State of Vermont
Green Mountain Care Board
144 State Street
Montpelier VT 05602

Report to the Legislature

REPORT ON THE TOTAL AMOUNT OF ALL EXPENSES ELIGIBLE FOR ALLOCATION PURSUANT TO 18 V.S.A. § 9374(h) AND THE TOTAL AMOUNT ACTUALLY BILLED BACK TO REGULATED ENTITIES DURING STATE FISCAL YEAR 2021

In accordance with 18 V.S.A. Sec. 9374(h)(5)(A)

Submitted to the
House Committee on Appropriations; the Senate Committee on Appropriations; and the Joint Fiscal Committee

Submitted by the
Green Mountain Care Board

September 15, 2021

Introduction

Title 18, section 9374 of the Vermont Statutes Annotated requires that the Green Mountain Care Board (Board) and the Vermont Department of Financial Regulation (Department) prepare a report showing "**the total amount of all expenses eligible for allocation pursuant to subsection (h) during the preceding State fiscal year and the total amount actually billed back to the regulated entities during the same period."** 18 V.S.A. § 9374(h)(5)(A). The Board and the Department must submit this report annually on or before September 15 to the House and Senate Committees on Appropriations. *Id.* The Board and the Department must also provide this information to the Joint Fiscal Committee at its September meeting. 18 V.S.A. § 9374(h)(5)(B). The report is listed on the non-action portion of the Joint Fiscal Committee's September meeting agenda, and is being submitted to satisfy that agenda item as well as 18 V.S.A. § 9374(h)(5)(B). Because the Department's billback is no longer governed by 18 V.S.A. § 9374(h), this report is being submitted on behalf of the Board only.

Background

In 1996, the Legislature first conferred billback authority to the Health Care Authority as a means of funding its duties and activities. When the Health Care Authority moved into the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), this authority was transferred to BISHCA (now the Department).

In 2012, the Legislature authorized the newly-formed Board to bill back to hospitals and insurance carriers the costs of certain activities related to health care system oversight. 2012, No. 171 (adj. sess.), § 5. The law provided that "[e]xpenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts" that are authorized by either the Department or the Board would be borne according to the following allocation:

- 40 percent by the State;
- 15 percent by the hospitals;
- 15 percent by nonprofit hospital and medical service corporations;
- 15 percent by health insurance companies; and
- 15 percent by health maintenance organizations.

18 V.S.A. §§ 9374(h)(1), 9415(a) (2012). In other words, for each dollar that the State billed back pursuant to this statutory authority, the regulated entities, as a group, would pay 60 cents, with the State remaining responsible for the other 40 cents.

In a February 2013 report, the Board and the Department advised the Legislature that since the inception of the billback authority, the State had not billed back the full scope of expenses made eligible by the authorizing legislation; for example, in fiscal year 2013 (FY13), the Department and the Board billed back for $395,117, although eligible regulatory activities exceeded $3 million and the regulated entities' full percent share would have been at least $1.8 million. In response, the Legislature mandated annual reporting and gave the Board and the Department discretion over the scope and the amount of the billback. 2013, No. 79, §§ 37a - 37c. The Legislature also expanded the scope of the billback to include funding for the Office of the Health Care Advocate (HCA). *Id.* at § 37d. Finally, the Legislature required the Department to

transfer one position and its associated funding to the Department of Health for the purpose of administering the hospital community reports in 18 V.S.A. § 9405b and to continue to collect funds for the publication of these reports under its billback authority. *Id.* at § 50(c).

In 2015, the Legislature repealed the statute giving the Department billback authority, 18 V.S.A. § 9415, while leaving intact the Board's authority under 18 V.S.A. § 9374(h) to continue to utilize the 60/40 billback formula "if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State." 2015, No. 54, § 61.

Effective July 1, 2016, the Legislature established a specific allocation for the billback of expenses incurred by the HCA for services related to the Board's and the Department's regulatory and supervisory duties. 2016, No. 134, § 28. The allocation is as follows:

- 27.5 percent by the State from State monies;
- 24.2 percent by the hospitals;
- 24.2 percent by nonprofit hospital and medical service corporations licensed under chapters 123 and 125 of Title 8 of the Vermont statutes; and
- 24.2 percent by health insurance companies licensed under chapter 101 of Title 8.

18 V.S.A. § 9607(b)(1).

In 2017, the Legislature changed the allocation of the Board's billback to hospitals and insurance carriers "for fiscal year 2018 only." 2017, No. 73, § 15a. The law provided that eligible expenses would be borne:

- 40 percent by the State;
- 15 percent by the hospitals;
- 45 percent by nonprofit hospital and medical service corporations; health insurance companies; and health maintenance organizations.

As the fiscal year 2018 billback allocation change expired June 30, 2018, effective July 1, 2018 the Legislature amended section 9374(h) of Title 18. The legislation authorized the Board to assess and collect from each regulated entity the actual costs incurred by the Board in carrying out its regulatory duties. It also changed the billback allocation for other expenses as follows:

- 40 percent by the State from State monies;
- 30 percent by the hospitals;
- 24 percent by nonprofit hospital and medical service corporations; health insurance companies; and health maintenance organizations;
- six percent by certified accountable care organizations.

2018, No. 167, § 17.

The Board deposits monies it receives from regulated entities in the Green Mountain Care Board Regulatory and Administrative Fund, which provides financial support for the Board's operations. 18 V.S.A. § 9404(d). This special fund "may also be used by the Department of

Health to administer its obligations, responsibilities, and duties as required by chapter 221 of [title 18],” and since the Department of Health assumed responsibility for hospital community reports in 2013, the Legislature has appropriated money from the fund to support this activity. In 2020, the Legislature reinstated the Board’s billback authority under 18 V.S.A. § 9374 (h)(1) for the hospital community reports. 2020, No. 88, Sec. 67.

Fiscal Year 2021 Billback

In FY21, the Board billed back approximately $4,466,296, as shown in Tables 4 and 5 of this report. This represented the FY21 budgeted billback of $5,045,980 less a credit of $579,685 for FY20 actual versus budget. The Board’s FY20 and FY21 expenses were under budget due to the pandemic. Given the complexity of prior year reconciliations, the Board is working with Finance and Management on the possibility of billback based on actuals instead of budget.

The FY21 net billback was $456,204 above the FY20 net billback. Below, Tables 1, 2 and 3 show the breakdown among the hospitals, insurance companies, and the accountable care organization, that can be billed under 18 V.S.A. § 9374(h) and 18 V.S.A. § 9607.

Table 1: Hospital Assessment FY21

HOSPITAL	Amount Billed FY21
Brattleboro Memorial Hospital	$ 69,991
Grace Cottage Hospital (Carlos Otis)	$ 15,611
Central Vermont Medical Center	$ 173,329
Copley Hospital	$ 55,825
Gifford Medical Center	$ 41,708
Mt Ascutney Hospital	$ 42,372
Northeastern Vermont Regional Hospital	$ 70,567
North Country Hospital	$ 67,192
Northwestern Medical Center	$ 88,769
Porter Medical Center	$ 70,797
Rutland Regional Medical Center	$ 214,312
Southwestern Vermont Medical Center	$ 136,619
Springfield Hospital	$ 39,492
University of Vermont Medical Center	$ 1,070,967
Total	$ 2,157,551

Table 2: Insurance Carrier Assessment FY21[1]

CARRIER	Amount Billed FY21
Blue Cross and Blue Shield of Vermont	$ 1,326,214
MVP Health Plan Inc	$ 337,985
Cigna Health and Life Insurance Company/Connecticut General Life Ir	$ 129,781
The Vermont Health Plan, LLC	$ 29,564
Metropolitan Life Insurance Co	$ 42,501
UnitedHealthcare Insurance Company	$ 26,059
Aetna Life Insurance Company	$ 12,482
QCC Insurance Company	$ 1,916
MVP Health Insurance Company	$ 1,526
State Farm Mutual Automobile Insurance Company	$ 1,295
United States Life Insurance Company in the City of New York	$ 208
AXA Equitable Life Insurance Company	$ 187
Trustmark Insurance Company	$ 158
New York Life Insurance Company	$ 152
Unified Life Insurance Company	$ 151
The Prudential Insurance Company of America	$ 150
Total	**$ 1,910,328**

Table 3: Accountable Care Organization Assessment FY21

ACO	Amount Billed FY21
One Care Vermont	$ 398,416

Table 4 shows the Board's billback calculations under 18 V.S.A. § 9374(h) and 18 V.S.A. § 9607.

[1] Amounts billed back to carriers under 18 V.S.A. § 98374(h)(2)(A)(iii) are based on each company's percentage of total "earned premium". Earned premium is reported annually to the Board by the carriers. Invoices were sent out on 2/18/21 and Metropolitan Life paid their invoice on 5/3/21. Board staff subsequently discovered that Metropolitan Life had submitted incorrect "earned premium" information for the FY21 calculation. At the Board's request, Metropolitan Life submitted updated earned premium information on 5/27/21 and on 6/8/21 the Board issued a full refund. Metropolitan Life will receive an invoice for the appropriate FY21 amount at the same time as billback invoices are issued for FY22 and the balance will be allocated to the rest of the carriers based on "earned premiums".

Table 4: FY21 Billback Detail

CALCULATION OF ASSESSMENTS (h)(1) Direct Expenses based on FY20 Actuals	Salaries, Benefits & Contracts	
ACO	$ 43,507	
HMO, HMS & Insurer	256,092	
Hospitals	265,706	
Direct Expenses Total	$ 565,305	
Note: up to 60% of actual cost. ACO contract dollars not directly billed back under Direct Expenses are allocated per (h)(2) Data & Hospital Assessment below. Remaining 40% = state (general) funds		
CALCULATION OF ASSESSMENTS (h)(2) Based on FY21 Budget		
Data & Hospital Budget Assessment		
ACO	$ 344,003	10%
HMO, HMS & INSURER - per statute	1,376,011	40%
Hospitals	1,720,014	50%
DATA (less HCA and VDH) TOTAL	$ 3,440,029	60%
Note: remaining 40% = state (general) funds		
HCA Data Assessment		
HMO	$ -	0.0%
HMS (currently only BCBS VT)	$117,300	24.2%
Insurer	$117,300	24.2%
Hospitals	$117,300	24.2%
DATA (HCA only) TOTAL	$ 351,900	72.5%
Note: remaining 27.5% = state (general) funds		
GRAND TOTAL	**$ 4,466,296**	

The Health Care Advocate expenses are allocated per 18 V.S.A. § 9607(b). The hospitals are assessed per 18 V.S.A. § 9374(h). Hospital calculations were based on budgeted acute admissions through FY19; budgeted Net Patient Revenue (NPR) in FY20; and actual NPR in FY21 (based on 2019 Actual NPR). Insurance carriers are assessed per 18 V.S.A. § 9374(h). The assessment is for those insurers licensed to do business in Vermont. Insurance carrier calculations were based on earned premium (FY21 based on 2019 ASSR). The ACO was assessed in FY21 per 18 V.S.A. § 9374(h) with a portion of ACO direct expenses deducted first per 18 V.S.A. § 9374(h)(1) and the balance of assessment calculated per 18 V.S.A. § 9374(h)(2). Table 5 shows the amounts the Board billed from FY14 through FY21.

Prior to FY20, the billback was lower because the Board received alternate funding from Special Funds, which included Global Commitment. For FY19, Global Commitment comprised

31% of the Board's total appropriation. 2018 Special Session, No. 11, § B.345. The Board's FY20 and subsequent appropriations did not include any Global Commitment funds. 2019, No. 72, § B.345.

Table 5: Billback History

GMCB Industry and HCA Billback (in thousands)								(excludes CON, Community Hospital Reports & Quality/VPQHC)		
Organization Name	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**		
								(h)(1)	**(h)(2)**	**Total**
Brattleboro	8	13	13	14	24	38	63			70
Grace Cottage (Carlos Otis)	1	2	1	1	2	4	14			16
CVMC	15	28	32	38	59	100	156			173
Copley	8	12	14	15	26	46	52			56
Gifford	6	10	11	12	19	28	38			42
Mt Ascutney	2	3	3	3	5	10	39			42
Northeastern	6	10	11	12	19	34	63			71
North Country	7	11	12	13	20	33	60			67
Northwestern	11	19	20	24	37	61	84			89
Porter	8	13	14	14	22	36	63			71
Rutland	28	46	49	57	89	167	192			214
Southwestern	19	32	30	30	48	84	124			137
Springfield	10	17	18	18	28	49	35			39
UVMMC	94	150	158	169	275	470	966			1,071
Total for Hospitals	$ 223	$ 369	$ 387	$ 421	$ 673	$ 1,158	$ 1,948	$ 266	$ 1,892	$ 2,158
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Blue Cross and Blue Shield of Vermont	$ 223	$ 369	$ 387	$ 421	$ 1,471	$ 809	1,250	116	1,210	1,326
MVP Health Plan Inc	53	9	107	122	111	60	206	112	226	338
MVP Health Insurance Company	82	244	237	223	122	84	83		-	-
The Vermont Health Plan, LLC	141	360	280	176	61	23	29	3	26	30
Cigna Health and Life Ins Co	5	63	106	129	-	-	-	-	-	-
Connecticut General Life Insurance Con	115	23	5	0	-	-	-	-	-	-
Cigna Health and Life Ins Co/Connectic	-	-	-	-	81	49	78	25	105	129
UnitedHealthcare Insurance Company	16	11	20	35	23	23	15		26	26
Aetna Life Insurance Company	17	14	12	24	18	16	30		12	12
MVP Health Services Corp	-	-	-	-	6	-	-		2	2
4 Ever Life Insurance Company	0	0	3	4	3	1	-		-	-
State Farm Mutual Automobile Insuranc	1	1	1	2	2	2	1		1	1
QCC Insurance Company	3	3	3	4	2	-	2		2	2
Metropolitan Life Insurance Company [2]									43	43
New York Insurance Company										-
MVP Health Insurance Company of Ne	11	9	-	-	-	-	-		-	-
All Other	2	1	0	-	-	2	3		1	1
Total for Insurers	$ 668	$ 1,106	$ 1,160	$ 1,139	$ 1,900	$ 1,069	$ 1,696	$ 256	$ 1,654	$ 1,910
										-
Total ACO	$ -	$ -	$ -	$ -	$ -	$ 208	$ 366	$ 44	$ 355	$ 398
Grand TOTAL	**$ 891**	**$ 1,474**	**$ 1,546**	**$ 1,560**	**$ 2,573**	**$ 2,435**	**$ 4,010**	**$ 565**	**$ 3,901**	**$ 4,466**

The amounts billed back to industry demonstrate the Board's commitment to utilize its billback authority consistent with legislative intent. While the Board acknowledges the need to defray certain categories of expenses through the billback function, however, it also acknowledges that it must utilize its discretion when appropriate to limit the burden on regulated entities, which ultimately pass these expenses on to Vermont health care consumers. The Board will continue its work to maximize funding from other sources when available,

including federal grants, for activities that may otherwise be funded through the billback function. In other words, to the extent an expense eligible for billback is being funded through federal or other grants, the Board uses its discretion under 18 V.S.A. § 9374(h) to exclude those dollars from the billback actually charged to industry.