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GREEN MOUNTAIN CARE BOARD

Overview and GMCB Authority: Commercial Health Insurance Reimbursement

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Background for today

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Health insurance premium	• The cost to a policy holder to maintain health insurance coverage, usually paid on a monthly basis. • Commercial insurance is usually provided through an employer or purchased through Vermont Health Connect.
Reimbursement	• The amount a medical provider receives for delivering medical care. • Often based on amounts negotiated between the provider and insurers and/or purchasers.
Medical claim	• Request from medical providers to insurers / administrators for payment for health care services delivered to a covered policyholder.

GMCB Health Insurance Rate Review: Covered Lives

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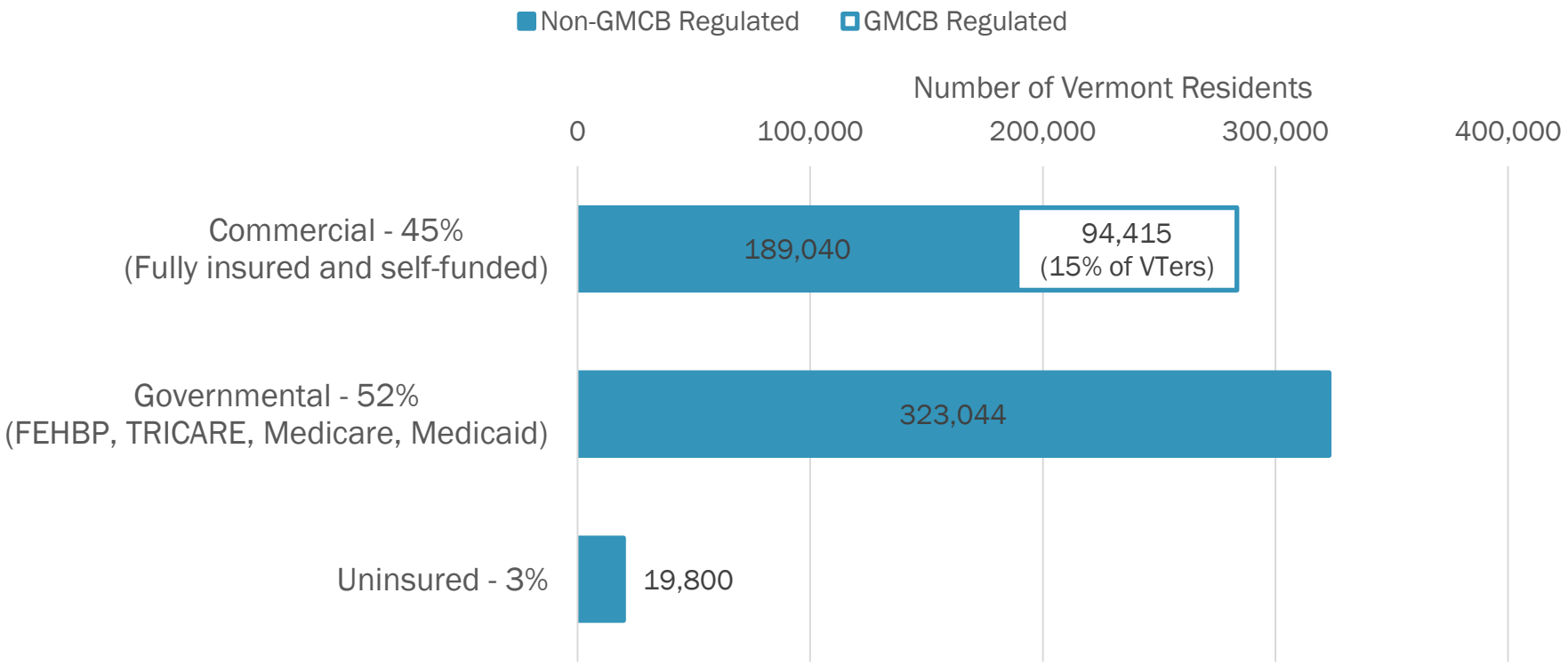
2018 Total Vermont Population: 626,299



FEHBP = Federal Employee Health Benefit Plan
TRICARE = Military employees

Data Source: 2018 Vermont Health Care Expenditure Analysis
https://gmcboard.vermont.gov/publications/expenditure

Premium Rate Increase: Unit Cost Trend

(VT Individual and Small Group PMPM example)

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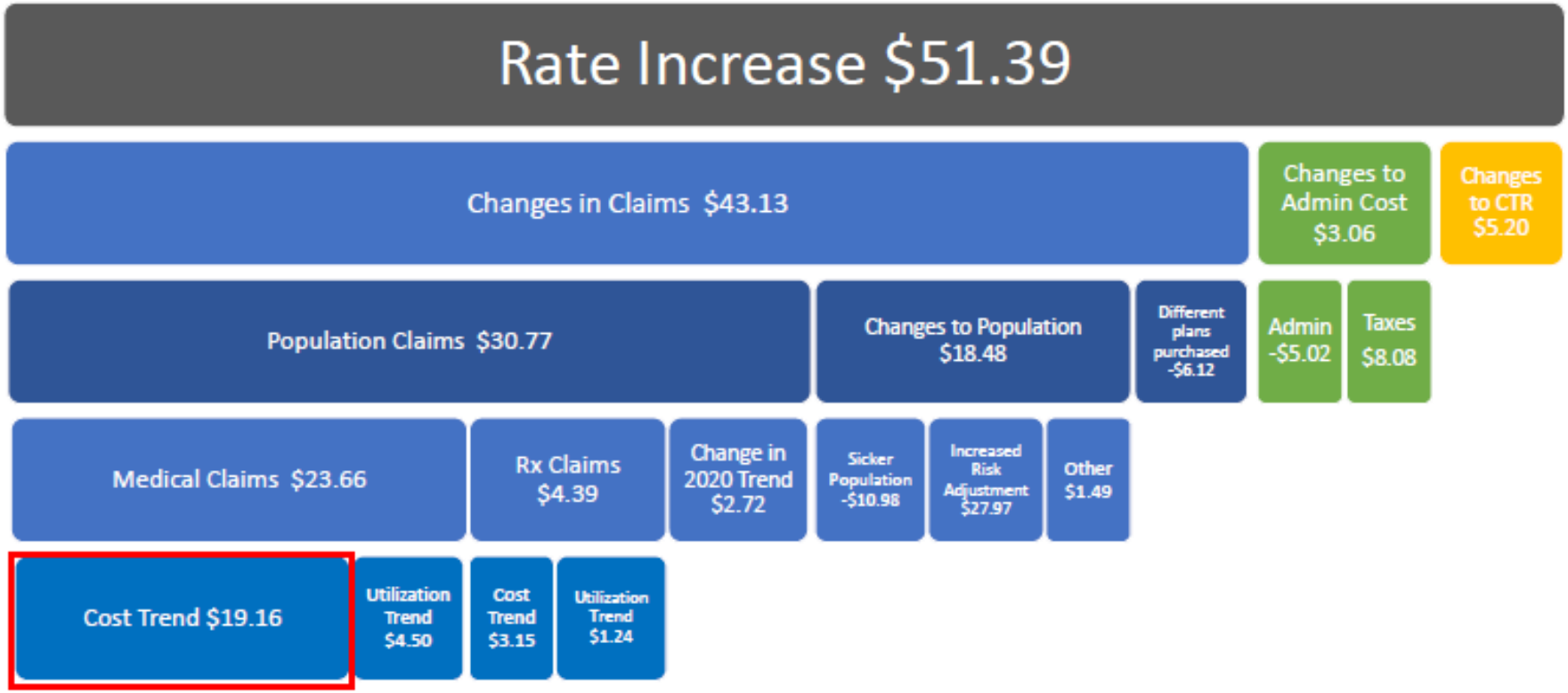

Insurance Rate Review: Unit Cost Trend

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The Board approves an average "unit cost trend" percentage increase for each rate filing.

- Approved unit cost trend – what is it?
  - The rate increase the insurer is permitted to add to its premiums to cover the increase in reimbursement rates the insurer expects to pay for members covered by the filing
- Approved unit cost trend – what is it not?
  - It does not set reimbursement rates between insurers and individual providers
- What is the purpose of the unit cost trend increase?
  - The unit cost trend increase approved by the Board is to adjust premiums to cover the anticipated reimbursement rate changes for insurers' payments to providers (both VT and out of state hospitals, FQHCs, independent providers) for outpatient, inpatient and professional services for members covered by the filing.

Reimbursement

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- Providers may receive payments based on:
  - Services delivered (i.e. fee-for-service)
  - Time period (e.g. per diem)
  - Episode / event (e.g. diagnosis-related group)
  - Individual (e.g. care coordination, capitation)

- The total reimbursement received by providers is often referred to as the *allowed amount*.

  Allowed amount = health insurer payment + expected patient payment

Reimbursement *is not…*

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- Charge/price: this is the amount requested by the provider to deliver a medical service

- Cost: this definition varies for different actors in the delivery system:
  - For **PATIENTS**: out-of-pocket obligation for medical care
  - For **PROVIDERS**: expenses incurred to deliver medical care
  - For **PAYERS**: expenses associated with medical care and administration of health insurance policy

Medical claim

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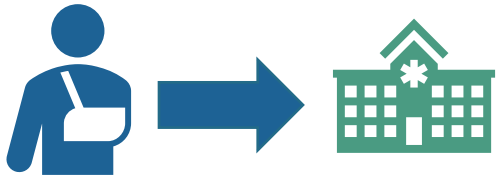
Patient share of reimbursement



Insurer share of reimbursement

Patient receives care from medical provider

Provider sends bill with requested amount (i.e. claim) to insurer or claims processor

Claim is reviewed to make sure patient is covered for the care

If covered, insurer's share of negotiated reimbursement is sent to the provider

Two main claim types

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Professional claims (CMS-1500)

- Services provided by trained professionals
- Charges associated with a *procedure*

Facility claims (UB-04)

- Resources used to provide medical care
- Charges associated with *revenue codes*

Professional claims

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- Each professional will submit a claim for the services they provided.
- The claim may span across time.
- Charges on the claim are associated with *line level procedure codes*.
- The procedure may include a *technical component* to cover supplies, equipment, and/or clinical staff.
- Charges differ based on the setting where the care was delivered.

Facility claims

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- Only one claim is permissible for the same patient, day, and facility covering all associated resources.
- Charges are associated with location and/or type of service provided at the facility, designated with a revenue code.
- Coding tends to be more complex and more information is found in the claim *header*.
- Reimbursement calculations may be much more complex.

Non-FFS Reimbursements

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Bundled/episode payments

- Reimbursement tied to a qualifying event (e.g. healthy newborn, FQHC encounter, joint replacement, dialysis)

Capitation

- A fixed payment associated with the care for a designated group of individuals

GMCB Enhanced Data Validation Project

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- Medical claims only include the amounts requested by providers and do not include the payments ultimately made (or subsequent adjustments).
- Therefore, the GMCB requests both the charges from the claims and actual reimbursement amounts in data submitted by payers to the state's All-Payer Claims Database, VHCURES.
- The GMCB is in the process of validating VHCURES's reimbursement data to see how it compares with:
  - Providers' records
  - Payers' financial data

Upcoming GMCB work

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- As required by Act 159 of 2020, the GMCB will be producing an interactive dashboard to show how reimbursement for certain services provided to Vermont residents vary based on the:
  - type of payer
  - provider
  - setting
- The initial report is slated for public release in February of 2022.