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GUIDANCE ON THE ASSESSMENT OF AFFORDABILITY IN THE REVIEW OF RATES

This document outlines the standards and processes by which the Green Mountain Care Board will assess the affordability of proposed health plan rates, pursuant to 8 V.S.A. § 4062(a)(3).

Health insurance has become increasingly expensive for Vermont families and employers. The average unsubsidized premium for an individual silver benchmark plan in 2024 is $11,400, representing almost 20 percent of household income for someone at 400 percent of the federal poverty level (FPL).[1] A Vermonter with employer-sponsored insurance pays, on average, $8,050 per year in premiums, well above the national average of $7,308 per year.[2]

Premiums reflect the prices of health care goods and services and the use of those goods and services. Vermonters use health care services relatively less than residents of other states: Vermont has the 5th lowest emergency room utilization in the country, and falls below the national average in the number of provider visits each year.[3] However, Vermonters spend more than residents of other states on personal health care services, averaging $12,756 per person in 2020, the 7h highest spending rate in the country.[4] This high rate of spending is driven in large part by the high prices Vermont's commercial issuers pay for health care goods and services. In the commercial market, issuers pay, on average, 161.6 percent of the Medicare rate for inpatient facility services and 261.7 percent of the Medicare rate for outpatient facility services.[5]

These high costs have very real impacts on Vermont families. In spite of our very low numbers of uninsured residents, 14.4 percent of Vermonters report that they have trouble paying medical

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[1] KFF, Average Marketplace Premiums by Metal Tier, 2018-2024, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; *see also* Vermont Health Connect "2024 Plan Designs & Premiums for Individuals and Families* (before any subsidies)," https://info.healthconnect.vermont.gov/sites/vhc/files/documents/2024_PlanDesigns_FinalRates.pdf.

[2] State Health Access Data Assistance Center (SHADAC) analysis of National Health Interview Survey data, State Health Compare, University of Minnesota, https://statehealthcompare.shadac.org/. Accessed February 7, 2024.

[3] SHADAC analysis of National Health Interview Survey data, State Health Compare, University of Minnesota, https://statehealthcompare.shadac.org/. Accessed February 5, 2024.

[4] KFF analysis of National Health Expenditure Data: Health Expenditures by State of Residence, https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Health%20Spending%20per%20Capita%22,%22sort%22:%22desc%22%7D. Accessed February 27, 2024.

[5] Whaley CM, Briscombe B, Kerber R, O'Neill B, and Kofner A, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1144-1.html.

bills, the 4th highest percentage in the country.[6] For those who remain uninsured, 51 percent report that cost is the main reason they do not have coverage, with another 21 percent reporting that cost is one of the main reasons.[7] Spending on health insurance and medical care crowds out family spending on housing, food, education, and other essentials. For employers, Vermont's high cost of health insurance reduces the amount they can spend on wages and invest in the growth of their businesses.

VERMONT HAS TAKEN NUMEROUS STEPS TO IMPROVE HEALTH CARE AFFORDABILITY

While health care spending poses significant challenges for Vermont families and their employers, Vermont has taken numerous steps to improve health care affordability. For example, Vermont makes health insurance more affordable by providing individuals and families who purchase coverage through Vermont Health Connect, and whose family income is below 300 percent FPL, with additional support for health insurance premiums and cost-sharing. This assistance supplements the federal assistance provided under the Affordable Care Act (ACA).[8] Vermont requires Vermont Health Connect issuers to offer standardized benefit designs which feature reduced consumer cost-sharing for key services. Vermont is also pursuing a policy of 'silver premium alignment' in the individual market like the one implemented in New Mexico.[9] In addition, the Board annually scrutinizes proposed rate increases for plans sold on Vermont Health Connect and other fully insured, state-regulated health plans and secures rate reductions when warranted.

Vermont has also acted on the underlying drivers of health care costs, such as the prices issuers pay for hospital care and the financial incentives that influence how providers deliver and manage care. For example, Vermont's All-Payer Model (APM) brings together Medicare, Medicaid, and commercial insurance under a payment structure that emphasizes high-value care and improved health outcomes, thus creating financial incentives for health providers to focus on quality and patient outcomes and reduce health care cost growth. Researchers looking at the APM's effect on Medicare spending, for example, determined that the APM reduced net Medicare spending per enrollee per year by nearly 6 percent in its first four years.[10] Vermont also promotes advanced primary care through the Blueprint for Health program, which supports Primary Care Medical Homes and other initiatives designed to transform care and promote the

[6] State Health Access Data Assistance Center (SHADAC) analysis of National Health Interview Survey data, State Health Compare, University of Minnesota, https://statehealthcompare.shadac.org/. Accessed February 5, 2024.
[7] Vermont Department of Health, "2021 Vermont Household Health Insurance Survey," https://www.healthvermont.gov/sites/default/files/documents/pdf/VT%20Household%20Health%20Insurance%20Survey%202021%20Report%205.6.22.pdf.
[8] 33 V.S.A. § 1812.
[9] New Mexico Office of Superintendent of Insurance, "2023 Individual and Small Group Market Rate Filing Guidance," https://www.osi.state.nm.us/wp-content/uploads/2022/04/2023PY-QHP-Issuer-Rate-Guidance_Final.pdf. *See also* Families USA and Axene Health Partners, "Misalignment between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges," March 2021, https://familiesusa.org/wp-content/uploads/2021/04/COV-2021-31_Gold-and-Silver-Report_4-9-21-002.final_.pdf.
[10] NORC at the University of Chicago, "Evaluation of the Vermont All-Payer Accountable Care Organization Model," https://www.cms.gov/priorities/innovation/data-and-reports/2023/vtapm-3rd-eval-full-report, accessed February 8, 2024.

health of all Vermonters.[11] The Board's annual review of Vermont hospitals' budgets also brings scrutiny to spending on hospital services, which represents 44 percent of total health care spending for Vermonters.[12]

In addition, Vermont was one of the first states to create an all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), which includes medical and pharmacy claims for commercially and publicly insured Vermonters. Research and analysis based on VHCURES data improves Vermonters' understanding of health inflation and price variation in Vermont's health care system, which strengthens Vermont's work to reduce cost growth.

Vermont health care stakeholders can take further steps to improve health care affordability for Vermont residents. Issuers can further invest in and expand access to critical primary care services, shift away from fee-for-service payment to methodologies that reward improved health outcomes and better population health, and push back on hospitals' demands for excessive reimbursement, while the state can hold issuers accountable for reducing health care costs for Vermonters. At the same time, Vermont faces certain obstacles to improving health care affordability. For example, the ACA's rules on actuarial value—the proportion of average costs for covered benefits a plan is required to pay for—constrain the ability of both state regulators and state issuers to create new cost-sharing designs that limit consumers' exposure to significant health care costs.

A STANDARD FOR RATE AFFORDABILITY IN THE INDIVIDUAL AND SMALL-GROUP MARKETS

Under Vermont law, the Green Mountain Care Board must assess whether a rate is affordable, promotes quality care, promotes access to health care, and is not "unjust" or "unfair."[13] To support this assessment, the Board may request, and issuers must provide, provider "fee schedules, payment methodologies, and other payment information specified by the Board."[14]

The criteria by which the Board must assess rates are interrelated and often in tension with one another and the Board's stated goal is "to balance [these criteria] as best we can in light of the facts and circumstances before us."[15] This balancing, however, is hampered by the absence of a clear and consistent standard by which to assess the affordability of proposed premium rates.

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[11] Agency of Human Services, "Annual Report on Blueprint Health," https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/2023-Blueprint-for-Health-Annual-Report.pdf, accessed February 9, 2024.

[12] KFF analysis of National Health Expenditure Data: Health Expenditures by State of Residence, https://www.kff.org/other/state-indicator/health-spending-per-capita-by-service/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22vermont%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Hospital%20Care%22,%22sort%22:%22desc%22%7D, accessed February 8, 2024.

[13] 8 V.S.A. § 4062(a)(3).

[14] 8 V.S.A. § 4062(b)(3)(A).

[15] *See e.g., In re: Blue Cross Blue Shield of Vermont 2024 Individual and Small Group Rate Filings,* GMCB-002-23rr & GMCB-003-23rr, Decision and Order (Aug. 7, 2023), 20.

The Board is therefore proposing to define an affordability standard that it will integrate into its review of proposed individual and small-group market rates. An affordability standard for large-group market rates is under consideration and will be addressed in future guidance.

Beginning with proposed plan year 2025 individual market rates, the Board will assess whether the required amount a policyholder must pay in premium for the issuer's standardized plans for each metal level, net of any premium tax credit or state subsidy, exceeds the most recent required contribution percentage for health insurance premiums established by the federal Internal Revenue Service (IRS), currently set at 8.39 percent of household income.[16] [17] The Board will also assess whether the combined deductible exceeds 5 percent of household income.[18]

Beginning with plan year 2025 small group market rates, the Board will assess whether the expected employee premium contribution for the issuer's standardized plans for each metal level exceed the most recent required contribution percentage threshold established by the IRS, currently set at 8.39 percent of household income. The expected employee contribution will be determined by the most recent share of full premiums borne by Vermont employees as published in the most recent Medical Expenditure Panel Survey; on average, Vermonters employed by establishments with less than 50 employees could expect to pay 30.1 percent of their self-only premium, 33.2 percent of a single + one premium, and 38.2 percent of their family's premium in 2022.[19] The Board will also assess whether the combined deductible exceeds 5 percent of household income.

APPLICATION TO PROPOSED RATES

In the individual market, the Board will review an issuer's standardized plans for each metal level and will deem a proposed rate unaffordable if an individual policyholder, net of any premium subsidy, must pay more than 8.39 percent of household income in premiums for the plan or if the plan's combined deductible exceeds 5 percent of household income.

In the small group market, the Board will review an issuer's standardized plans for each metal level and will deem a proposed rate unaffordable if:

for self-only coverage, 30.1 percent;

for single + one coverage, 33.2 percent; or

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[16] Internal Revenue Service, Rev. Proc. 2023-29, https://www.irs.gov/pub/irs-drop/rp-23-29.pdf.

[17] The IRS Affordability Standard was established for 2014 Exchange plans at 9.5 percent—at the time the upper limit of premium tax credits for individual plans covering households with an income between 300 and 400 FPL. It has since been annually indexed to the rates of premium growth relative to the rates of income growth in National Health Expenditures data.

[18] There are multiple metrics that could be used to assess the affordability of premiums and plan cost-sharing for Vermont households. To determine premium affordability, the Board chose the required premium contribution percentage established in the Affordable Care Act because it is a well-established and widely understood metric, is updated annually, and is relatively simple to operationalize. To assess the affordability of plan cost-sharing, the Board chose measures of underinsurance adapted from the Commonwealth Fund's health care affordability tracking survey, https://www.commonwealthfund.org/series/affordability-tracking-surveys.

[19] Medical Expenditure Panel Survey, Insurance Component. https://datatools.ahrq.gov/meps-ic/#table-series.

for family coverage, 38.2 percent

of the total premium for the plan exceeds 8.39 percent of household income or if the plan's combined deductible exceeds 5 percent of household income. Household-level thresholds for total premium will be drawn from the most recent data available from the Medical Expenditure Panel Survey.[20]

Federal poverty levels (FPLs), also called federal poverty guidelines, are released each January by the U.S. Department of Health and Human Services.[21] For plan year 2025, the required percentage contribution will be determined according to the 2024 FPLs table below:

% of FPL	**Annual Income for Household Size*:**			
	1	2	3	4
100%	$15,060	$20,440	$25,820	$31,200
150%	$22,590	$30,660	$38,733	$46,800
200%	$30,120	$40,880	$51,640	$62,499
250%	$37,650	$51,100	$64,550	$78,000
300%	$45,180	$61,320	$77,460	$93,600
350%	$52,710	$71,540	$90,370	$109,200
400%	$60,240	$81,760	$103,280	$124,800

**U.S. Department of Health & Human Services, 2024 Poverty Guidelines for the 48 Contiguous States and the District of Columbia*

For plan rates deemed unaffordable, the Board will order (a) rate adjustments, (b) smaller contributions to reserves, (c) premium adjustments for some or all metal levels, and/or (d) any other modifications of the rate factors driving premium increases that the Board concludes are reasonably within the issuer's control, to the extent possible within statutory and solvency constraints.

For plan year 2026 and beyond the Board plans to promulgate rules to enforce requirements that rates are affordable, promote quality care, promote access to health care, and are not unjust or unfair.

[20] Percent of total premiums contributed by employees enrolled in single, employee-plus-one, or family coverage at private-sector establishments that offer health insurance by firm size (Less than 50 employees) and state (Vermont). (Table II.D.3, Table II.E.3, and Table II.F.3)

[21] Federal Poverty Guidelines. U.S. Department of Health and Human Services. https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines