

**Review of Draft Regulations for Catamount Health
Keller & Fuller, Inc.
7/20/2006**

What the Rule Says:	Our comment:
<p>Sec 3(g) defines community rating to allow for premium deviations among individuals based on incentives pursuant to rules adopted by the Commissioner relating to health promotion and disease prevention.</p>	<p>Act 191 allows “financial incentives” related to health promotion and disease prevention. This interpretation will allow carriers to use premium rates as one of those incentives. We strongly support this.</p>
<p>Sec 3 (l) defines “Network” to means “the network defined by the carrier in its Catamount Health policy, subject to approval of the Commissioner at his or her discretion.”</p> <p>Sec 8 (a) of the rules states that “benefits shall be delivered through a preferred provider organization (“PPO”) plan. Catamount Health carriers shall define their PPO within the parameters of commonly accepted industry practices, but such definition shall be consistent with the purposes of the Act and shall be subject to the approval of the Commissioner in his or her discretion.”</p>	<p>The combination of these two definitions gives the carriers broad latitude to set up their networks, consistent with law. This is significant because how the carriers contract with providers and set up their networks may be the only significant cost containment feature they are allowed, given the other restrictions in the law. We strongly support this.</p>
<p>Sec 3 (o)(iii) is the definition of “Uninsured individual” who is eligible for Catamount, and is almost literally from Act 191. However, the rules add that the category “shall not include an individual who would be entitled to Catamount Health coverage without being uninsured for 12 months under 8 V.S.A. § 4080f(a)(9)(A) if the carrier determines that such status was created primarily to obtain access to Catamount Health. Such carrier determination shall be subject to approval or denial of the Commissioner at the person or carrier’s written request. The Commissioner’s review shall be made pursuant to the procedures in Section 10 below.”</p>	<p>Bravo to BISHCA for this “You can’t fool us,” anti-crowd out provision. This says that if the carrier believes that someone is gaming to rules to become eligible in less than 12 months (i.e. the employer lays everyone off and then hires them back without insurance under another company name, making them “uninsured” because of a layoff), then the carrier can declare the person is not an “uninsured person.”</p> <p>This regulation is badly needed and we strongly support it.</p>
<p>Sec 6(e) relates to the pre-existing</p>	<p>Consistent with the emphasis on</p>

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<p>condition exclusion. Act 191 requires the standard exclusion to be waived for an individual who is enrolled in a chronic care management program. The draft regulations establish standards (parts A-D) by which carriers can judge whether someone qualifies for the waiver. Part (A) states participation shall mean individual has "indicated a willingness to become enrolled."</p> <p>Part (C) allows the carrier to place reasonable time limits for the insured to become enrolled.</p> <p>Part (D) states that qualifying participation in a chronic care management program shall not be premised on an individual achieving a specified health status, but it may be premised on specific participation obligations.</p>	<p>improved chronic care management, the law allows a waiver for persons who have a pre-existing condition, as long as they are participating in a management program.</p> <p>This proposed rule provides some guidance and authority on how carriers may enforce this important provision. Pre-ex condition exclusions, after all, are meant to prevent people from only becoming enrolled once they are sick, and disrupting the insurance mechanism. We strongly support these provisions.</p> <p>However, there may be an ambiguity created by potentially conflicting language in (A) and (D). According to (A), participation shall mean individual has "indicated a willingness to become enrolled." However, (D) allows the carrier to premise "participation" on "specific participation obligations." The final rule must resolve this ambiguity and give carriers clear standards that can be applied to all insureds.</p>
<p>Sec 7 (a), quoting Act 191, requires Catamount Health carriers to provide insureds access to chronic care management programs. The rule goes on to say that programs, subject to approval by the Commissioner, shall be "substantially similar to the chronic care management program established under" Act 191.</p>	<p>Because the requirements in the law are in large part what our carriers are already doing today in their disease management programs, the use of the term "substantially similar to" should allow the Commissioner to approve the chronic care management programs already in operation with only minor changes and little new expense.</p>
<p>Section 7 (c) states that Catamount health carriers may offer different benefit level plans for Catamount Health products, subject to Act 191 and other applicable laws.</p>	<p>As stated above, the specificity in the law provides little if any latitude for benefit design variations. However, to the extent that carriers can be creative and produce more cost effective plans that fit the law, they should have that opportunity. We strongly support this provision.</p>
<p>Section 8(i) allows carrier to provide a greater financial burden on an individual's access to treatment by the type of health care provider professional only if it is related to the efficacy or cost</p>	<p>This language is taken from Act 191, and must be carried forward in the regulations to allow carriers to use information on efficacy and cost effectiveness to hold down plan cost. We</p>

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effectiveness of the services, subject to the approval of the Commissioner.	strongly support this provision.
Sec 10 (a)(iii) states that an individual who loses eligibility for the employer sponsored premium assistance under 33 V.S.A. § 1974 shall be allowed to purchase Catamount Health without being uninsured for 12 months.	<p>Because one of the biggest dangers posed by Catamount is that it would “crowd out” private coverage, it’s important to build high walls around the plan. Enforcing the 12-month waiting period is crucially important to the sustainability of the plan.</p> <p>This language must be redrafted to make any waiver of the waiting period as narrow as possible. This could be accomplished by specifying the valid “triggering events” that would allow a waiver. For example, under this draft language, a person whose income increased thereby making them ineligible for premium assistance, could drop the employer plan and skip the 12-month waiting period. That is clearly not the intent of the statute or rules.</p> <p>We suggest adding to this section a repeat of the “triggering events” from the definition of uninsured that allow waiver of the 12 month waiting period for someone who previously had employer-sponsored coverage, e.g. (A) loss of employment; (B) death of the principal insurance policyholder; (C) divorce or dissolution of a civil union; (D) no longer qualifying as a dependent under the plan of a parent or caretaker relative. BISHCA should state these specific triggering events so that carriers have explicit guidance and the wall around Catamount and the state budget is maintained.</p>