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April 9, 2024

Owen Foster, Chair
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

RE: HCA Comment regarding the Green Mountain Care Board's Proposed Guidance on the Assessment of Affordability in the Review of Rates

Dear Chair Foster and Members of the Green Mountain Care Board:

The Office of the Health Care Advocate (HCA) thanks the Green Mountain Care Board (Board) for their development of the draft rate review affordability guidance (Guidance). Adopting the Guidance would be a major step toward adopting health insurance rate regulation that is informed by the real challenges Vermonters face paying for health insurance and health care.

The HCA supports the creation of an affordability standard which encompasses both the premium households pay and the deductible exposure they face, as is proposed in the Guidance. We also agree that the metrics for assessing affordability incorporated into the Guidance are appropriate.

At the same time, there are substantial complexities attendant to the calculation of the Advanced Premium Tax Credit (APTC) benchmark plan, the interaction of Cost Sharing Reduction (CSR) plans and other qualified plans, the interaction of adult Medicaid and children's Medicaid (Dr. Dynasaur or Dr. D) and subsidies, the assumptions needed to make such calculations, and the policy considerations of calculating current versus future plan affordability. Proper implementation of the Guidance will likely take ongoing collaboration among the stakeholders to the rate review process. We provide the technical implementation issues we have thus far identified in Appendix A.

Finally, we encourage the Board to consider the timing of the Guidance implementation. Proposed rates for 2025 will be filed next month. Given the short timeframe, the complexity and scale of the task, and the imperative to get this right, the Board may want to consider partial implementation this year—perhaps just a subset of plans—with an eye toward full implementation next year.

Thank you for your consideration.

/s/ Mike Fisher, Chief Health Care Advocate /s/ Eric Schultheis, Staff Attorney

Appendix A

We list some initial Guidance implementation concerns below. Guidance implementation should result in a reproducible affordability metric that accords with the experiences of Vermonters. None of the concerns listed below should hinder successfully implementing the Guidance. They are all issues that can be remedied by stating assumptions and/or implementing calculations that can be done in Microsoft Excel.

1. Standardized Plans

First, the Board should define "standardized plans." If standardized plans means just the plans that have the same design across carriers, we are unclear why the Board would not assess the affordability of all the qualified health plans. The Board's rate setting powers cover all plans sold on the Exchange. Further, all qualified health plans are considered when determining the APTC benchmark plan, not just the plans that have the same design across carriers.

2. Medicaid Eligibility Threshold

We recommend that the Board only calculate plan affordability for households above the Medicaid income-eligibility threshold. Relatedly, the Board should specify that it uses the Medicaid income-eligibility threshold that is used by Vermont Health Connect (VHC), i.e. 138%, which is equal to 133% plus a 5% income disregard. Although there is a possibility that a household would be income-eligible for Medicaid but fail some other Medicaid eligibility criterion (likely related to immigration status), we consider the possibility small. However, the Board may want to contact the Department of Vermont Health Access for data about how frequently households below 138% FPL purchase qualified health plans.

3. Plan Deductibles

The Board should clarify how it intends to resolve two issues related to Plan deductibles. One issue is how the Board calculates the deductible for plans that do not have a combined prescription and medical deductible. The Board could deem a non-combined deductible as just the medical portion of deductible, or it could implement the Guidance such that the sum of the medical deductible and the prescription deductible is a plan's deductible. When looking at affordability, the HCA applies the second option when looking at plans with non-combined deductibles, i.e. total deductible exposure equals the medical deductible plus the prescription deductible.

Another issue arises when deductible exposure for both stacked and aggregate deductible plans is calculated. With an aggregate deductible, the household must meet the deductible before the insurance plan pays benefits. With a stacked deductible, the insurance plan pays benefits to each household member who meets an individual deductible and to any household member once the household meets the household deductible. The HCA has not dealt with this deductible variety issue, as we have only examined the affordability of plans with an aggregate deductible. However, accurate implementation of the guidance will require accounting for whether a plan utilizes stacked or aggregate deductibles.

4. Vermont Premium Assistance

In accounting for Vermont Premium Assistance (VPA), the Affordability Template allows VPA to reduce the patient share amount below 0%. VPA cannot, however, reduce the patient share amount below 0%. We believe this issue affects cells I6-7, I15-16, I24-25, and I33-34. Using cell I6 as an example, one solution could be to use a conditional statement to set the total adjusted premium (TAP) multiplied by a household's income to $0 if said amount would be less than $0.

5. Impact of Dr. Dynasaur

The Affordability Template also does not account for whether a household's children are eligible for Dr. Dynasaur (Dr. D). Not accounting for Dr. D eligibility could produce an inaccurate assessment of affordability. For instance, a family of four at 300% FPL, assuming the children are under 19, would purchase a couple plan and the two children would be on Dr. D. The APTC benchmark used to calculate the amount of subsidy the household receives is the APTC benchmark couple plan premium. The children would have no deductible exposure, but may have a modest premium exposure,[1] in addition to the premium exposure for the couple plan accounting for federal and state subsidies. Once the household's children are no longer eligible for Dr. D, e.g. if the family's income was 350% of FPL, the household would need to purchase a family plan. The APTC benchmark plan used to calculate the subsidy amount would be for a family plan. Note that the APTC amount calculation and the Dr. D income-eligibility threshold sometimes use FPLs from different years depending on the point in time at which subsidies are calculated. The Board should incorporate Dr. D eligibility in the Guidance implementation.

6. Cost Sharing Reduction Plans

We also suggest that the Board consider substituting in a CSR plan for a Silver plan if the household is income-eligible and that the Board use the CSR plan to calculate household deductible exposure. For example, it seems unlikely that a household whose income is 139% FPL and who purchases on-Exchange Silver plan would not be enrolled in a 94 CSR plan (it is perhaps more likely that that household would mistakenly pay for a Platinum plan even though it was eligible for a 94 CSR plan). It appears that the Affordability Template does not substitute in the CSR plan deductible for a given Silver plan deductible if the household is eligible for the CSR plan and instead calculates CSR plan affordability separately. We recommend that the deductibles of the CSR plan for which the person is eligible be substituted for the Silver plan deductible.

7. Affordability Increments

The Board should calculate affordability for households at various incomes at a higher resolution/smaller increment. Vermont Medicaid income-eligibility thresholds do not align with the premium tax credit breaks. This means that using 50% FPL increments will present a picture

[1] Dr. D premiums are currently suspended. This was initially done during the public health emergency and was just extended while DVHA resolves Dr. D premium billing issues. It is unclear whether there will be Dr. D premiums in 2025.

that could misstate plan affordability. Further, calculating at smaller FPL increments does not increase the administrative burden of implementing the affordability standard as the amount of federal and state subsidies a household receives can be programmatically/formulaically calculated (as opposed to the "hard coding" which is implemented in the Affordability Template).[2] We recommend using increments of 10 percentage points.

8. Determining the Benchmark

Lastly, it is unclear to us whether the Board envisions combining the proposed plan pricing of all carriers in the exchange to predict the APTC benchmark plan. If the Board looks across carriers to predict the APTC benchmark, the Board implicitly assumes that the relationship of the proposed rates to approved rates, for all market participants, will be the same. Such an assumption does not align with historical data on proposed and approved rates. Further, any assumption made sets aside issues attendant to amendments to the proposed rates which likely impact the APTC benchmark plan. If the Board is using the proposed rates but not combining the carrier's proposed rates, it is unclear how the Board determines the APTC benchmark plan.

In either case, predictions of future year affordability present issues related to assumed future APTC benchmark, future federal poverty limits (potentially), and future patient share percentages. Considering the assumptions needed to predict future affordability, the HCA has chosen to use the most recent *approved* rates to assess plan affordability. We concluded that the 1-year data lag caused by using *approved* rates outweighs issues related to the uncertainty of the future benchmark plan, future applicable FPLs, and future patient share percentages. If the Board decides that the benefits of assessing the affordability of the proposed rates outweighs the needed assumptions to assess future affordability, the required assumptions should be delineated in such a fashion that the Board's calculations are reproducible.

[2] VHC annually produces a worksheet that VHC assisters use to calculate what subsidies an applicant household is eligible for. The calculations the worksheet uses can be implemented in Excel allowing for a formulaic calculation of subsidy eligibility.