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## *Frequently Asked Questions About The Health Insurance Market in Vermont 2007*

### **Introduction**

Vermonters obtain their health coverage from a variety of sources, including government programs and commercial health insurance companies. In this publication, “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 publication 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.

### **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 run by the Social Security Administration for people age 65 or older and people with disabilities. Medicaid is a state program jointly funded by the state and federal government ([www.ovha.state.vt.us](http://www.ovha.state.vt.us)) and pays for medical care for certain individuals and families with low incomes and limited 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.

## **Private Insurance Policies**

The private insurance market can be broken down into four market segments: large group, small group, nongroup (individual), and self-funded.

### **■ Small Group Health Insurance Plans**

“Small group” insurance includes insurance issued to a “small employer,” an association or a trust.. A small employer is an employer that employs at least one and no more than 50 employees. The definition of a small employer includes businesses operated by a sole proprietor.

Associations are also considered a small group regardless of the number of members or insured’s it has. 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. Some associations sell standard products generally available in Vermont. However, the Commissioner of BISHCA may exempt an association from some small group rules if the association meets certain requirements. Associations granted exemptions under 8 V.S.A. § 4080a(h) are referred to as “exempt associations.”

Small group health insurance plans are subject to both federal and state laws, as well as regulation by BISHCA. Small group insurance policies must comply with Vermont’s benefit mandates. Thus, all small group policies are filed for approval and reviewed by BISHCA. BISHCA must also review and approve premium rates for small group policies prior to sale of these policies. Small group plans must be community rated and sold on a guaranteed issue basis. Community rating means that each small group buying a plan from a carrier will pay the same premium regardless of health risk factors, age or other underwriting factors (See FAQ #6). Guaranteed issue means that the carrier must sell any small group plan to any small group willing to pay the premium; groups cannot be turned away because of the health of their members.

### **■ Large Group Health Insurance Plans**

Large group insurance includes employer groups with over 50 employees. Large group health insurance plans are subject to both federal and state laws, as well as regulation by BISHCA. Large group policies must comply with Vermont’s benefit mandates. There are significant differences in how large and small groups premiums are developed, and how BISHCA regulates the premium development. Large groups are experience-rated, which means that rates are based upon the claims experience of a particular insured group (See FAQ #7). BISHCA does not review premium rate development for large group insurance plans. However, BISHCA reviews and approves the methodology for large group premium rates. BISHCA also approves

numerous components used in the development of the insurance rates for large group plans, including the trend and administrative expenses components.

### ■ **Non-Group (Individual) Health Insurance Plans**

A non-group plan is an insurance policy that is “offered or issued to an individual.” 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 plans are subject to both federal and state laws, as well as regulation by BISHCA. Carriers selling non-group policies must register, policies must be community rated, and guaranteed acceptance is mandated. BISHCA reviews and approves non-group insurance forms to ensure compliance with Vermont law, and reviews and approves premium rates for non-group policies.

Catamount Health, a new product introduced in 2007, is also considered a non-group product. Catamount Health Insurance is an individual health insurance product created for uninsured Vermonters who do not have access to employer (group) insurance and do not qualify for other state subsidized health programs. Two private health insurance companies (BCBSVT and MVP) sell Catamount Health Insurance products. You can find more information about Catamount Health in the consumer publication entitled “Shopping for Vermont's Catamount Health Insurance,” located on BISHCA’s website at:

[http://www.bishca.state.vt.us/HcaDiv/consumerpubs\\_healthcare/index\\_consumerpubs.html](http://www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/index_consumerpubs.html)

### ■ **Self-Funded Employer Plans**

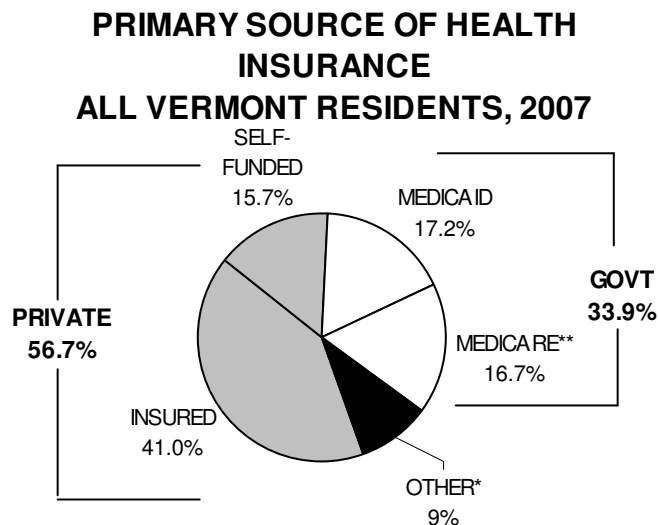
Self-funded plans pay benefits from a fund established by an employer or organization. The employer is ultimately liable for paying health care claims. Generally speaking, self-funded employer plans are subject to a federal law known as “ERISA” and are not subject to most state law or BISHCA regulation.<sup>1</sup>

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

**Private** — In 2007, out of a total of 621,300 Vermont residents, 57% (352,300) had private insurance as their primary source of coverage, including insured group plans and Vermont residents covered by out of state plans (254,600), insured non-group plans (8,960, which includes Catamount Health Insurance), and self-funded employer plans (97,700) (Figure 1).<sup>2</sup>

**Government** — In 2006 (the most current data available), approximately 103,700 of Vermonters (16.7%) were enrolled in the Federal Medicare Program. In 2007, 106,606 Vermonters (17.2%) were enrolled in the State Medicaid program. The count for Medicaid does not include individuals covered under the prescription drug and Long Term Care programs. Approximately 14,000 Vermonters (13.1%) that are covered by the State Medicaid program were considered dually eligible for Medicaid and Medicare.<sup>3</sup>

**Figure 1.**



\* The "Other" category is a residual amount and may include the uninsured and those covered by military insurance coverage which is currently not collected by BISHCA

\*\* The Most recent Data from Medicare is 2006

**Uninsured** — The uninsured rate in Vermont has not been estimated for 2007 and therefore is not included and discussed in this publication. BISHCA is currently gathering information about the uninsured through the 2008 Vermont Household Health Insurance Survey. This survey will help BISHCA estimate the number of uninsured Vermonters for 2008.

**FAQ #2: How much have health premiums changed?**

According to a national survey of private employers by the Kaiser Family Foundation, between spring of 2007 and spring of 2008, premiums for employer-sponsored health insurance rose by 5%, lower than the 6.1% increase in 2007 and the 7.7% increase in 2006.<sup>4</sup> This premium rate increase is the lowest average premium rate increase since 1999. The annual rate of increase was lower for small employers with fewer than 200 employees than for large employers with 200 or more employees.

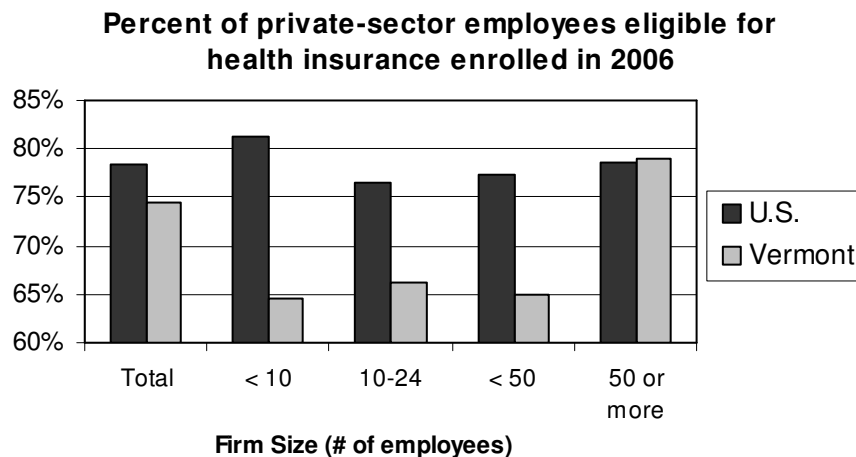
According to Kaiser Family Foundation, in 2008, the national average monthly premium for a single plan was \$392 and \$1,009 for a family plan. By comparison, The U.S. Agency for Healthcare Research and Quality's (AHRQ) national study shows the average monthly premium for a single plan sold in Vermont in 2006 was \$360 and \$969 for a family plan.<sup>5</sup>

**FAQ #3: How many Vermont residents obtain health coverage through their employers, and how does Vermont compare to national estimates?**

In a national survey of employers conducted by AHRQ in 2006, which has national as well as state specific data, 57.9% of Vermont's **private-sector establishments** offered health insurance. This estimate is higher than the national average of 55.8%.<sup>6</sup> According to the Vermont Department of Labor's most recent Fringe Benefits Survey conducted in 2005, 51% of private-sector establishments with fewer than 10 employees offered insurance and 99% of private-sector establishments with more than 100 employees offered insurance.<sup>7</sup>

Not all employees who are offered health insurance through their workplace choose to enroll themselves or their dependents. According to AHRQ's 2006 survey, in Vermont, 74.5% of private-sector employees eligible for employer-sponsored insurance enrolled in an offered health plan. This is lower than the national average of 78.3% (Figure 2).<sup>8</sup> One reason people decide not to enroll in an employer plan is because they are already insured in a family member's plan or a public program.

**Figure 2.**



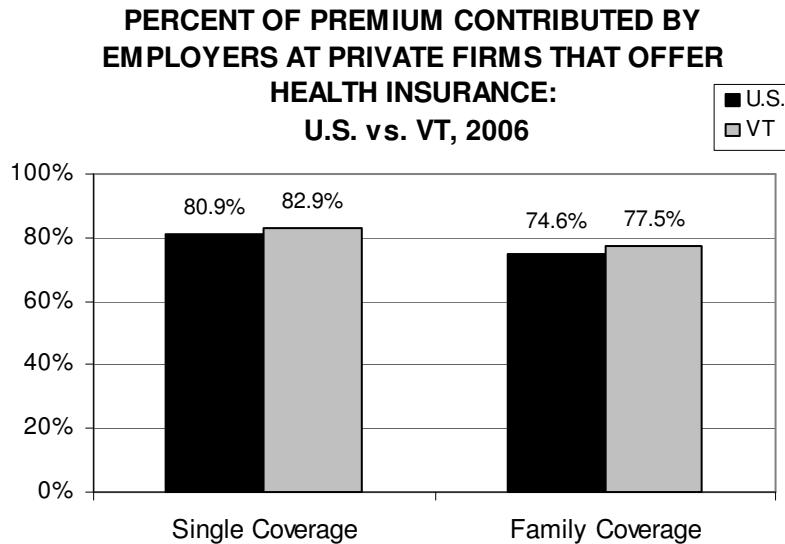
Data Source: AHRQ Medical Expenditure Panel Survey- Insurance

**FAQ #4: 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 often share the cost of health insurance and services through premium contributions, deductibles, co-payments and coinsurance. According to the Kaiser Family Foundation, since 2000, the amount employers contribute to total premium has remained relatively unchanged. In 2008, employers contributed approximately 84% for single coverage and 73% for family coverage.<sup>9</sup>

However, according to AHRQ’s 2006 survey with state specific data, Vermont employers contributed 82.9% towards the premium for single coverage plans, which was more than the national average of 80.9% (Figure 3).<sup>10</sup> Vermont employers also contributed more money toward family coverage in 2006. Specifically, Vermont employers contributed 77.5% towards the premium for family coverage, higher than the national average of 74.6% (Figure 3).

**Figure 3.**



Data Source: AHRQ, 2006 Medical Expenditure Panel Survey - Insurance Component

While cost sharing between employers and employees related to premium contributions remained relatively unchanged since 2000, the average deductible has increased. According to Kaiser Family Foundation, at a national level in 2008, for covered workers in plans with a general annual plan deductible, the average deductible amounts for single coverage were: \$503 in health maintenance organization plans (HMOs), \$560 in preferred provider organization plans (PPOs), \$752 in point-of-service plans (POS), and \$1,812 in high-deductible health plans with a savings health account option (HDHP/ HSA ). Substantial percentages of covered workers are in health plans with no general annual deductible, including most workers in HMO and POS plans and almost one-third of workers in PPO plans. However, many have co-payments or other charges when they are hospitalized or have outpatient surgery.<sup>11</sup>

Health Savings Account plans (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 a high deductible health plan (HDHP). Employers may contribute to an employee's HSA. As of December 31, 2007, approximately 33,600 Vermonters were enrolled in a HDHP.<sup>12</sup> Enrollment of Vermonters in HDHP's has increased dramatically in Vermont. Almost 10% of enrollees in the total private health insurance market (including the self-funded market), were enrolled in a HDHP plan in 2007.

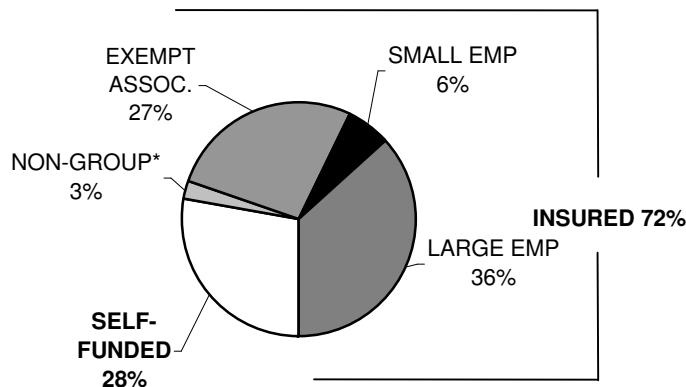
**FAQ #5: How many Vermonters are enrolled in the different segments of the private health insurance market?**

Out of a total private insurance market of 352,300 lives (private insurance as primary source of coverage) in 2007, enrollment in self-funded employer plans accounted for 27.7% (97,700) of the total private market. Enrollment in insured plans (including those Vermonters covered by out-of-state health plans) accounted for 72.3% (254,600) (Figure 4). Between 2006 and 2007 there was an overall net decrease of almost 6,300 lives in the private health insurance market as a whole, and a net decrease of 2,760 lives in the insured group market not including the self funded market.

Catamount Health is a new non-group product introduced in the fall of 2007 (see introduction). As of December 31, 2007, enrollment in Catamount Health was 1,482 lives. Enrollment in the non-group market including Catamount Health was 8,964 lives in 2007. If Catamount's enrollment numbers are backed out of the non-group market's total, the enrollment is 7,482 lives, which is an overall net decrease of 822 lives from 2006. This decline in the non-group market is consistent with the national trend.<sup>13</sup>

**Figure 4**

**ENROLLMENT IN PRIVATE MAJOR MEDICAL INSURANCE  
BY MARKET SEGMENT: VERMONT, 2007  
N = 352,313**



Data Source: Annual Statement Supplement  
\* Non-Group Includes Catamount Health Numbers

**FAQ #6: How many Vermonters are enrolled in the different segments of the insured market excluding the self-funded employer plans and the Blue Cross Blue Shield of Vermont Blue Card Program?**

This section focuses on the insured market (202,800) that is regulated by the state of Vermont, excluding 97,670 covered under self-insured employer plans and the roughly 52,000 Vermont residents covered by health plans licensed in other states.

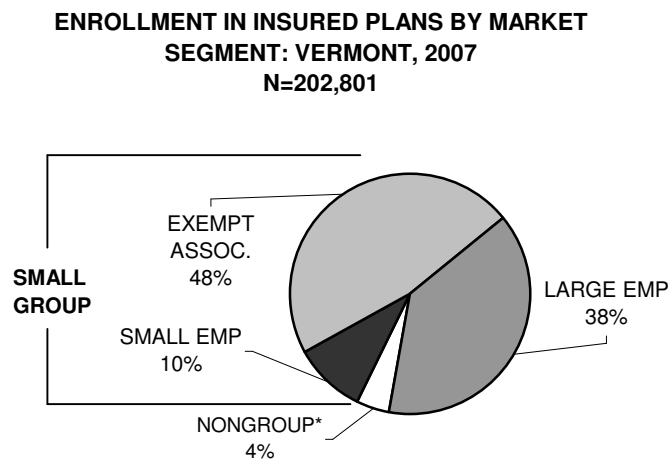
In 2007, the largest insured market segment was exempt association (part of the small group market), accounting for 47% (95,400) of the insured market (Figure 5). Associations are primarily composed of groups of businesses clustered by specific industries, professions or types of businesses such as automobile dealers, chambers of commerce, agriculture, etc. See FAQ #7 for an explanation of exempt associations and how they are rated.

The second largest market segment in 2007 was the large employer market (51 or more employees in a group). This market segment accounts for 38.3% (77,600) of the insured market. The large employer market segment is experience rated. See FAQ #8 for an explanation of experience rating.

The small employer segment (50 or fewer employees and self-employed individuals) is part of the small group market. This market segment accounted for 9.7% (19,700) of the insured market in 2007.

Finally, the non-group or individual market was the smallest segment in 2007, accounting for 4.4% (8,960, which includes Catamount Health Insurance) of the insured market.

**Figure 5.**



Data Source: 2007 Annual Statement Supplement  
\*Non-Group Includes Catamount Health Numbers

## **FAQ #7: What does “community rated” mean in Vermont?**

Small group and non-group plans must be community rated and sold on a guaranteed issue basis. Community rating means that each individual or small group buying a plan from a carrier will pay the same premium regardless of health risk factors, age or other underwriting factors. Guaranteed issue means that the carrier must sell any insurance plan to an individual or small group willing to pay the premium; individuals and groups cannot be turned away because of the health of their members.

When a product is "community rated," 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 group and non-group markets. Within the insured market, 62% of the lives were enrolled in community-rated products in the small group and non-group markets (Figure 5).

The exempt association segment in the small group market must also apply community rating within its own association. This means that the risk and claims experience for association members within a given association must be blended together to develop premium rates. Thus, with an exemption from BISHCA, an association can create its own rating pool and manage its risk pool and benefit structure. Health insurance rates available to small employers through an exempt association have historically been lower than those charged in the non-association small group market. However, those rates may also be higher when the association’s members have higher-than-average claims experience.

There are some differences between Vermont’s community rating laws for the small group and non-group markets. 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 are prohibited by statute from using age or gender variations when setting rates. For example, nonprofit hospital service corporations, like Blue Cross Blue Shield of Vermont, and nonprofit health maintenance organizations, like MVP Health Plan, may not vary premium rates based upon age or gender variations.

**FAQ #8: What does “experience rated” mean in Vermont?**

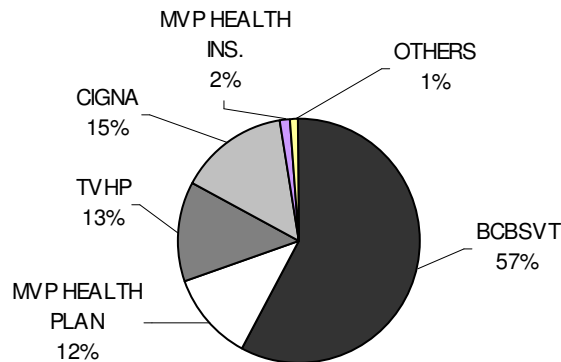
“Experience rated” or “merit rated” means that rates are based on the claims experience of the particular insured group. In Vermont, all large employer groups are experience rated. This means that premium rates for large employer groups are determined based on that group’s claims experience.

**FAQ #9: Who are the major private health insurers in Vermont?**

In 2007, Vermont insurers earned \$771 million in premiums for insured comprehensive major medical products. This estimate does not include self-insured employer plans, which accounted for approximately 97,670 Vermonters in 2007. 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 (57.7%), CIGNA (14.8%), The Vermont Health Plan (13.2%), and MVP Health Plan (11.8%). These four carriers accounted for 97% of the Vermont market for insured comprehensive major medical products in 2007 (Figure 6).

**Figure 6.**

**DISTRIBUTION OF EARNED PREMIUM BY HEALTH INSURANCE CARRIERS SERVING THE MAJOR MEDICAL MARKET: VERMONT, 2007**



Data Source: Annual Statement Supplement  
Note: Does not include Self Funded

Similar to the national trend, the comprehensive major medical health market in Vermont is concentrated with four insurers covering 97% of covered lives.<sup>14</sup> Over the last three years, Blue Cross Blue Shield of Vermont accounted for roughly 57% of all lives in the insured major medical market including nearly 75% of all lives in the non-group market.

**2007 Vermont Carriers by Market Segment  
Comprehensive Major Medical Insurance**

Insurer	Lives	% of Lives	Premium	% of Premium
<b>ALL INSURED PLANS (Total of Non-group, Exempt Association, Employer, Small Employer, Others)</b>				
BLUE CROSS BLUE SHIELD VT	107,881	53.2%	\$444,453,337	57.6%
MVP HEALTH PLAN	20,934	10.3%	\$91,106,823	11.8%
THE VERMONT HEALTH PLAN	26,735	13.2%	\$101,864,349	13.2%
CIGNA	40,432	19.9%	\$113,830,225	14.8%
OTHERS	6,819	3.4%	\$19,854,269	2.6%
<b>TOTAL</b>	<b>202,801</b>	<b>100.0%</b>	<b>\$771,109,003</b>	<b>100.0%</b>
<b>NONGROUP MARKET</b>				
BLUE CROSS BLUE SHIELD VT	6,371	71.1%	\$22,272,353	83.7%
MVP HEALTH INSURANCE CO.	2,450	27.3%	\$4,119,756	15.5%
OTHER	143	1.6%	\$202,354	0.8%
<b>TOTAL</b>	<b>8,964</b>	<b>100.0%</b>	<b>\$26,594,463</b>	<b>100.0%</b>
<b>EXEMPT ASSC. MARKET</b>				
BLUE CROSS BLUE SHIELD VT	65,817	69.0%	\$276,329,206	76.3%
CIGNA	17,188	18.0%	\$43,997,183	12.1%
THE VERMONT HEALTH PLAN	12,266	12.9%	\$41,371,225	11.4%
OTHER	144	0.2%	\$551,549	0.2%
<b>TOTAL</b>	<b>95,415</b>	<b>100.0%</b>	<b>\$362,249,163</b>	<b>100.0%</b>
<b>LARGE EMPLOYER MARKET</b>				
BLUE CROSS BLUE SHIELD VT	35,518	45.7%	\$144,217,504	49.8%
MVP HEALTH PLAN	12,183	15.7%	\$50,642,682	17.5%
THE VERMONT HEALTH PLAN	8,104	10.4%	\$34,202,438	11.8%
CIGNA	18,413	23.7%	\$48,018,951	16.6%
MVP HEALTH INSURANCE CO.	1,796	2.3%	\$6,782,031	2.3%
OTHER	1,627	2.1%	\$6,011,468	2.1%
<b>TOTAL</b>	<b>77,641</b>	<b>100.0%</b>	<b>\$289,875,074</b>	<b>100.0%</b>
<b>SMALL EMPLOYER MARKET</b>				
MVP HEALTH PLAN	8,737	44.4%	\$40,380,810	46.3%
THE VERMONT HEALTH PLAN	6,129	31.1%	\$25,279,415	29.0%
CIGNA	3,983	20.2%	\$17,955,439	20.6%
MVP HEALTH INSURANCE CO.	460	2.3%	\$1,220,290	1.4%
BLUE CROSS BLUE SHIELD VT	165	0.8%	\$1,456,547	1.7%
OTHER	207	1.1%	\$1,009,470	1.2%
<b>TOTAL</b>	<b>19,681</b>	<b>100.0%</b>	<b>\$87,301,971</b>	<b>100.0%</b>

Note: This chart 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.

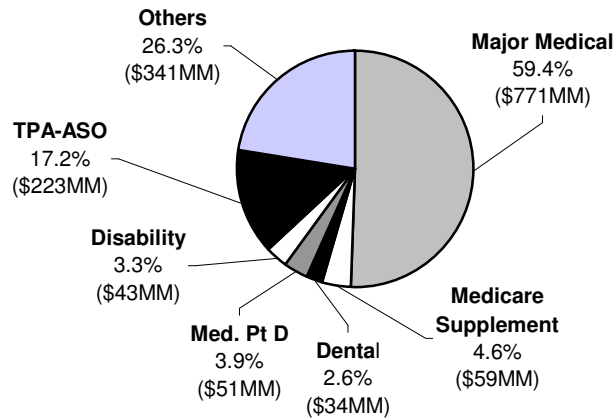
Data Source: 2007 Annual Statement Supplement

**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 for health care-related services. For example, Vermonters can purchase Medicare Supplement (sometimes referred to as Medigap), Medicare Advantage, disability, long-term care, dental, accident, student policies, specified disease and other limited benefit products. Of the \$1.3 billion in total earned premium reported by Accident & Health insurers in Vermont in 2007, comprehensive major medical insurance accounted for 59.4% (\$771 million). The following chart shows the distribution of other accident and health products in Vermont:

**Figure 7**

**DISTRIBUTION OF EARNED PREMIUM BY ACCIDENT AND HEALTH LINES OF BUSINESS: VERMONT, 2007**



Note: Does not include the self-funded market.

## NOTES

<sup>1</sup> “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.

<sup>2</sup> 2007 Annual Statement Supplement Report, Vermont Dept. of Banking, Insurance, Securities and Health Care Administration;; Medical Assistance Count, Office of Vermont Health Access; 2007 Population Estimates, U.S. Census Bureau.

<sup>3</sup> See # 2

<sup>4</sup> 2008 *Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2008. <http://ehbs.kff.org/PDF/7790.PDF>

<sup>5</sup> U.S. Agency for Healthcare Research and Quality. 2006 Medical Expenditures Panel Survey- Insurance Component. Available at:

[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2006/tiid1.htm](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiid1.htm)

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<sup>6</sup> U.S. Agency for Healthcare Research and Quality. 2006 Medical Expenditures Panel Survey- Insurance Component. Available at:

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<sup>7</sup> Vermont Department of Labor. 2005 Fringe Benefits. <http://www.vtmi.info/fringebene.pdf>

<sup>8</sup> U.S. Agency for Healthcare Research and Quality. 2006 Medical Expenditures Panel Survey- Insurance Component. Available at:

[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2006/tiib2a1.pdf](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiib2a1.pdf)

<sup>9</sup> 2008 *Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2008. <http://ehbs.kff.org/PDF/7790.PDF>

<sup>10</sup> U.S. Agency for Healthcare Research and Quality. 2006 Medical Expenditures Panel Survey- Insurance Component. Available at:

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[http://www.meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/state/series\\_2/2006/tiid3.htm](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiid3.htm)

<sup>11</sup> 2008 *Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2008. <http://ehbs.kff.org/PDF/7790.PDF>

<sup>12</sup> 2007 Annual Statement Supplement Report. Vermont Department of Banking, Insurance, Securities and Health Care Administration.

<sup>13</sup> 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.

<sup>14</sup> James C. Robinson. Consolidation And The Transformation Of Competition In Health Insurance. *Health Affairs*, Vol 23, Issue 6, 11-24.

## 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 policies that provide fully insured indemnity, HMO, PPO, POS or fee for service coverage for hospital, medical, and surgical expenses. This category **excludes** Short Term Medical Insurance (Mini Med), the Federal Employees Health Benefit Program and non – comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this document.

**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. HSAs 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:** To be eligible for a High Deductible Health Plan (HDHP) that qualifies under a Health Savings Account (HSA) in 2008, the deductible must be at least \$1,100 for an individual and \$2,200 for a family. The total out-of-pocket annual expense (including the deductible and other out of pocket expenses) can be no more than \$5,600 for an individual and \$11,200 for a family. (There are other requirements not detailed here). The maximum annual HSA contribution for 2008 is the lesser of 100% of the HDHP deductible or \$2,900 for an individual and \$5,800 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.

**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 Part D:** Created under the Medicare Modernization Act of 2003 (MMA), it is a voluntary outpatient prescription drug benefit for Medicare Beneficiaries that began in 2006. Medicare Part D does not need to be Licensed by the state of Vermont as it is Licensed by CMS.

**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 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.