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Division of Health Care Administration

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Frequently Asked Questions About The Health Insurance Market in Vermont

Introduction

Vermonters obtain their health coverage from a variety of sources, including government programs and commercial health insurance companies. In this issue brief, "health coverage" and "health insurance" refer only to comprehensive major medical coverage and not other kinds of health insurance such as limited benefit, specified disease, Medicare supplement, and other non-comprehensive products. The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is responsible for monitoring and regulating the commercial health insurance market in Vermont. The purpose of this issue brief is to answer frequently asked questions (FAQ) about the Vermont health insurance market.

Background: Types of Health Coverage

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.

Employer-Sponsored Private Coverage (Self-funded and Insured Group Plans)

Many employers make health coverage available to their employees and their dependents. Employers, employees or some combination of both pay for the cost. There are two major categories of employer-sponsored health insurance 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. Typically, self-funded employer plans are subject to a federal law known as "ERISA" and are not subject to state law or BISHCA regulation.[1]

Insured Group Plans

Under insured plans, a health insurance company is ultimately liable for paying

health care claims because an employer or an association has purchased a contract for group health insurance (insured group plans). Insured group plans are subject to both federal and state laws as well as state regulation. These can be "large group" (more than 50 employees) or "small group" (50 or fewer employees and self-employed individuals).

"Association" plans also fall under the "small group" category in Vermont Associations are primarily composed of groups of businesses clustered by specific industries, professions or types of businesses such as automobile dealers, chambers of commerce, agriculture, etc. See FAQ #6 and 7 for a discussion of rating provisions.

Individual or Non-group Health Insurance

Persons who cannot obtain group health coverage from an employer or association can purchase individual or non-group health insurance directly from an insurance company (or its producers). "Individual" and "non-group" are interchangeable terms for health insurance that is not purchased in the group market. Individual health insurance is subject to both federal and state laws, as well as regulation by BISHCA.

Government Programs

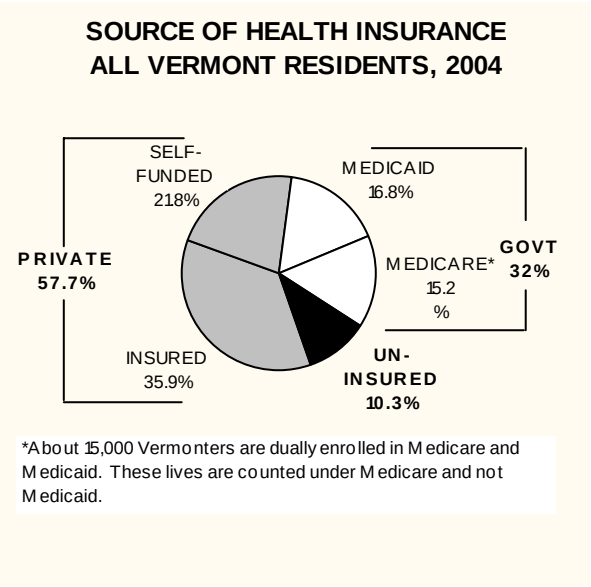
Government programs refer to health coverage obtained through government programs including Medicare, Medicaid, coverage through military service, and similar programs. Medicare is federal health insurance for people 65 or older and people with disabilities and is run by the Social Security Administration. Medicaid is a state program that pays for medical care for certain individuals and families with low incomes and resources including children, pregnant women, and some adults. It also covers certain eligible seniors aged 65 or older and people who are blind or disabled.

FAQ #1: What are the sources of health insurance for Vermonters?

Private — Out of a total of 621,394 Vermont residents, 57.7% (358,445) obtained health coverage through the private market, including insured group plans (213,168), insured non-group plans (10,266), and self–funded employer plans (135,011) in 2004 (Figure 1).[2]

Government — Approximately 196,000 or 32% of Vermonters received comprehensive major medical coverage through government programs in 2004. Specifically, 16.8% (103,421) of Vermont residents were enrolled in the state Medicaid program and 15.2% (92,724) were enrolled in the federal Medicare program. The count for Medicaid did not include individuals receiving benefits for prescription drugs only or for screening tests such as mammography and colonoscopy. About 15,000 persons who were dually eligible for Medicaid and Medicare were counted under Medicare.

Figure 1.



Uninsured — Nearly 64,000 Vermonters (10.3%) were without health insurance in 2004. According to the U.S. Census Bureau, the national uninsured rate was 15.7%.[3] Compared to other states, the Vermont Medicaid program covers children and non-custodial adults at higher income levels. This may partially explain Vermont's lower uninsured rate.

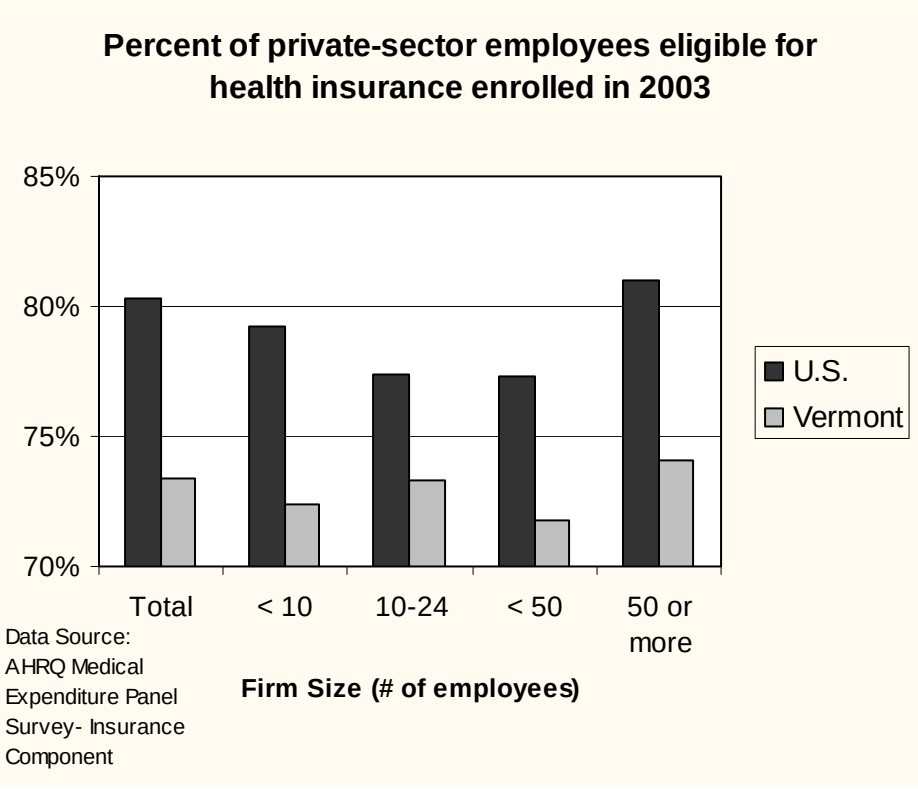
FAQ #2: How many Vermont residents obtain health coverage through their employers?

According to the U.S. Census Bureau, 59.4% of all Vermonters, including workers and their dependents, were covered by employer-sponsored health insurance in 2004. This compared to a national average of 59.8%.[4]

In a national survey of employers conducted in 2003, 54.9% of Vermont's private-sector establishments offered health insurance compared to a national average of 56.2%.[5] This survey indicated that Vermont was similar to the national profile wherein establishments with larger numbers of workers were more likely to offer health insurance. Whereas 36.8% of Vermont's private-sector establishment with fewer than 10 employees offered insurance, 98.7% of those with more than 100 employees offered insurance in 2003. (The Vermont Department of Employment and Training will have data from a 2005 Vermont employer survey available by early 2006).

Not all employees who are offered health insurance through their workplace choose to enroll themselves or their dependents. In 2003 in Vermont, 73.4% of private-sector employees offered health insurance by their employers enrolled in comparison to the national average of 80.3%. [6] Reasons for non-enrollment may include being enrolled in health insurance through another family member or public program, cost of insurance, and lack of interest in having health insurance.

Figure 2.

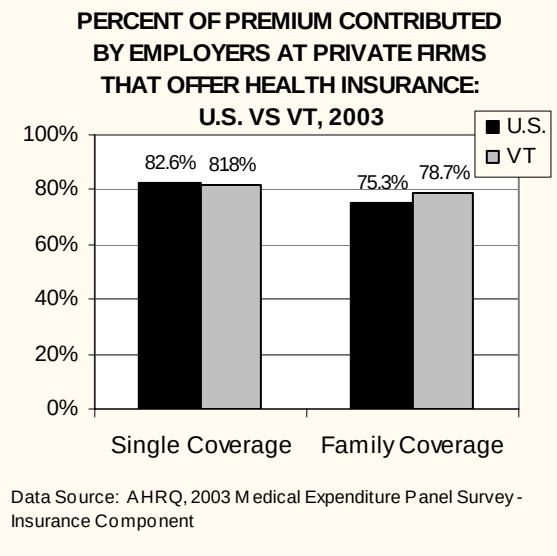


FAQ #3: What is the current status of cost sharing between Vermont employers and employees related to health insurance?

Due to the rising cost of health insurance and health care services, employees share the cost of health insurance and services through premium contributions, deductibles, co-payments and coinsurance. In the U.S. since 2000, the employer contribution to total premium has remained relatively unchanged and was 84% for single coverage and 71% for family coverage in 2004.[7]

According to a national survey, the Vermont employer contribution of 81.8% towards the premium for single coverage plans was close to the national average in 2003 (Figure 3). [8] However, Vermont employers contributed more towards the premium for family coverage at 78.7% compared to the national average of 75.3% in 2003.

Figure 3.



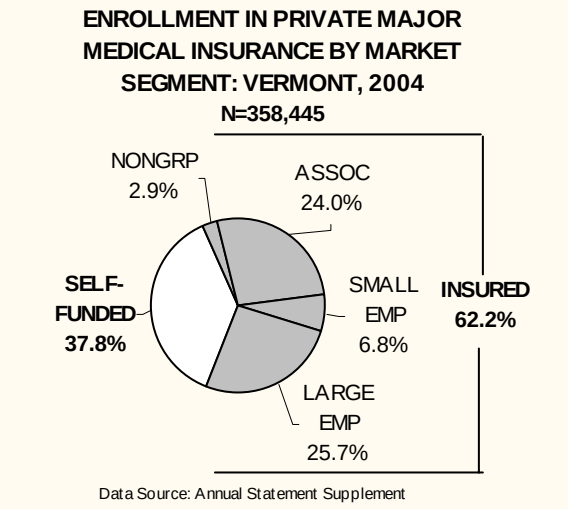
While cost sharing between employers and employees related to premiums remained relatively unchanged since 2000, the average deductible has increased. Between 2003 and 2005 in the U.S., the average deductible per employee increased from $785 to $1,192 for conventional fee-for-service plans and from $65 to $141 for HMOs for family coverage. [9]

The high-deductible health plan (HDHP) is a more recent development related to cost sharing. Health Savings Accounts (HSA) became available under federal law on January 1, 2004. An HSA is a savings fund that offers consumers an option to pay for some of their health care with tax-free dollars. An HSA is available only when a consumer has an HDHP. Employers may also contribute to an employee's HSA. As of December 31, 2004, about 7,000 Vermonters were enrolled in a HDHP mainly offered through Blue Cross and Blue Shield of Vermont.[10] See FAQ #11 for additional information about national trends related to HSA, HDHP and consumer-driven plans.

FAQ #4: How many Vermonters are enrolled in the different segments of the private health insurance market?

Out of a total private insurance market of 358,445 lives in 2004, enrollment in self-funded employer plans constituted 37.7% of the total private market while enrollment in insured plans accounted for 62.3% (Figure 4). Between 2003 and 2004 there was a net decrease of 1,987 lives in the private insurance market with a decrease of 15,409 lives enrolled in self-insured employer plans (135,011), an increase of 18,791 lives enrolled in insured group plans (213,168), and a decrease of 5,369 lives enrolled in the individual or non-group insured market (10,266). In line with the national trend, enrollment in the non-group market in Vermont has been in a continuous state of decline over the last decade. [11]

Figure 4.



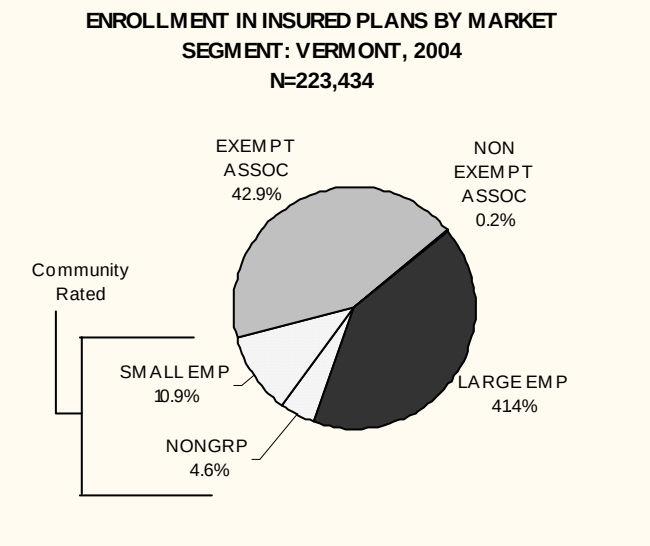
FAQ #5: How many Vermonters are enrolled in the different segments of the insured market (excludes the self-funded employer plans)?

The remainder of this section focuses on the insured market, affecting 223,434 Vermont residents. In 2004, the largest segment of the Vermont insured market was exempt association (part of the small group market), accounting for 42.9% (95,863) of privately insured lives (Figure 5). Associations are primarily composed of groups of businesses clustered by specific industries, professions or types of businesses such as automobile dealers, chambers of commerce, agriculture, etc. See FAQ #7 for an explanation of exempt associations and how they are rated.

The second largest segment was the large employer market (51 or more employees in a group), accounting for 41.4% (92,541). The large employer market segment is experience rated. See FAQ #7 for an explanation of experience rating.

The small employer segment (50 or fewer employees and self-employed individuals) accounted for 10.9% (24,325) of Vermont residents with private health insurance. The smallest insured market segment was the non-group or individual market, accounting for 4.6% (10,266) of Vermont residents with private health insurance coverage in 2004. These two market segments (small employer and non-group) are community rated with some variations. See FAQ #6 for an explanation of community rating and how it is applied in the non-group and small employer market segments.

Figure 5.



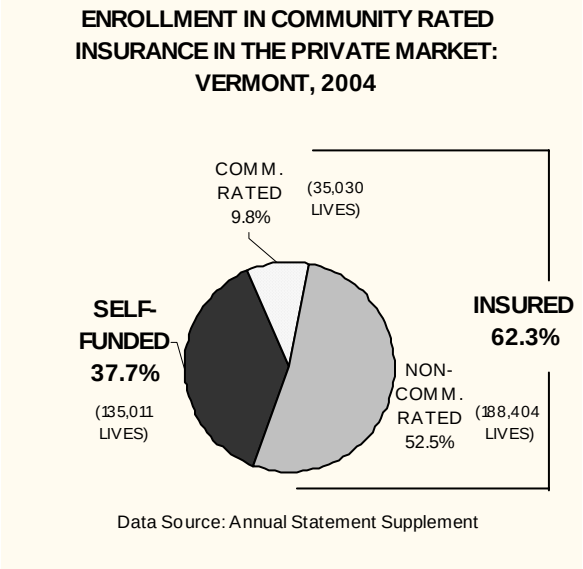
FAQ #6: What does "community rated" mean in Vermont?

"Community rated" means that the risks of all insured persons 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 in that market. 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 employer and non-group markets. Approximately 9.8% (35,030) of Vermonters in the privately insurance market (358,445) had community rated premiums in 2004 (Figure 6).

There are some differences between Vermont's community rating laws for the small employer and non-group markets. Vermont regulations require insurance companies selling health insurance in the small employer market to charge the same premium to all of their small employer customers for the same type and amounts of coverage. They cannot charge small employer members more or less than the community rate, regardless of the group's risk or claims experience, unless the group is exempt.

Vermonters insured through the individual or non-group 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 the pure community rate by adding or subtracting up to 20%, based on actuarial assumptions of how the person's age or gender influences risk for claims. Other insurers, nonprofit hospital service corporations, like Blue Cross Blue Shield of Vermont, and nonprofit health maintenance organizations, like MVP Health Plan, are prohibited by statute from using age or gender variations when setting non-group rates and thus use pure community rating.

Figure 6.



FAQ #7: What does "experience rated" mean in Vermont?

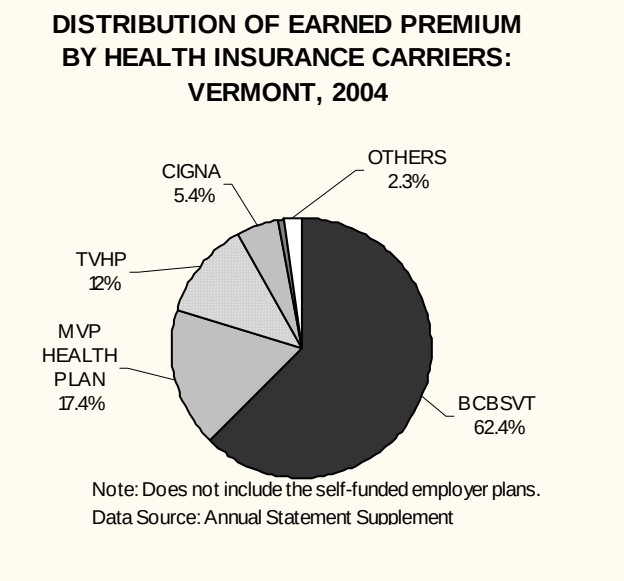
"Experience rated," also called "merit rated," means that rates are based on the claims experience of the particular insured person or group. In Vermont, all large employer groups are experience rated meaning that each large employer group has a distinct rate determined on the basis of that group's claims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

In addition, under Vermont law, small employers can join certain associations that may be able to obtain 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.

FAQ #8: Who are the major private health insurers in Vermont?

In 2004, Vermont insurers earned $656 million in premiums for comprehensive major medical products. Using earned premium as a measure of market share in comprehensive major medical insurance, the top carriers in Vermont were Blue Cross Blue Shield of Vermont (62.4%), MVP Health Plan (17.4%), The Vermont Health Plan (12.0%), and CIGNA (5.4%). These three carriers accounted for just over 97% of the Vermont market in 2004.

Figure 7.



According to a 2001 study of state health insurance markets, concentration of market share in major comprehensive health insurance has been typical of most states.[12] Insurers were most highly concentrated in the individual market with a single insurer controlling at least 50% of the market as the United States average. In 2004 in Vermont, Blue Cross Blue Shield of Vermont accounted for 80% of the lives and 93% of premium in the non-group market. This study of state health insurance markets also noted that between 1997 and 2001 market concentration had increased throughout the United States.

2004 Vermont Carriers by Market Segment
Comprehensive Major Medical Insurance

Insurer	Lives	% of Lives	Premium	% of Premium
ALL INSURED PLANS (Total of Non-group, Exempt Association, Large Employer, Small Employer, Non-exempt Association, Discretionary/Union)				
BLUE CROSS BLUE SHIELD VT	129,384	57.9%	$409,821,337	62.4%
MVP HEALTH PLAN	32,859	14.7%	$114,209,500	17.4%
THE VERMONT HEALTH PLAN	22,333	10.0%	$78,886,707	12.0%
CIGNA	31,988	14.3%	$35,583,324	5.4%
OTHERS	6,870	3.1%	$17,878,679	2.7%
TOTAL	**223,434**	**100.0%**	**$656,379,547**	**100.0%**
NONGROUP MARKET				
BLUE CROSS BLUE SHIELD VT	7,932	77.3%	$22,783,340	77.6%
MVP HEALTH INSURANCE CO.	1,974	19.2%	$1,734,191	5.9%
OTHER	360	3.5%	$4,841,171	16.5%
TOTAL	**10,266**	**100.0%**	**$29,358,702**	**100.0%**
EXEMPT ASSOCIATION MARKET				
BLUE CROSS BLUE SHIELD VT	90,938	94.9%	$284,645,679	94.3%
THE VERMONT HEALTH PLAN	4,637	4.8%	$16,375,963	5.4%
OTHER	288	0.3%	$718,479	0.2%
TOTAL	**95,863**	**100.0%**	**$301,740,121**	**100.0%**
LARGE EMPLOYER MARKET				
BLUE CROSS BLUE SHIELD VT	29,827	32.2%	$98,828,951	41.1%
MVP HEALTH PLAN	17,879	19.3%	$65,395,984	27.2%
THE VERMONT HEALTH PLAN	10,111	10.9%	$33,704,842	14.0%
CIGNA	31,953	34.5%	$35,452,332	14.7%
MVP HEALTH INS.	639	0.7%	$887,461	0.4%
OTHER	2,132	2.3%	$6,339,797	2.6%
TOTAL	**92,541**	**100.0%**	**$240,609,367**	**100.0%**
SMALL EMPLOYER MARKET				
MVP HEALTH PLAN	14,930	61.4%	$48,324,446	58.3%
THE VERMONT HEALTH PLAN	7,226	29.7%	$27,502,492	33.2%
JOHN ALDEN	1,322	5.4%	$3,703,025	4.5%
BLUE CROSS BLUE SHIELD VT	629	2.6%	$3,199,899	3.9%
CIGNA	35	0.1%	$130,992	0.2%
OTHER	183	0.8%	$93,484	0.1%
TOTAL	**24,325**	**100.0%**	**$82,954,338**	**100.0%**
NON-EXEMPT ASSOCIATION MARKET				
THE VERMONT HEALTH PLAN	359	85.7%	$1,303,410	77.9%
BLUE CROSS BLUE SHIELD VT	58	13.8%	$363,468	21.7%
OTHER	2	0.5%	$7,075	0.4%
TOTAL	**419**	**100.0%**	**$1,673,953**	**100.0%**
TRUSTS & DISCRETIONARY				
UNION LABOR LIFE INS CO	18	90.0%	$15,928	37.0%
OTHER	2	10.0%	$27,138	63.0%
TOTAL	**20**	**100.0%**	**$43,066**	**100.0%**

Note: Does not include the self-funded employer plans or other Accident & Health products such as Medicare supplement, long term care, specified disease, dental, disability, etc.

FAQ #9: How much have health premiums changed?

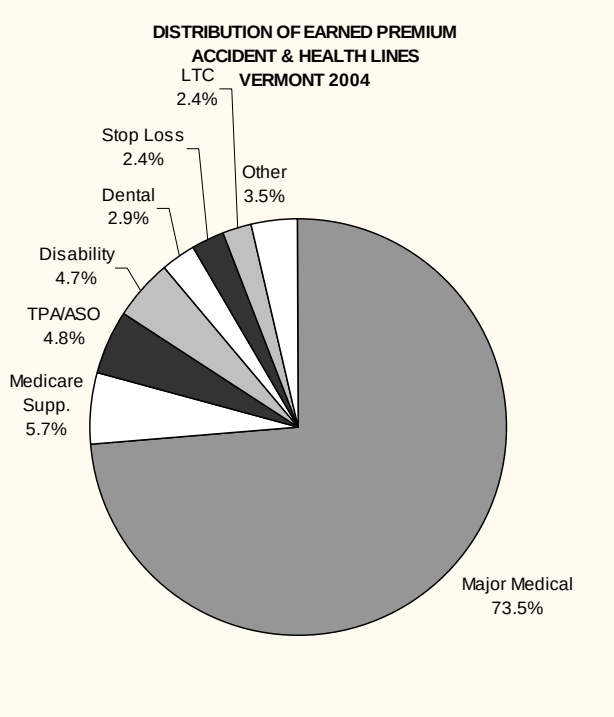
In the U.S., between spring of 2004 and spring of 2005, premiums for employer-sponsored health insurance rose by 9.2%, lower than the 11.2% increase in 2004 and the 13.9% increase in 2003.[13] Premiums for family coverage have increased an average of 73% between 2000 and 2005 at the national level.

In 2004 in Vermont, the average rate increases in the various segments of the insured market included the following: 6.2% for large employer; 10.6% for small employer; 14.8% for exempt association; and 15.8% for non-group. [14] Premium rate changes can vary widely between groups in the experience rated large employer and exempt association markets. Rate increases in those markets are not entirely regulated by BISHCA.

FAQ #10: What other types of accident and health insurance products do Vermonters purchase?

In addition to comprehensive major medical insurance, there are other types of accident and health insurance with some coverage of health or health care-related services or costs including Medicare supplement or Medigap, disability, long term care, dental, accident, student policies, specified disease and limited benefit. Of the $893 million in total earned premium reported by Accident & Health insurers in Vermont in 2004, comprehensive major medical insurance accounted for 73.5% ($656 million) of the total, followed by Medicare supplement accounting for 5.7% ($51 million), third party administrator (TPA/ASO) at 4.8% ($43 million) and disability at 4.7% ($42 million).

Figure 8.



FAQ #11: What are some national trends in health insurance?

Between 2000 and 2004, enrollment in employer-based health insurance has steadily declined for both adults and children. However, outreach and enrollment in state Medicaid programs and the State Children's Health Insurance Program (S-CHIP) has decreased the proportion of uninsured children during the same period. Adults accounted for all of the growth in the number of uninsured between 2000 and 2004 with over two-thirds being low-income and over half aged 19-34 years of age. [15]

Due to a variety of factors including several years of high premium growth and a changing economy, the percentage of all workers receiving health coverage from their employers fell from 65% in 2001 to 61% in 2004. [16] This decline in employer-sponsored insurance meant that at least five million fewer jobs were providing health insurance in 2004 than in 2001. A likely contributing factor was a decline in the percentage of all small firms (3-199 employees) offering health insurance over this same period. Across the U.S. in 2004, 63% of all small firms offered health benefits to their workers, down from 68% in 2001. Jobs shifted from larger firms to businesses with fewer than 25 employees, self-employment, and to industries less likely to offer health benefits. [17]

There has been growth in the number of employers familiar with and offering consumer-directed health plan (CDHP) arrangements, specifically those that combine a high-deductible plan (HDHP) with a personal or health savings account (HSA) option. Consumer-directed, or consumer-driven health plans are intended to give enrollees a financial stake in their health care and to encourage them to make informed choices about their care and treatment. These health plans typically make comparative information available to their enrollees in an effort to help them manage their health care costs and choose effective treatments. [18] In 2005, 20% of firms offering health benefits offered a high-deductible health plan compared to 10% in 2004.[19] According to a national 2005 census of 1,300 health insurance companies, the number of insurance companies offering HSA plans increased from 29 to 99 between September 2004 and March 2005 with enrollment increasing from 438,000 to 1,031,000 covered lives. [20] As noted in a prior section, 7,000 Vermonters were enrolled in an HSA as of December 2004 comprising 2% of the private health insurance market (including insured and self-insured employer plans).

NOTES

[1] "ERISA" stands for the Employee Retirement Income Security Act of 1974. Some types of self-funding arrangements, such as Multiple Employer Welfare Arrangements (MEWAs), are subject to state insurance law and BISHCA regulation.

[2] Data sources for "Figure 1: Source of Health Insurance, All Vermont Residents, 2004" include: 2004 Annual Statement Supplement Reports, Vermont Dept. of Banking, Insurance, Securities and Health Care Administration; Medicare Enrollment by State, U.S. Center for Medicaid and Medicare Services; Medical Assistance Count, Office of Vermont Health Access; U.S. Census Bureau, 2004 Current Population Survey, March Supplements; 2004 Population Estimates, U.S. Census Bureau.

[3] U.S. Census Bureau. 2004 Current Population Survey (March Supplement). Health Insurance Coverage: 2004, Detailed Tables, Table HI05. Available at: http://pubdb3.census.gov/macro/032005/health/h05_000.htm

[4] See 3.

[5] U.S. Agency for Healthcare Research and Quality. 2003 Medical Expenditures Panel Survey- Insurance Component. Available at: http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIA2.pdf

[6] U.S. Agency for Healthcare Research and Quality. 2003 Medical Expenditures Panel Survey- Insurance Component. Available at: http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIB2A1.pdf

[7] *2004 Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2004.

[8] U.S. Agency for Healthcare Research and Quality. 2003 Medical Expenditures Panel Survey- Insurance Component. Available at: http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIC3.pdf and http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIID3.pdf

[9] *2005 Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2005.

[10] 2004 Annual Statement Supplement Report. Vermont Department of Banking, Insurance, Securities and Health Care Administration.

[11] Melinda Beeuwkes Buntin, M. Susan Marquis and Jill M. Yegian. The Role Of The Individual Health Insurance Market And Prospects For Change. Health Affairs, Vol 23, Issue 6, 79-90.

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

[13] See 9.

[14] Average rate increases were calculated by the Rate and Form section of the Division of Health Care Administration and were not weighted for enrollment. The average rate increases are based on the largest insurance carriers in each segment of the insured market in Vermont.

[15] *Health Coverage in America, 2004 Data Update*. Kaiser Family Foundation, November 2005. Available at: http://www.kff.org/uninsured/7415.cfm

[16] See 7.

[17] *Covering the Uninsured: Growing Need, Strained Resources*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, November 4, 2005. Available at: http://www.kff.org/uninsured/7429.cfm

[18] *Online Tools for Consumer-Directed Health Plans*. Kaiser Family Foundation. Available at: http://www.kff.org/insurance/insurance012505pkg.cfm

[19] See 9.

[20] *Number of HSA Plans Exceeded One Million in March 2005*. AHIP Policy and Research Center. America's Health Insurance Plans (AHIP). Available at: http://www.ahipresearch.org/

Glossary of Health Insurance Terms

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

Comprehensive Major Medical Insurance: Includes but is not limited to health insurance plan types such as indemnity, HMO, PPO and POS offering comprehensive major medical health insurance coverage in terms of benefit design. This category excludes other types of non-comprehensive hospital-surgical-medical coverage such as basic hospital expense coverage and hospital confinement indemnity coverage.

Consumer-directed or Consumer-driven Health Plans: A CDHP is intended to give enrollees a financial stake in their health care and to encourage them to make informed choices about their care and treatment. These health plans typically make comparative information available to their enrollees in an effort to help them manage their health care costs and choose effective treatments.

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.

Health Savings Account: A Health Savings Account (HSA) is a savings fund that offers consumers an option to pay for some of their health care with tax-free dollars. They are available only when a consumer has a "High Deductible Health Plan (HDHP)." Individuals and/or employers can contribute funds to HSAs. HSA funds can be spent on qualified medical expenses, including costs not paid by the person's insurer, as well as for certain costs not covered by insurance including prescription and over the counter drugs, premiums for continuation of health insurance under COBRA, certain long term care services and federally-tax qualified long-term care premiums, health insurance premiums during a period of unemployment, premiums for Medicare Part A and B (but not Medicare Supplement insurance) and the employee share of health insurance premiums for retirees over 65 for employer-sponsored plans.

High Deductible Health Plan: In 2005, federal regulations defined a High Deductible Health Plan (HDHP) that qualifies under a Health Savings Account (HSA) to be one with a deductible of at least $1,000 for an individual and $2,000 for a family and a total out-of-pocket annual expense (including the deductible and other out of pocket expenses) of no more than $5,100 for an individual and $10,200 for a family. (There are other requirements not detailed here). The maximum annual HSA contribution for 2005 is the lesser of 100% of the HDHP deductible or $2,650 for an individual and $5,250 for a family.

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

Insured Market: 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.

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

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.

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).

Self –funded (also known as self-insured) Employer Plans: 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 (enrollees may be issued a health card with the third party administrator's name on it) and may purchase a "stop loss" or "excess loss" insurance policy for the self-funded plan. (The stop-loss 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.

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