SHCRF REVENUE	267,992,899	268,984,365	96,173,000	99,173,000	101,173,000	103,173,000	105,173,000

[4] Further analysis of the cigarette tax estimate is needed given the large variance between the current law and GMC estimates.

Assumptions and Notes

Several SHCRF revenue streams would be repealed or substantially reduced after GMC implementation: The claims assessment would be repealed. The employer assessment would be repealed as all Vermont residents would have insurance. Current Medicaid premiums would be repealed. Provider Taxes would be repealed. Estimated cigarette tax revenue would increase due to increased wage growth and consumer spending change. GME would likely change as FMAP changes; however, any additional dollars needed to draw down federal match would likely be paid by the University of Vermont.

Appendix F-2: Detailed Information on Financing

This appendix provides additional information on issues related to the development of financing concepts and the results of the economic modeling. First, the appendix provides some additional perspective on the difficult task of transitioning businesses into GMC. Second, the appendix provides additional data on the wage effects of GMC. Third, the appendix provides additional data on changes in federal and state tax liability and collections due to GMC.

Payroll Tax Phase-In

Governor Shumlin asked for a plan that would provide a transition for small employers. Accordingly, we focused on providing a way for businesses with less than $1M in total payroll to transition into the plan over 3 years. We considered several approaches to phase in Vermont businesses, thereby providing transition relief to small businesses. The first approach was a three year phase in with a non-refundable credit.

Step Up Approach

A temporary non-refundable tax credit could be granted for the first three years of the tax, allowing businesses with smaller payrolls, those least likely to pay for insurance now, to phase into the system. The credit would work in the following way, using 8% as an example payroll tax rate.

- All businesses would determine their payroll tax liability at 8% of qualifying payroll.
- Businesses could apply the annual credit to their tax liability.
- The credit amount would be $40,000 in year 1, $25,000 in year 2, and $12,000 in year 3.
- The credit would be phased out on a dollar for dollar basis for every dollar of tax incurred beyond the credit limit.
- The credit would be reduced annually until all businesses are phased into the full 8% tax in year four, 2020.

The result of the credit system would be that in each year of the phase-in the smallest employers are excluded from the tax, others pay a reduced rate, and the largest businesses by payroll pay the full tax. The credits phase out so that the largest employers do not receive the credit and unnecessarily drive up the needed payroll tax rate. The specific payroll thresholds for each category of business (excluded from the tax, reduced tax, and pay full tax) are set forth in Table F-2.1.

Table F-2.1: Payroll Thresholds for Utilization of Phase-In Credit

Tax Year	2017	2018	2019	2020
Excluded from Tax Due to Credit	Qualifying Payroll < $500,000	Qualifying Payroll < $312,500	Qualifying Payroll < $150,000	Businesses Pay Full Tax
Reduced Tax Due to Credit	Qualifying Payroll between $500,000 and $1,000,000	Qualifying Payroll between $312,500 and $625,000	Qualifying Payroll between $150,000 and $300,000	
Pay Full Tax	Qualifying Payroll > $1,000,000	Qualifying Payroll > $625,000	Qualifying Payroll > $300,000	

Examples of credit utilization are set forth below in the Tables using examples with $1 million, $575,000, and $150,000 of qualifying payroll.

Table F-2.2: 8% Payroll Tax with Phase-In for Business with $1,000,000 in Qualifying Vermont Payroll

Tax Year	2017	2018	2019	2020
Qualifying Vermont Payroll	$1,000,000	$1,000,000	$1,000,000	$1,000,000
GMC Payroll Tax Liability @ 8%	$80,000	$80,000	$80,000	$80,000
Credit Value	$40,000	$25,000	$12,000	$0
Credit Phase Out	$40,000	$25,000	$12,000	N/A
Value of Credit	$0	$0	$0	N/A
Tax Due	$80,000	$80,000	$80,000	$80,000

In this scenario, the business would be ineligible for the credit and would pay the full tax liability in year 1.

Table F-2.3: 8% Payroll Tax with Phase-In for Business with $575,000 in Qualifying Vermont Payroll

Tax Year	2017	2018	2019	2020
Qualifying Vermont Payroll	$575,000	$575,000	$575,000	$575,000
GMC Payroll Tax Liability @ 8%	$46,000	$46,000	$46,000	$46,000
Annual Credit Value	$40,000	$25,000	$12,000	$0
Credit Phase Out	$6,000	$21,000	$12,000	N/A
Value of Credit	$34,000	$4,000	$0	N/A
Tax Due	$12,000	$42,000	$46,000	$46,000

In this scenario, the business would be eligible for a tax reduction via the credit in the first two years of the tax and would pay the full tax in year 3 and thereafter.

Table F-2.4: 8% Payroll Tax with Phase-In for Business with $150,000 in Vermont Payroll

Tax Year	2017	2018	2019	2020
Qualifying Vermont Payroll	$150,000	$150,000	$150,000	$150,000
GMC Payroll Tax Liability @ 8%	$12,000	$12,000	$12,000	$12,000
Annual Credit Value	$40,000	$25,000	$12,000	$0
Credit Phase Out	$0	$0	$0	N/A
Value of Credit	$12,000	$12,000	$12,000	N/A
Tax Due	$0	$0	$0	$12,000

In this scenario, the business would be able to use the full value of the credit annually. They would be excluded from the tax during the phase-in and would pay the full tax in year 4 and thereafter.

The economic modeling revealed that these credits were expensive, creating a funding problem for the payroll tax and Green Mountain Care. This is due to the large number of small businesses in Vermont. Table F-2.5 sets forth the cost of the payroll tax phase in compared to the revenue generation potential of the payroll tax levied at eight percent.

Table F-2.5: 8% Payroll Tax with Phase-In Credit Value in Millions

Tax Year	2017	2018	2019	2020	2021
Revenue Potential at 8%	1,051	1,073	1,095	1,117	1,140
Credit Value	525	496	441	0	0
Tax Collected	526	577	654	1,117	1,140

A major issue with the credit described above is that it would bring large employers down in their spending while not bringing smaller employers up in spending. Fixing the credit would be expensive, requiring a high transitional payroll tax rate or an additional major revenue source. We constructed an option that could potentially have addressed this issue of losing revenue from employers that pay more today than the target rate while transitioning smaller businesses or those that pay an amount lower than the target GMC payroll tax. This was the step up/step down phase in.

<u>Step Up/Step Down Phase In</u>

The step up/step down would try to transition each business from where they are currently to the target payroll tax rate. It would require four steps.

- Select a base measurement year.
- Determine the current amount the firm spends on health care.
- The firm determines whether they pay more or less than the new tax at the target rate.
- Each firm moves 20% toward the goal each year.

Table F-2.6 illustrates how the phase-in works.

Table F-2.6: Notional Example of Step Up/Step Down Payroll Tax Phase-In

Company A		Company B	
2016 Health Care Spending	**$100,000**	**2016 Health Care Spending**	**$0**
Target GMC Tax at 8% Payroll	**$50,000**	**Target GMC Tax at 8% Payroll**	**$50,000**
Firm A Pays (Step Down)		**Firm B Pays (Step Up)**	
2017	**$90,000**	**2017**	**$10,000**
2018	**$80,000**	**2018**	**$20,000**
2019	**$70,000**	**2019**	**$30,000**
2020	**$60,000**	**2020**	**$40,000**
2021 (Target Tax)	**$50,000**	**2021 (Target Tax)**	**$50,000**

This solution to the phase-in issue prompted several concerns. First, it would create a complicated set of firm specific tax rates. Also, it would create uncertainty about what behavior firms may engage in during the base measurement year. The finance plan would need substantial modification if many firms dropped or reduced health care coverage prior to the base measurement year to enjoy preferential tax treatment during the first five years. This could be remedied by selecting a base year in the past; however, we rejected this idea as arbitrary and not reflecting a business's current cash position. Also, this concept prompted some concern over legal risk.

Ramp Up

Another alternative was to ramp employers up to the target payroll tax rate over time prior to implementation of GMC. The major concern with this approach was that businesses would be paying prior to receiving benefits, and they would be paying twice if they continued to offer insurance.

Large Employer Credit

We designed a credit for large employers to use in Green Mountain Care if the legislature so chose to exempt large businesses. The credit would work in the following way.

- All businesses would be assessed GMC payroll tax
- Large employers over a certain number of employees would be eligible for a credit against payroll tax.
- A dollar for dollar credit would be granted for all health spending, including, but not limited to, employer sponsored insurance.
- The credit would be taken against the Green Mountain Care payroll tax.

Our legal analysis determined that such a credit likely would pass legal muster.

Overall, the credit proved too costly to be deployed within a sustainable finance plan. The credit would have cost $394 million if applied to all firms with more than 1,000 employees at a payroll tax of 11.5%, more than 25% of the payroll tax base. The credit would cost $468 million if applied to all firms with more than 500 employees at a payroll tax rate of 11.5%, more than 30% of the payroll base. Here, the proportion of the base is more important than the dollar amount. We drew the tentative conclusion that it does not seem possible to construct a publicly financed system that excludes Vermont's largest employers.

Tiered Brackets

We considered and rejected tiered payroll tax brackets due to three main concerns. First, a tiered structure would likely require high and seemingly uncompetitive payroll tax rates. Second, a tiered system would not create a level playing field for Vermont's businesses. Third, we wanted to ensure tax neutrality, meaning that we did not want a tax system that created an incentive to avoid adding the next dollar of payroll.

Wage Effects of GMC

Each firm would determine whether they pay more or less under GMC than the status quo given a firm's current level of health care spending and their prospective payroll tax due. The economic model made certain assumptions about firm behavior regarding employee wages depending on whether the firm would pay more or less under GMC and whether the firm chose to purchase supplemental GMC coverage or continue to offer its own coverage. (See Appendix C.) Generally, the model measured three types of firm behavior in regards to wages.

- Firms that would pay less under GMC shift some of the savings to workers in the form of higher wages.
- Firms that would pay more under GMC would likely shift this cost onto workers except that they generally cannot due to nominal and minimum wage restrictions. This amount would be the "remaining unshifted" amount.
- Given our assumptions about wage stickiness, some firms would retain dollars that they would otherwise shift to wages. These would be called "wages withheld."

Figure F-2.7 breaks down wage shifting in each of the above categories by employer type. How firms would act with dollars in the unshifted and shifting withheld categories would be a major focus of any future macroeconomic analysis.

Table F-2.7: GMC Wage Effects, 2017 – 2021. (Value in Millions)

	2017	2018	2019	2020	2021
Private Business					
Payroll Tax	1,163	1,186	1,216	1,236	1,257
Total Amount Shifted to Wages	78	68	129	67	22
Total Remaining Unshifted	518	367	249	163	102
Total Shifting Withheld	189	103	-	-	-
State					
State Employee Spending	111	114	117	121	124
Payroll Tax	111	114	117	121	124
Total Amount Shifted to Wages	44	43	60	68	80
Total Remaining Unshifted	30	23	15	8	3
Total Shifting Withheld	57	43	22	12	-
Local Government					
Payroll Tax	62	63	64	66	67
Total Amount Shifted to Wages	9	6	9	10	12
Total Remaining Unshifted	22	16	11	7	4
Total Shifting Withheld	18	14	8	4	-
Schools					
Payroll Tax	145	149	153	158	162
Total Amount Shifted to Wages	43	43	60	69	83
Total Remaining Unshifted	45	32	21	11	5
Total Shifting Withheld	62	50	26	14	-

GMC Tax Effects

Green Mountain Care would change the total tax collected by the State and Federal government. We estimate that State revenues would improve modestly due to increased wages and a resulting increase in consumption. We estimate that the federal government would collect less in tax revenue as a result of GMC, due primarily to the use if Schedule A to deduct the public premium.

State Tax Effects

We estimate state tax collections would increase $34 million in 2017, increasing annually thereafter, and grow to $99 million over the status quo by 2021. The increase would be driven mostly by property tax collections. Income tax collections would be down. We believe that this estimate is due to increased utilization of the EITC and some additional utilization of itemized deductions, as Vermont allows taxpayers to deduct up to $5,000 of state taxes paid for income tax purposes.

Table F-2.8: GMC State Tax Effects, 2017 – 2021 (Value in Millions)

Tax Type	2017	2018	2019	2020	2021
State Income Taxes	-2	-7	-4	-7	-8
Property Tax	22	33	48	58	67
Sales Tax	6	10	15	18	19
Meals/Alcohol/Hotel Tax	2	2	3	3	4
Gas Tax	1	2	3	3	3
Cars Tax	3	5	7	8	9
Cigarette Tax	1	3	3	4	4
Corporate Tax	0	0	0	0	0
Other Tax	1	1	1	1	1
TOTAL	**34**	**49**	**76**	**88**	**99**

Federal Tax Effects

We estimate that Vermont residents would pay less in federal taxes under GMC. The main driver of this estimate is the ability to deduct the public premium from federal income taxes on Schedule A. The table below compares the change in federal tax liability between federal income taxes and federal payroll taxes (FICA and Medicare Taxes) under GMC.

Table F-2.9: GMC Federal Tax Effects, 2017 – 2021 (Value in Millions)

	2017	2018	2019	2020	2021
Federal Income Taxes	-191	-222	-223	-236	-242
Payroll Taxes	56	57	75	70	70

It is important to note that some Vermonters would pay more in federal income tax due to higher wages; however, the Schedule A impact offsets in the aggregate the taxes owed due to wage gains. Increased payroll taxes would be due solely to wage gains. GMC would change the value of other federal tax calculations. For more information see the modeling output, which can be viewed online at http://hcr.vermont.gov/library.

Appendix F-3: Alternative Financing Concepts and Balance Sheets

We considered and tested myriad finance concepts during the project. Some concepts were tested using State of Vermont data prior to the microsimulation modeling project. We tested other concepts during the development of microsimulation model but prior to its completion. We ran a variety of concepts through the completed microsimulation model, defining completion as a point at which we had a high degree of confidence that the model was forecasting health care coverage costs correctly. This appendix describes alternative financing concepts that were run through the microsimulation model after its completion.

Population Scenarios

Ultimately, we tested finance concepts against two distinct population scenarios. The first is described in the body of the report. The alternative makes the following changes to the underlying assumptions.

Alternative Population Scenario

The alternative scenario changes the population assumptions in the following ways:

- GMC would not cover non residents working for Vermont firms.
- GMC would not cover federal employees.
- GMC would not provide wrap coverage for employer sponsored insurance.

This reduces the population receiving GMC and the cost. Also, it more closely matches the assumptions of the 2013 report, being the same population except for wrap coverage of employer sponsored insurance. Multiple finance concepts were tested against both population scenarios.

Key Notes

Each alternative concept contains a description of the coverage assumptions. The two key pieces of coverage information are the actuarial value of the plan and the population covered. The concepts include three separate AV levels (80, 87, and 94) and two separate population concepts. Also, the 80AV concepts include concepts with the recommended focused deductible plan designed described in the coverage chapter and appendices and a standard deductible design.

Each alternative concept contains a description of finance assumptions. These include a payroll tax and Public Premium set at varying levels. Alternative financing concepts 1-7 mirror the standard report assumptions, including commuters and federal employees in the coverage and taxes. Also, these concepts assume repeal of provider taxes. Alternative financing concepts 8 - 14 contain different population assumptions, excluding commuters and federal employees from the coverage and tax. Also, these scenarios assume that Vermont retains provider taxes.

Alternative Finance Concept 1

- Coverage Assumptions
  - 94 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - Phased-In Payroll Tax with credit designed to transition businesses with up to $1 million in qualifying payroll.
  - The credit is phased out on a dollar for dollar basis for every dollar of tax incurred beyond the credit limit.
  - Payroll Tax is 21% in year 1 and 20% in years 2 and 3.
  - The credit is reduced annually until all businesses are phased into the full 12.5% tax in year four.
  - The credit amount is $105,000 in year 1, $50,000 in year 2, and $25,000 in year 3.
  - Sliding scale Public Premium from 0% - 9.5% up to 400% FPL.
  - Requires all Vermonters at or above 400% FPL to pay 9.5% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Financing Concept 1 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-4,340	-4,579	-4,820	-5,001	-5,177
Current Law Revenue Estimates					
Federal Medicaid Match	1,310	1,364	1,413	1,445	1,505
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,580**	**-2,756**	**-2,935**	**-3,073**	**-3,174**
Payroll Tax Starting at 21% and Phasing in to 12.5%	1,511	1,631	1,754	1,746	1,781
Public Premium up to 9.5% at 400% FPL Capped at $27,500	1,247	1,306	1,359	1,373	1,382
GMC Fund Fiscal Position	**178**	**181**	**178**	**46**	**-11**

Alternative Finance Concept 2

- Coverage Assumptions
  - 94 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - Phased-In Payroll Tax with credit designed to transition businesses with up to $1 million in qualifying payroll.
  - The credit is phased out on a dollar for dollar basis for every dollar of tax incurred beyond the credit limit.
  - Payroll Tax is 8% annually.
  - The credit is reduced annually until all businesses are phased into the full 8% tax in year four.
  - The credit amount is $40,000 in year 1, $25,000 in year 2, and $12,000 in year 3.
  - Sliding scale Public Premium from 0% - 8.0% up to 624% FPL.
  - Requires all Vermonters over 624% FPL to pay 9.5% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Financing Concept 2 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-4,340	-4,579	-4,820	-5,001	-5,177
Current Law Revenue Estimates					
Federal Medicaid Match	1,310	1,364	1,413	1,445	1,505
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,580**	**-2,756**	**-2,935**	**-3,073**	**-3,174**
Payroll Tax of 8% with Three Year Phase In	526	577	654	1,117	1,140
Public Premium up to 8% at 624% FPL Capped at $27,500	949	995	1,037	1,047	1,055
GMC Fund Fiscal Position	**-1,105**	**-1,184**	**-1,244**	**-909**	**-979**

Alternative Finance Concept 3

- Coverage Assumptions
  - 94 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - 12% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 9% up to 400% FPL.
  - Requires all Vermonters at or above 400% FPL to pay 9% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Financing Concept 3 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-4,340	-4,579	-4,820	-5,001	-5,177
Current Law Revenue Estimates					
Federal Medicaid Match	1,310	1,364	1,413	1,445	1,505
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,580**	**-2,756**	**-2,935**	**-3,073**	**-3,174**
Payroll Tax of 12%	1,576	1,609	1,642	1,676	1,710
Public Premium up to 9% above 400% FPL capped at $27,500	1,191	1,247	1,298	1,311	1,320
GMC Fund Fiscal Position	**187**	**100**	**5**	**-86**	**-144**

Alternative Finance Concept 4

- Coverage Assumptions
  - 80 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - Phased-In Payroll Tax with credit designed to transition businesses with up to $1 million in qualifying payroll.
  - The credit is phased out on a dollar for dollar basis for every dollar of tax incurred beyond the credit limit.
  - Payroll Tax is 13% in years one through three and 9.5% in years four and five.
  - The credit is reduced annually until all businesses are phased into the full 9.5% tax in year four.
  - The credit amount is $65,000 in year 1, $32,500 in year 2, and $16,250 in year 3.
  - Sliding scale Public Premium from 0% - 9.5% up to 400% FPL.
  - Requires all Vermonters at or above 400% FPL to pay 9.5% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Finance Concept 4 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,751	-4,000	-4,291	-4,452	-4,613
Current Law Revenue Estimates					
Federal Medicaid Match	1,294	1,344	1,400	1,432	1,491
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,007**	**-2,197**	**-2,419**	**-2,537**	**-2,624**
Payroll Tax Starting at 13% and Phasing in to 9.5%	886	983	1,102	1,327	1,354
Public Premium up to 9.5% above 400% FPL capped at $27,500	1,153	1,237	1,340	1,354	1,365
GMC Fund Fiscal Position	**32**	**23**	**23**	**144**	**95**

Alternative Finance Concept 5

- Coverage Assumptions
  - 80 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - 9.5% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8.0% up to 400% FPL.
  - Requires all Vermonters at or above 400% FPL to pay 8.0% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Finance Concept 5 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,751	-4,000	-4,291	-4,452	-4,613
Current Law Revenue Estimates					
Federal Medicaid Match	1,294	1,344	1,400	1,432	1,491
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,007**	**-2,197**	**-2,419**	**-2,537**	**-2,624**
Payroll Tax at 9.5%	1,248	1,274	1,300	1,327	1,354
Public Premium up to 8.0% above 400% FPL capped at $27,500	994	1,068	1,158	1,170	1,181
GMC Fund Fiscal Position	**235**	**145**	**39**	**-40**	**-89**

Alternative Finance Concept 6

- Coverage Assumptions
  - 80 AV Plan
  - Population assumptions consistent with main body of report, including:
    - Vermont residents
    - Commuters
    - Federal employees
    - Wrap of employer sponsored insurance
    - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
  - 11.5% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 9.5% up to 400% FPL.
  - Requires all Vermonters at or above 400% FPL to pay 9.5% of income, capped at $27,500.
  - Repeals Provider Taxes

Alternative Finance Concept 6 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,751	-4,000	-4,291	-4,452	-4,613
Current Law Revenue Estimates					
Federal Medicaid Match	1,294	1,344	1,400	1,432	1,491
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,007**	**-2,197**	**-2,419**	**-2,537**	**-2,624**
Payroll Tax at 9.5%	1,510	1,542	1,574	1,606	1,639
Public Premium up to 9.5% above 400% FPL capped at $27,500	1,153	1,237	1,340	1,354	1,365
GMC Fund Fiscal Position	**656**	**582**	**495**	**423**	**380**

Alternative Finance Concept 7

- Coverage Assumptions
    - 80 AV Plan with standard deductible plan design
    - Population assumptions consistent with main body of report, including:
        - Vermont residents
        - Commuters
        - Federal employees
        - Wrap of employer sponsored insurance
        - Population excludes TRICARE and Non-Medicare retirees, excluding state and teacher retirees
- Finance Assumptions
    - 9.5% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
    - Sliding scale Public Premium from 0% - 8.0% up to 400% FPL.
    - Requires all Vermonters at or above 400% FPL to pay 8.0% of income, capped at $27,500.
    - Repeals Provider Taxes

Alternative Finance Concept 7 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,773	-4,027	-4,320	-4,482	-4,643
Current Law Revenue Estimates					
Federal Medicaid Match	1,293	1,344	1,400	1,432	1,491
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	344	341	350	358	366
New Revenue Needed	**-2,030**	**-2,224**	**-2,448**	**-2,567**	**-2,654**
Payroll Tax at 9.5%	1,248	1,274	1,300	1,327	1,354
Public Premium up to 9.5% above 400% FPL capped at $27,500	992	1,067	1,158	1,170	1,181
GMC Fund Fiscal Position	**210**	**117**	**10**	**-70**	**-119**

Alternative Finance Concept 8

- Coverage Assumptions
  - 94 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 8.0 % payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size. Sliding scale covers 90% of Vermont households.
  - Requires all Vermonters at or above 624% FPL to pay 8.0% of income, capped at $27,500.
  - Retains Provider Taxes

Alternative Finance Concept 8 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,792	-4,008	-4,225	-4,381	-4,543
Current Law Revenue Estimates					
Federal Medicaid Match	1,291	1,344	1,392	1,424	1,483
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,893**	**-2,037**	**-2,182**	**-2,283**	**-2,358**
Payroll Tax of 8%	1,051	1,073	1,095	1,117	1,140
Public Premium up to 8% at 624% FPL Capped at $27,500	803	847	885	896	906
GMC Fund Fiscal Position	**-39**	**-117**	**-202**	**-270**	**-312**

Alternative Finance Concept 9

- Coverage Assumptions
  - 94 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 9.5 % payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 400% FPL to pay 8.0% of income, capped at $27,500.
  - Retains Provider Taxes

Alternative Finance Concept 9 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,792	-4,008	-4,225	-4,381	-4,543
Current Law Revenue Estimates					
Federal Medicaid Match	1,291	1,344	1,392	1,424	1,483
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,893**	**-2,037**	**-2,182**	**-2,283**	**-2,358**
Payroll Tax of 9.5%	1,248	1,274	1,300	1,327	1,354
Public Premium up to 8% at 400% FPL Capped at $27,500	911	960	1,002	1,015	1,026
GMC Fund Fiscal Position	**266**	**197**	**120**	**59**	**22**

Alternative Finance Concept 10

- Coverage Assumptions
  - 94 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 9.5 % payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 500% FPL to pay 8.0% of income, capped at $27,500.
  - Retains Provider Taxes

Alternative Finance Concept 10 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,792	-4,008	-4,225	-4,381	-4,543
Current Law Revenue Estimates					
Federal Medicaid Match	1,291	1,344	1,392	1,424	1,483
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,893**	**-2,037**	**-2,182**	**-2,284**	**-2,359**
Payroll Tax of 9.5%	1,248	1,274	1,300	1,327	1,354
Public Premium up to 8% at 500% FPL Capped at $27,500	861	908	947	960	971
GMC Fund Fiscal Position	**216**	**145**	**65**	**3**	**-11**

Alternative Finance Concept 11

- Coverage Assumptions
  - 94 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 8.95 % payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 624% FPL to pay 8.0% of income capped at $27,500. Sliding scale covers 90% of Vermont households.
  - Retains Provider Taxes

Alternative Finance Concept 11 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,792	-4,008	-4,225	-4,381	-4,543
Current Law Revenue Estimates					
Federal Medicaid Match	1,291	1,344	1,392	1,424	1,483
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,893**	**-2,037**	**-2,182**	**-2,284**	**-2,359**
Payroll Tax of 8.95%	1,175	1,200	1,225	1,250	1,275
Public Premium up to 8% at 624% FPL Capped at $27,500	803	847	885	896	906
GMC Fund Fiscal Position	**85**	**10**	**-72**	**-138**	**-178**

Alternative Finance Concept 12

- Coverage Assumptions
  - 87 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 8 % payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 624% FPL to pay 8.0% of income, capped at $27,500. Sliding scale covers 90% of Vermont households.
  - Retains Provider Taxes

Alternative Finance Concept 12 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,563	-3,785	-4,018	-4,168	-4,322
Current Law Revenue Estimates					
Federal Medicaid Match	1,284	1,335	1,386	1,418	1,476
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,671**	**-1,823**	**-1,981**	**-2,076**	**-2,144**
Payroll Tax of 8%	1,051	1,073	1,095	1,117	1,140
Public Premium up to 8% at 624% FPL Capped at $27,500	771	825	875	888	897
GMC Fund Fiscal Position	**151**	**75**	**-11**	**-71**	**-107**

Alternative Finance Concept 13

- Coverage Assumptions
  - 80 AV Plan with standard deductible plan design
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 8% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 624% FPL to pay 8.0% of income, capped at $27,500. Sliding scale covers 90% of Vermont households.
  - Retains Provider Taxes

Alternative Finance Concept 13 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,354	-3,559	-3,806	-3,949	-4,097
Current Law Revenue Estimates					
Federal Medicaid Match	1,274	1,324	1,379	1,411	1,469
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,472**	**-1,608**	**-1,776**	**-1,864**	**-1,926**
Payroll Tax of 9.5%	1,051	1,073	1,095	1,117	1,140
Public Premium up to 8% at or above 624% FPL Capped at $27,500	754	807	874	886	897
GMC Fund Fiscal Position	**333**	**272**	**193**	**139**	**111**

Alternative Finance Concept 14

- Coverage Assumptions
  - 80 AV Plan
  - Alternative coverage population
    - No commuters
    - No federal employees
    - No wrap of employer sponsored insurance
- Finance Assumptions
  - 8% payroll tax on all Vermont businesses on their qualifying Vermont payroll, no exceptions and no transitions.
  - Sliding scale Public Premium from 0% - 8% of income, depending on income and family size.
  - Requires all Vermonters at or above 624% FPL to pay 8.0% of income, capped at $27,500.
  - Retains Provider Taxes

Alternative Finance Concept 14 Continued

	2017	2018	2019	2020	2021
Spending (All Values in Millions)					
GMC Coverage and Operations	-3,343	-3,550	-3,796	-3,938	-4,085
Current Law Revenue Estimates					
Federal Medicaid Match	1,275	1,324	1,379	1,411	1,469
Federal ACA Waiver Funding	106	118	122	125	132
State Medicaid Dollars	502	509	529	549	570
New Revenue Needed	**-1,460**	**-1,599**	**-1,766**	**-1,853**	**-1,914**
Payroll Tax of 9.5%	1,051	1,073	1,095	1,117	1,140
Public Premium up to 8% at or above 624% FPL Capped at $27,500	754	807	873	886	897
GMC Fund Fiscal Position	**345**	**281**	**202**	**150**	**123**

Appendix F-4: GMC Public Premium Tax Exclusions and Credits

Medicare

Medicare enrollees would be exempt from the public premium. Joint filers where one member of a household is a Medicare enrollee and others are not (split households) would pay a reduced tax, one half of the normal tax liability. The Medicare exclusion could be revisited during a subsequent phase of GMC where Medicare enrollees may receive wrap around coverage from GMC.

Table F-4.1: Medicare, Split Household, and Non-Medicare Public Premium Tax Liability

Taxpayer	Medicare Household	Split Household	Non-Medicare Household
Income	$68,848	$68,848	$68,848
Family Size	2	2	2
FPL	400%	400%	400%
Public Premium	$0	$3,147	$6,294

An additional policy question is how to treat Medicare and Medicare split households the year they enroll in Medicare. The legislature could devise a credit system, make taxpayers pay a pro rata share of the tax based on time in the system, or treat Medicare recipients as enrolled for the full year during the year of Medicare enrollment.

TRICARE

Active duty and retired military service members with active TRICARE coverage would be enrolled in GMC but have their enrollment suspended for any period of time where they have TRICARE coverage. TRICARE recipients would be allowed a non-refundable tax credit for each month where they are enrolled in TRICARE coverage. The tax calculation would work in the following way for TRICARE recipients.

- Determine public premium tax liability
- Divide liability by 12 to determine credit amount per month of TRICARE coverage.
- Determine number of months covered by TRICARE
- Multiply credit amount and months enrolled in TRICARE to determine full credit value
- Subtract credit amount from public premium
- Pay remaining tax liability.

Table F-4.2: Example of TRICARE Recipient Public Premium Tax Liability

Taxpayer	TRICARE Household #1	TRICARE Household #2
Income	$55,462	$55,462
Family Size	4	4
FPL	200%	200%
Public Premium	$1,973	$1,973
Monthly Credit Amount (public premium/12)	$164.42	$164.42
Months Enrolled in TRICARE	6	12
Credit Value	$987	$1,973
Public Premium Tax Liability	$986	$0

As shown above, someone with TRICARE coverage for an entire year would be exempt from the tax.

Non-Medicare Retirees, Excluding State and Teacher Retirees

There would be a limited credit for Non-Medicare retirees, excluding state and teacher retirees. Eligible retirees, generally under age 65, would be enrolled in GMC but have their enrollment suspended for any period of time where they have employer-sponsored retiree health care coverage. These taxpayers would be allowed a non-refundable tax credit for each month where they have employer coverage. The tax calculation would work in the following way, mirroring the TRICARE credit.

- Determine public premium tax liability
- Divide liability by 12 to determine credit amount per month of employer retiree coverage.
- Determine number of months covered by employer retiree coverage
- Multiply credit amount and months enrolled in employer retiree coverage
- Subtract credit amount from public premium
- Pay remaining tax liability.

The credit would be aimed primarily at existing federal retirees and those with existing private sector employer-sponsored retiree coverage. In a sense, the credit would be an attempt to grandfather these employees who are close to Medicare eligibility and already relying on their retiree coverage. This credit should sunset by January 1st, 2027 to reflect the fact that Vermont residents would have time to plan for retirement considering the impact of GMC coverage and taxes. State and teacher retirees would be ineligible for the credit, as the State retiree system would be readjusted to account for the transition to Green Mountain Care.

Table F-4.3: Limited Non-Medicare Retiree Credit Recipient Public Premium Tax Liability

Taxpayer	Retiree Household #1	Retiree Household #2
Income	$55,462	$55,462
Family Size	1	1
FPL	200%	200%
Public Premium	$1,973	$1,973
Monthly Credit Amount (public premium/12)	$164.42	$164.42
Months Enrolled in TRICARE	6	12
Credit Value	$987	$1,973
Public Premium Tax Liability	$986	$0

As shown above, retirees with coverage for an entire year would be exempt from the tax.