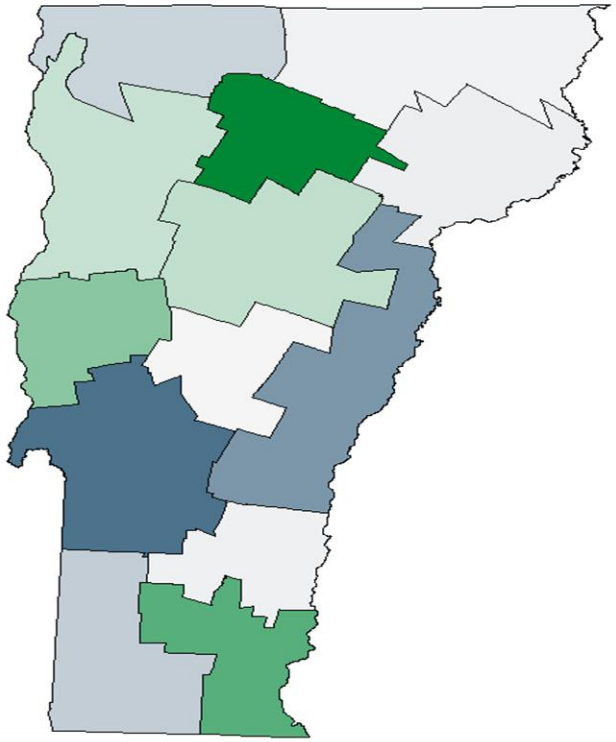

Rate Review 101

Presented by:

Green Mountain Care Board

Department of Vermont Health Access

Department of Financial Regulation

June 12, 2019

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GREEN MOUNTAIN CARE BOARD

Topics for Today

1. What is the difference between rate review for Large Groups vs Small Groups/Individuals?
2. What are the consumer trends and issues?
3. What are the components of a setting a premium rate increase?
4. Who regulates insurance plans and rate increases in Vermont?
5. What is the process for approving a plan/rate and implementing that plan/rate?
6. How do other regulatory processes and the federal landscape impact rates?

Vermont Insurance Market

Category	2017
Commercial Insured Market	
Insured Plans	
Individual	32,112
Small Employer	42,568
Merged Market	74,680
Large Employer	17,610
Association	
Large Group Market	17,610
Insured Market Subtotal	**92,290**
Self-insured Employer Plans	
Self-insured Employer Plans	182,972
Federal Employee Plan	14,604
Military	16,900
Self Insured Market Subtotal	**214,476**
VT residents covered by insurers outside VT	15,540
Other	**15,540**
Commercial Insured Market	**322,306**
Government Coverage	
Medicaid	150,375
Medicare	133,915
Government Coverage	**284,290**
Uninsured	
Uninsured	**19,800**
Total of Assigned Lives	**626,396**
Duplicated Count	**-2,739**
Total Vermont Population	**623,657**

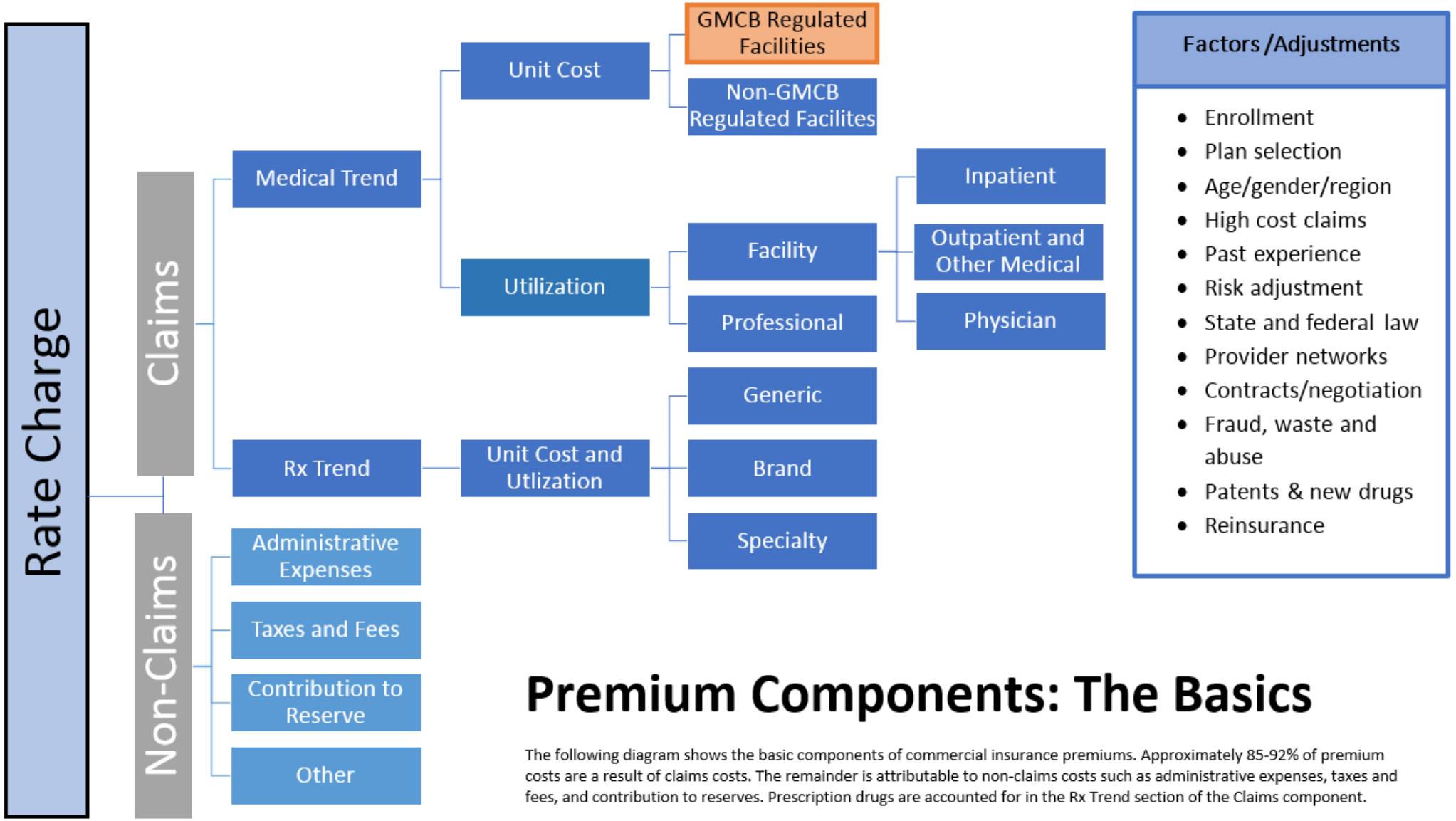
Chart Highlights:

- Data year: 2017
- Major Medical Insurance only
- Population of Vermont: 623,000
- Insurance Breakdown:
  - Government Market: 284,000 (Medicare/Medicaid)
  - Self Insured Market: 214,000 (Employer Plans)
  - Insured Market: 92,000 (GMCB Rate Review)
  - Other: 15,000 (non-VT insurance coverage)
  - Uninsured: 20,000

HCA : Consumer Issues & Trends

Differences Between Large & Small Group Rates

	Large Group	Small Group & Individuals
Definition	101 or more employees	100 employees or less & individuals
Approval Timeline	Throughout the year (number of filings vary year to year)	Rates filed in early May to ensure compliance with federal regulations for open enrollment in November (2 filings)
Type of Rate	Experience rated	Community Rated
Rate Effective Date	Varies by filing	January 1st
Plans offered	Outside Vermont Health Connect	Qualified Health Plans through VHC or outside VHC, including reflective silver plans
Subsidies available	No	Yes, for QHPs offered through VHC (not for small group, off exchange QHPs or reflective plans)
Covered Lives	~ 17,000	~ 75,000



Premium Components: The Basics

The following diagram shows the basic components of commercial insurance premiums. Approximately 85-92% of premium costs are a result of claims costs. The remainder is attributable to non-claims costs such as administrative expenses, taxes and fees, and contribution to reserves. Prescription drugs are accounted for in the Rx Trend section of the Claims component.

Timeline & Regulatory Roles

1) Health Plan Design & Compliance with Federal Parameters (DVHA)*
2) Health Plan Design Approval (GMCB)*
3) Form Filing Approval (DFR)
4) Rate Review
    1. Insurer Solvency Review (DFR)
    2. Rate Approval (GMCB)
5) Plan Certification (DVHA)*
6) Open Enrollment & Compliance with Federal Parameters (DVHA)*

* Small group and individual qualified health plans and reflective silver plans

Large Group Rate Review

Rate Review Process:

- Insurers file rates with GMCB - typically 4-6 months before rates will be effective
- The GMCB has 90 days to review and approve, modify or deny a rate:
    - Insurers provide an actuarial analysis to support the proposed rates
    - GMCB's actuary reviews the proposed rates and provides its analysis
    - DFR provides an analysis of the insurer's solvency
    - Hearings are typically waived, but the parties (insurers and the HCA) provide memorandums in support of their recommendations on the proposed rates
    - Board issues its decision around Day 90

Some items of note:

- Large group rates affect approximately 17,000 covered lives
- The GMCB only approves a manual rate for large group filings

Small Group & Individual Plans

DVHA: Annual Qualified Health Plan (QHPs) Design

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- **Oct – Jan**: DVHA convenes a stakeholder group (DVHA, issuer representatives, GMCB and DFR staff representatives, VT Legal Aid, DVHA Actuary) to discuss, select changes to standard plan benefits.
  - Implement new federal guidance (see next slide)
  - Stakeholders select first choice and alternative benefit changes from among multiple options
- **Jan – Feb**: DVHA presents a proposal of standard plan designs to Green Mountain Care Board
- **Jan – Feb**: GMCB formal approval of standard QHPs
- **Feb**: DVHA (via actuary) communicates standard plan design to QHP issuers

DVHA: Annual Federal Guidance

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Federal rules govern the design of qualified health plans

Source: Annual ***Notice of Benefit & Payment Parameters***:

- Includes an updated federal actuarial value calculator (AVC),
  - May update underlying health cost data
  - May update the services included within the calculator
- Defines compliant actuarial value (Range) for QHPs at each metal level
- Establishes the maximum out of pocket (MOOP) amount
- Provides other policy information, could impact QHPs

Rule is typically published in the fall and finalized early in the year prior to applicability. Rule delay complicates QHP process.

DFR: QHP FORM REVIEW

- Authority: 8 V.S.A. § 4062 – DFR reviews policy forms for major medical insurance
- Licensure and Good Standing
- Benefit Standards and Product Offerings
- EHB and State Mandated Benefits
  - Federal and State Statutes
- Annual Limitations on Cost Sharing
  - Summary of Benefits and Coverages
- Mental Health Parity – quantitative and non-quantitative measures
- Network Adequacy
  - I-2009-03 – Consumer Protection Quality Requirements Standards

DFR: SOLVENCY ANALYSIS

- Title 8 V.S.A. § 4062(a)(2)
  - DFR provides the GMCB analysis on and opinion on the impact of the filing as proposed on the filing insurer's solvency.
- Domestic v. Foreign Insurer
  - DFR primary regulation of Vermont domestic insurers
  - Rely primarily on oversight of other states for foreign companies' solvency

GMCB: Small Group & Individual Rate Review

Rate Review Process:

- Insurers file rates with GMCB in early May
- The GMCB has 90 days to review and approve, modify or deny a rate:
    - Insurers provide an actuarial analysis to support the proposed rates
    - GMCB's actuary reviews the proposed rates and provides its analysis
    - DFR provides an analysis of the insurer's solvency
    - Hearings are typically held toward the end of July
    - Board issues its decision around Day 90 (early August)

Some items of note:

- These rates affect approximately 75,000 lives
- Unlike the approval of only a manual rate during large group rate review, the rates approved for small groups/individuals will show the premiums paid by enrollees

DVHA: Annual QHP Certification

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- **August**: After rates are final, DVHA certifies plans for the benefit year.
  Issues letter of certification to QHP issuers by Sept 1.

Standards:

State law: 33 VSA § 1806. Commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.

Federal law: 45 CFR 155 Subpart K. Certification if plan meets minimum standards and is in the interest of qualified individuals; Exchange must complete the QHP recertification process no later than 2 weeks prior to the beginning of the open enrollment.

DVHA: Annual QHP Implementation

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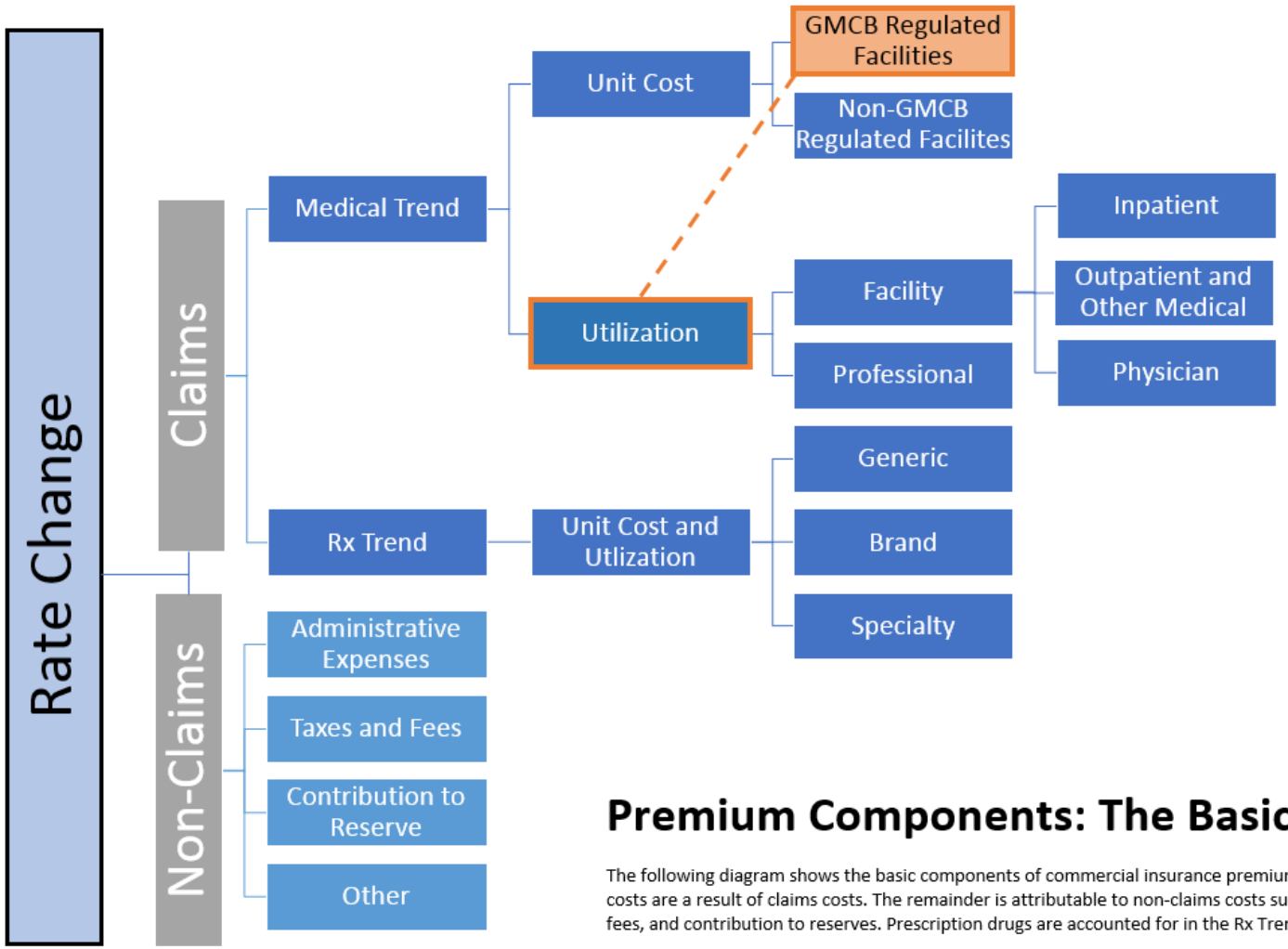
- **Aug-Oct**: Prepare consumer outreach and plan comparison materials for upcoming benefit year
- **Aug-Sept**: Complete data-entry of plan benefit and rate updates in to eligibility system
- **Aug-Sept**: Update subsidy calculation factors
- **Sept**: Complete system testing
- **Oct**: System must be ready to run annual redeterminations
- **Nov 1**: Open Enrollment

Regulatory Integration

Regulatory Integration: Effect on Premiums



Regulatory Integration of Hospital Budgets & Rate Review

Where we are now:

- Alignment of unit cost (GMCB regulated entities) review with hospital budget decisions

What's next:

- Better understanding of how data and utilization projections from GMCB regulated entities (2018 hospital budget data) informs rate review

Challenges in integrating the data from these two regulatory processes:

- Services covered = provided in different settings
- Patients served = different yet overlapping populations
- Timeframe = data covers different years

Premium Components: The Basics

The following diagram shows the basic components of commercial insurance premiums. Approximately 85-92% of premium costs are a result of claims costs. The remainder is attributable to non-claims costs such as administrative expenses, taxes and fees, and contribution to reserves. Prescription drugs are accounted for in the Rx Trend section of the Claims component.

Federal and State Landscape: Impact on Rates

State Laws: Individual Mandate

State Individual Mandate: Act 182 (2018) & H.524 (2019)

- New state laws to address to the concern that loss of the federal financial penalty for the federal individual mandate would negatively impact Vermonters' enrollment in health insurance.
    - **Act 182 (2018)** created a state individual mandate for health insurance coverage effective 1/1/2020 (no financial penalty)
    - **H.524 (2019)** would establish a reporting requirement for the state mandate (no financial penalty)

State Laws: Loss of CSR Funds

Loss of CSR Funding: Act 88 (2018) & Act 89 (2019)

Loss of Cost-Sharing Reduction funding in late 2017 would have resulted in significant premium increases for 2019 and 2020 plan years

- **Act 88 (2018)** created the option for off-exchange non-QHPs (reflective silver plans), allowing for "silver-loading" of QHP premiums
  - Result: increased subsidies and minimized impact of premium increases
- **Act 89 (2019)** creates the option for more reflective plans (platinum, gold, bronze, etc.) in case silver-loading is not permitted after the 2020 plan year

ASSOCIATION HEALTH PLANS – Timeline

- Federal and State Regulations
  - DOL Rule – June 2018
    - Expanded access to AHPs (Pathway 2)
  - State Regulations
    - Fully and self insured MEWAs/AHPs
- District Court – March 2019
  - Vacated DOL Rule
- DOL appealed but did not seek stay; DOL guidance very clear that AHPs have no safe harbor after PY2019

ASSOCIATION HEALTH PLANS- Status

- DFR Guidance – Bulletin 205
  - No new association health plans (Pathway 2) for plan year 2020
  - Existing association health plans formed under the DOL Rule can continue to operate for plan year 2019
    - No new member enrollment
    - No advertising

PENDING FEDERAL LITIGATION

- Texas et al v. United States of America et al
  - 5th Circuit Court of Appeals
- State of New York et al v. United States Department of Labor et al
  - Appeal pending in the Circuit Court of the D.C. – Expedited appeal but decision not expected until 2020
- Association for Community Affiliated Plans et al v. United States Department of the Treasury et al
  - Pending in the U.S. District Court, District of Columbia

Texas v U.S. – Individual Mandate

- Plaintiffs' Arguments
  - ACA Individual mandate tax penalty was eliminated
  - Stand-alone mandate without tax penalty is not supported by the Commerce Clause
  - Other ACA provisions are inseverable from the mandate, therefore injunction must apply to the rest of the ACA provisions i.e. guaranteed issue, community rating etc.
- Defendants' Arguments
  - Individual mandate penalty remains and production of revenue is not a constitutional requirement. The penalty can be characterized as a tax with a delayed effective date or suspension. Penalty payments will continue to raise revenue because liability for 2018 is not due until April 2019.
  - The Tax Cut and Jobs Act amendment to reduce the penalty to $0 is unconstitutional.
  - If the Individual Mandate as amended is found to be unconstitutional it is severable from the entire ACA.

Texas v U.S. - Status

- District Court's Opinion
  - Individual Mandate is "essential" to ACA and cannot be severed from remaining provisions
  - Cannot sever mandate from remainder of the law
  - Declared entire ACA invalid
- Appealed to 5th Circuit

New York v. U.S. – Association Health Plans

- Case considers lawfulness of the Department of Labor's 2018 Rule permitting individuals and small employers to form Association Health Plans and thereby avoid requirements of the Affordable Care Act.

New York v U.S. – Status

- District Court vacated DOL rule on AHPs
  - Rule is an "end run" around the ACA
- DOL has appealed decision to Circuit Court of D.C.
  - Did not request a stay
  - DOL has now issued written guidance (April and May 2019), and confirmed orally (June 2019) that there is "no comfort" for Pathway 2 AHPs after PY2019.

ACAP v. U.S. – STLDI

- Plaintiff's Arguments
  - Final rule exceeded agencies authority and discretion and circumvents ACA
  - Unreasonably interpreted "limited duration" to mean up to 3 years
- Defendant's Arguments
  - Congress did not define "short term, limited duration insurance" and left it up to the agencies to define
  - The final rule's provision to permit renewal of 36 months restricts duration and so is "limited." Prior ACA rule permitted unlimited extensions.

ACAP v. U.S. – Status

- Oral arguments
- Pending in District Court

Resources

GMCB – Rate Review:
https://ratereview.vermont.gov/

DVHA – Vermont Health Connect:
https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

DFR – Health Insurance:
https://dfr.vermont.gov/industry/insurance/health-insurance

Office of the Health Care Advocate:
https://vtlawhelp.org/health-insurance-rate-reviews