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Frequently Asked Questions About Health Coverage and the Vermont Health Insurance Market

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Introduction

Vermonters obtain their health coverage from a variety of sources, including government programs and commercial health insurance companies. For the purposes of this issue brief, "health coverage" and "health insurance" refer only to comprehensive major medical insurance and not other kinds of health insurance. The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is responsible for monitoring and regulating the commercial health insurance market in Vermont.[1] The purpose of this issue brief is to answer frequently asked questions (FAQ) about the Vermont health insurance market and health coverage that is not obtained through government programs.

Glossary

Insured: Under insured plans, premiums are paid to an insurer by the individual, employer or sponsor to cover the risk of health care expenses. BISHCA regulates insured plans.

Self –funded (also known as self-Insured): Under self-funded plans, the employer or sponsor assumes the risk of health care costs, although the employer may contract with a third party to administer its plan and may purchase a "stop loss" or "excess loss" insurance policy for the self-funded plan. (The insurance policy itself is subject to state law and regulation by BISHCA). Most self-funded plans are regulated at the federal level by the Department of Labor and are not subject to state insurance laws or state-mandated benefits.

Medicaid: A state and federally-funded program that provides health insurance to certain eligible people. Eligibility for Medicaid is based on income, requirements of special-needs children and other criteria.

Medicare: A federally funded federal health insurance program for people 65 years and older, some persons with disabilities under 65 years of age and people with end-stage renal disease.

Background: Types of Health Coverage

In order to understand how health insurance markets work, it is necessary to understand the different types of health coverage and the various parts of the health insurance market.

Private Coverage (Self-funded and Insured)

Many employers make health coverage available to their employees and their dependents. The cost may be paid by employers, employees or some combination of both. There are two major categories of employer-sponsored health coverage: self-funded employer plans and insured plans.

Self-funded Employer Plans

Under self-funded or self-insured plans, the employer is ultimately liable for paying health care claims (please see glossary for more information). Self-funded employer plans that are subject to a federal law known as "ERISA" are not regulated by BISHCA and are not subject to state law.[2]

Insured Group Plans

Under insured plans, a health insurance company is ultimately liable for paying health care claims because the employer has purchased a contract of group health insurance (insured group plans). Insured group plans are subject to both federal and state regulation. These can be "large group" (more than 50 employees) or "small group" (50 or fewer employees and self-employed individuals).

[1] The Vermont Agency for Human Services is responsible for administering government-sponsored health programs (except Medicare).
[2] "ERISA" stands for the Employee Retirement Income Security Act of 1974.

"Association" plans also fall under the "small group" category in Vermont (associations are primarily composed of groups of businesses clustered by specific industries or types of businesses such as automobile dealers, chambers of commerce, agriculture, etc).

Individual Health Insurance

Individual or nongroup health insurance is purchased from an insurance company (or its agent or broker) by persons who are not able to obtain health coverage from an employer. Individual health insurance is also a type of private insurance coverage.

Government Programs

Health coverage obtained through government programs includes Medicare, Medicaid, coverage through the military service and similar programs.

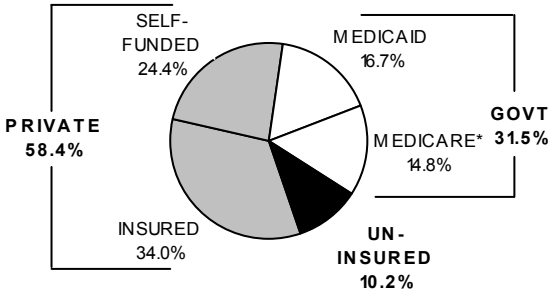
FAQ #1: What are the sources of health coverage for Vermont residents?

Private — Out of a total of 617,000 Vermont residents in 2002, approximately 58 percent (360,000) obtained health coverage through the private market, including self–funded employer plans and insured group and nongroup plans (Figure 1). In 2002, 34 percent (209,000) were covered by insured group and nongroup plans. Another 24 percent (151,000) of Vermonters were covered by self-funded employer plans.

Government — Nearly 194,000 Vermont residents received comprehensive major medical coverage through government programs in 2002. Specifically, 17 percent of Vermonters were enrolled in the state Medicaid program and 15 percent were enrolled in the federal Medicare program in 2002. (The count for Medicaid did not include individuals only receiving a pharmacy benefit or individuals dually eligible for Medicaid and Medicare. About 15,000 dually eligible persons were counted under Medicare.) Less than one percent of Vermont residents received their health coverage exclusively through the military.[3]

Figure 1:

SOURCE OF HEALTH INSURANCE ALL VERMONT RESIDENTS, 2002



*About 15,000 Vermonters are dually enrolled in Medicare and Medicaid. These lives are counted under Medicare and not Medicaid.

Data Source: Annual Statement Suppplement, OVHA, CMS, Current Population Survey

Uninsured — About 62,000 (10 percent of Vermonters) were without health insurance in 2002 (Figure 1). According to the U.S. Census Bureau, the national uninsured rate was 15 percent in 2002.[4] Compared to other

[3] Vermont Department of Banking, Insurance, Securities and Health Care Administration, 2000 Vermont Family Health Insurance Survey. Table: Source of Health Insurance, All Vermont Residents. Available at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/SurveyIndex2000.htm.
[4] Mills, R. and Bhandari, S. "Health Insurance Coverage in the United States: 2002." U.S. Census Bureau, September 2003. Available at: http://www.census.gov/hhes/www/hlthin02.html.

states, Vermont has lower income eligibility thresholds for the state Medicaid program. This may account for some of the difference in the uninsured rates between the United States and Vermont. For example, children in Vermont households earning up to 300 percent of the federal poverty level ($45,200 for a family of three in 2002) were eligible for the Vermont Medicaid program in 2002.[5]

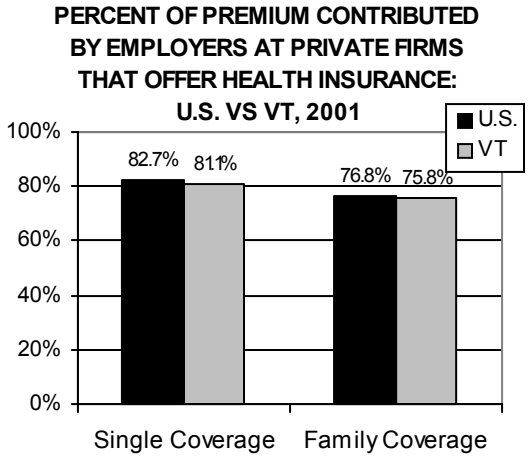
FAQ #2: How many Vermonters obtain health coverage through their employers?

Comparable to the U.S. average of 78 percent, about 77 percent of Vermont's private-sector employees were eligible for health insurance benefits where employers offered health insurance in 2001.[6] In 2002, 63 percent of all Vermonters, including workers and their dependents, were covered by employer-sponsored health coverage compared to a national average of 61 percent.[7] According to the 2000 Vermont Family Health Insurance Survey, 96 percent of Vermont residents with employer-sponsored health coverage received their coverage through current employers or associations, while the remaining 4 percent had retirement plans or continuation of coverage procured through former employers under COBRA or a similar state law.[8]

FAQ #3: How much do Vermont employers contribute towards employment-based health insurance?

On average, Vermont employers that offer health insurance contribute a major portion of the total insurance premium. In 2001, employers at private-sector establishments in Vermont that offered health insurance contributed 81 percent of the total premium for single coverage and 76 percent for family coverage (Figure 2). This compared to an average of 83 percent for single coverage and 77 percent for family coverage in the United States. Both nationally and in Vermont, consumers are assuming more of the cost of covered health services through deductibles, copayments and coinsurance rates.

Figure 2:



Data Source: AHRQ, Medical Expenditure Panel Survey - Insurance Component

[5] Kaiser Family Foundation, State Health Facts Online, Medicaid and SCHIP Eligibility, available at http://statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?.
[6] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2001 Medical Expenditure Panel Survey-Insurance Component, Table IIB.2.a (2001). Available at: http://www.meps.ahrq.gov/MEPSDATA/ic/2001/Index201.htm.
[7] U.S. Census Bureau, Health Insurance Coverage: 2002, Detailed Tables, Table HI05. Available at: http://ferret.bls.census.gov/macro/032003/health/toc.htm.
[8] Vermont Department of Banking, Insurance, Securities and Health Care Administration, 2000 Vermont Family Health Insurance Survey. Employment and Health Insurance in Vermont: Summing it Up, January 2002. Available at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/SurveyIndex2000.htm.

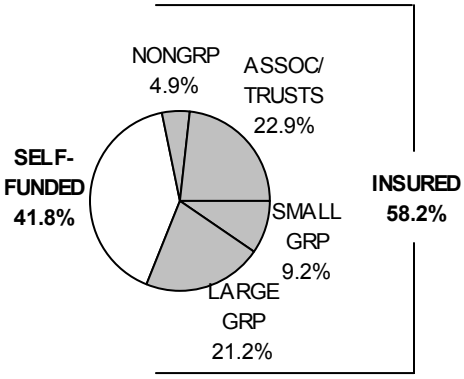
For more information about Vermont insurers and market share or Vermont health insurance carriers and rates, visit BISHCA's web site at: www.bishca.state.vt.us and click on Health Care.

FAQ #4: How many Vermonters are enrolled in the different private (non-gov't) market segments?

Enrollment in self-funded employer plans constituted 42 percent of the total private market in Vermont in 2002, while enrollment in insured plans accounted for 58 percent of the total private market (Figure 3). The remainder of this section will focus on the insured market, affecting 209,000 Vermont residents.

Figure 3:

ENROLLMENT IN PRIVATE MAJOR MEDICAL INSURANCE BY MARKET SEGMENT: VERMONT, 2002



Data Source: Annual Statement Supplement

In 2002, the largest segment of the Vermont insured market was association/trust (part of the small group market), accounting for 23 percent (82,000) of privately insured lives (Figure 3). The second largest segment was the large group market, accounting for 21 percent (76,000). For the most part, these segments are experience rated (for an explanation of "experience rated," see FAQ #6).

The non-association segment of the small group market accounted for 9 percent (33,000) of Vermont residents with private health insurance. The smallest insured market segment was the nongroup or individual market, accounting for 5 percent (18,000) of Vermont residents with private health insurance coverage in 2002. These two markets are community rated (for an explanation of "community rated", see FAQ #5).

Glossary

Large Group: Insurance that is available to employers with 51 or more employees.

Association/Trust: Insurance sponsored by an association of businesses, typically clustered by specific industries or types of businesses.

Small Group: Insurance that is available to employers with 1 to 50 employees, including self-employed persons.

Individual or Nongroup: Insurance bought directly by a person (or through a broker) who does not have access to group coverage through an employer or association.

FAQ #5: What does "community rated" mean in Vermont?

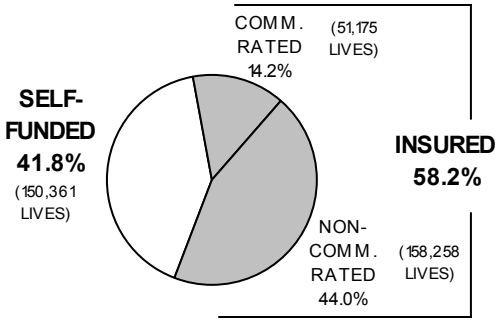
"Community rated" means that the risks of all insureds in a defined "community" are blended together to develop the premiums for health insurance. A "community" is made up of all individuals having a particular insurance plan. Community rating spreads the cost of insurance evenly among all the individuals in a community with that plan, instead of charging significantly higher or lower costs for a person or group based on risk or claims experience. Vermont statutes require that each insurer set community rates in the small group and individual markets. Approximately 14 percent (51,000) of Vermonters in the privately insured market had community rated premiums in 2002 (Figure 4).

There are some differences between Vermont's community rating laws for the small group and individual markets. Vermont regulations require insurance companies selling health insurance in the small group market to charge the same premium to all their small group customers for the same type and amounts of coverage. They cannot charge small group members more or less than the community

rate, regardless of the group's risk or claims experience, unless the group is exempt (see FAQ #6). About 29 percent of lives in the small group market were community rated in 2002. The remaining 71 percent of lives in the small group market were enrolled in the exempt association segment and were experience rated (FAQ #6).

Figure 4:

ENROLLMENT IN COMMUNITY RATED INSURANCE IN THE PRIVATE MARKET: VERMONT, 2002



Data Source: Annual Statement Supplement

Vermonters receiving insurance through the individual market are subject to one of two types of community rating. By law, all insurers must calculate a person's premium by starting with the same rate for the same type and amounts of coverage. Some insurers can then alter this pure community rate by adding or subtracting 20 percent, based on actuarial assumptions of how the person's age or gender influences their risk for making claims. Other insurers, nonprofit hospital service corporations, like Blue Cross Blue Shield of Vermont, and nonprofit health maintenance organizations, like MVP, are prohibited by statute from using age or gender variations when setting non-group rates and thus use pure community rating.

A list of exempt associations can be found on BISHCA's web site at www.bishca.state.vt.us. Click on Health Care–Consumer Publications. Open the publication titled "Shopping for Individual or Small Group Health Insurance," and see the section titled "Important Explanation of Insurance Terms" - "Exempt Association Plans."

FAQ #6: What does "experience rated" mean in Vermont?

"Experience rated," also called "merit rated," means that rates are based on the claims experience of the particular insured. In Vermont, all large employer groups are experience rated— each large employer group has distinct rates determined on the basis of that employer group's claims experience.

In addition, under Vermont law, small employers can join an association that can ask for an exemption from the community rating law, thereby becoming experience rated. Rates for each "exempt" association are based on the claims experience of all members of the particular association and their dependents, rather than on the claims experience of all small employers throughout the state. Health insurance rates available to small employers through an exempt association tend to be lower than statewide small group rates when members' claims experience is lower. However, those rates may also be higher when members have higher-than-average claims experience. Approximately 71 percent of Vermonters in the small group market had health insurance through an exempt association in 2002.

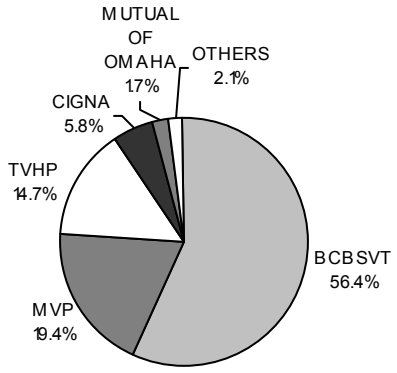
[9] *Mapping State Health Insurance Markets, 2001: Structure and Change.* Academy Health, September 2003. Available at: http://statecoverage.net/pdf/mapping2001.pdf.

FAQ #7: Who are the major private health insurers in Vermont?

Using earned premium as a measure for market share in comprehensive major medical insurance, the top carriers in Vermont in 2002 were Blue Cross Blue Shield of Vermont (56 percent), MVP (19 percent); and The Vermont Health Plan (15 percent). These three carriers accounted for over 90 percent of this Vermont market in 2002.

Figure 5:

DISTRIBUTION OF EARNED PREMIUM OF INSURANCE CARRIERS: VERMONT, 2002



Note: Does not include the self-funded market.

Data Source: Annual Statement Supplement

2002 Major VT Carriers: Comprehensive Major Medical Insurance

Insurer	Lives	Premium
BCBSVT	114,810	$295,576,898
MVP	35,120	$101,414,772
TVHP	27,651	$76,844,362
CIGNA	18,276	$30,233,712
MUTUAL OF OMAHA*	8,284	$8,830,628
OTHERS	5,292	$10,893,188
TOTAL	**209,433**	**$523,793,560**

Note: Does not include the self-funded market or other Accident & Health products like Medicare supplement, long term care, etc.
*Mutual of Omaha has withdrawn from the non-group market nationwide and will cease providing such coverage in Vermont beginning June 1, 2004.

Such a concentration of market share is typical of most states, according to a national study of state health insurance markets in 2001.[9] The study noted that in most states, the health insurance market is concentrated with the top three insurers dominating most of the market.[10] Insurers are most highly concentrated in the individual market with a single insurer controlling at least 50 percent of the market as the United States average.[11] This study also noted that between 1997 and 2001 market concentration had increased in the United States.[12]

FAQ #8: How much have health premiums changed in 2002?

According to a national study, premiums rose an average of 12.7 percent for employer-sponsored health insurance in 2002 for the second consecutive year of double-digit increases.[13] In Vermont, the average rate increase approved by BISHCA was 15.8 percent in the nongroup market and 15.8 percent in the small group market (excluding associations) in 2002. Premium rate changes can vary widely between groups in the experience rated large group and exempt association markets; rate increases in those markets are not regulated by BISHCA and data is currently not available on the average rate increase experienced by those markets.

[10] *Mapping State Health Insurance Markets, 2001: Structure and Change.* Academy Health, September 2003. Available at: http://statecoverage.net/pdf/mapping2001.pdf.
[11] Ibid.
[12] Ibid.
[13] *2002 Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2002. Available at: http://www.kff.org/content/2002/3251/.

FAQ #9: What types of non-comprehensive health insurance products do Vermonters purchase?

In addition to comprehensive major medical insurance, there are other types of insurance with some coverage of health or health care related services or costs including non-comprehensive coverage (hospital only), Medicare supplement or Medigap, specified disease, long term care, accident, dental and disability. Of the total earned premium reported by accident and health insurers in Vermont in 2002 ($710 million), comprehensive major medical insurance accounted for 74 percent ($524 million) of the total, followed by Medicare supplement accounting for 6 percent ($46 million) and disability insurance representing 5 percent ($37 million) of the total (Figure 6).

Glossary

Medicare Supplement: Insurance that pays for expenses not covered by Medicare, like deductibles and coinsurance, if the services are covered by Medicare. This insurance may also pay for some services that Medicare does not cover (e.g., prescription drugs).

Disability: Insurance that provides replacement income, a set schedule of payments, or coverage for expenses if an individual can no longer work at his or her regular job.

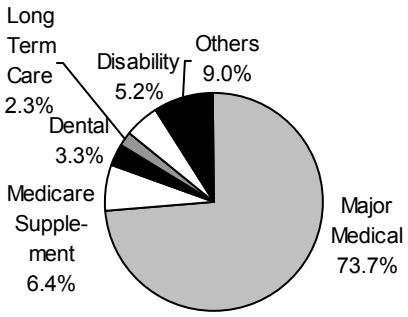
Long Term Care: Insurance that helps to pay for the costs of nursing home, home health, adult day care, and other similar types of care.

Dental: Insurance that pays for dental services.

Other: Insurance that makes a payment or payments for accidents, accidents and sickness, accidental death and dismemberment, student policies, and specific diseases.

Figure 6:

DISTRIBUTION OF EARNED PREMIUM BY ACCIDENT AND HEALTH LINES OF BUSINESS: VERMONT, 2002



Note: Does not include the self-funded market.

Data Source: Annual Statement Supplement

FAQ #10: What are some national trends in health insurance?

Future trends in health insurance products and pricing will continue to be heavily influenced by job-based health insurance that covers not only active workers and their dependents, but also early retirees and Medicare-eligible retirees.[14] In the short term, consumers will be responsible for more of the cost through incremental changes in existing cost-sharing mechanisms. These include increased contributions towards premiums, increased copayments for specified services, higher coinsurance rates for hospital services and prescription drugs, and increased deductibles for use of out-of-network providers and hospital services.[15]

In the longer term, insurance products may be modified in a manner requiring consumers to be more cost conscious. Copayments for physician visits may be replaced by coinsurance rates of 20 percent or higher to encourage enrollees to comparison shop.[16] More employers are also offering "consumer-driven plans" which have a high deductible combined with an employer-funded health care reimbursement account that employees use to help cover expenses.[17] Through these plans, consumers are receiving detailed information about treatments and cost to assist with purchasing decisions. With the continuing trend of rising health costs, innovations that transfer more decision-making and cost-sharing to consumers appear to be inevitable.[18]

[14] Jon Gabel, Gary Claxton, Erin Holve, Jeremy Pickreign, Heidi Whitmore, Kelley Dhont, Samantha Hawkins, and Diane Rowland. "Health Benefits In 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms Of Cost Sharing." *Health Affairs*, September/October 2003; 22(5): 117-126.
[15] Ibid.
[16] *The Kiplinger Letter*. "Benefit Trends," Volume 80, No. 48, November 26, 2003.
[17] *Business Insurance.* "Benefits Management, Consumer-Driven Health Care: Shopping for Savings," May 26, 2003.
[18] Ibid.