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October 30, 2020

Kevin Mullin, Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Re: HCA Comments – First and Second GMCB Regulatory Alignment White Papers

Chair Mullin and Members of the Green Mountain Care Board:

The Office of the Health Care Advocate (HCA) thanks you for the opportunity to comment on the first two Green Mountain Care Board (Board) Regulatory Alignment white papers. We submit the comments below for the Board's consideration. We previously submitted technical comments on these two papers directly to Board staff. We would be happy to discuss these comments and/or the previously submitted technical comments with Board staff.

It is important to frame these comments within the complex process of regulatory alignment. We understand that some of our comments may be addressed in the third white paper. Similarly, additional feedback may arise when we have reviewed all three papers together and engaged with Board staff and other stakeholders. With this in mind, we submit the comments below on the topic of regulatory alignment.

Data Alignment Across and Within Regulatory Processes

The clearest opportunity for increasing regulatory process alignment is to improve comparability of data within and across processes.

To maximize regulatory alignment, it is essential for the Board to work with its regulated entities to create templates for collecting information that is comparable within and across processes. This will ensure that the same data points are submitted in a uniform way by all regulated entities. These templates should include standardized data element definitions. For data points that apply to more than one regulatory process, if there is agreement between entities on the data, the first submission/s could be adopted in later regulatory processes. If there is not agreement between entities, then updates or points of disagreement should be clearly noted and explained, to the extent possible, by parties in subsequent regulatory processes. This would make it easier for the Board, the HCA, and the public to compare and contrast data and assumptions among the different regulated entities, identify areas of agreement and disagreement, and ultimately ensure

the data and assumptions are as accurate as possible. A multi-year, uniform reporting methodology would also make it easier to compare data across time.

One example: Regarding Accountable Care Organization (ACO) risk reserves, the Board states that an "area of ongoing analysis and work at the GMCB" is to determine "the right amount of risk" held by the hospitals, "how that risk may be funded," and "how to record the risk on hospital financial statements."[1] As we have previously stated in hospital budget comments, it is critical that hospitals record risk and risk reserves in a consistent fashion to allow third parties to understand how ACO risk and risk reserves are affecting the Vermont hospital system. It would therefore be useful for each hospital to fill out a template related to its ACO risk as part of its budget review. Then, during the ACO budget review process, the ACO could either adopt the hospitals' reports or note areas of change or disagreement. In subsequent years, it would be easy to see how each hospital's risk changed from previous years.

Rate Setting and Changes to the Regulatory Timeline

Setting Hospital Commercial Rates for Qualified Health Plans

The white papers spend substantial time discussing the complications of aligning hospital commercial insurance rates for rate review and hospital budgets. One of the most significant changes the Board can make to improve regulatory alignment and health care affordability is to use its rate setting power to set hospital commercial rates for qualified health plans (QHPs) at an affordable level. In addition to helping to stabilize costs for this vulnerable group, setting provider rates would remove a variable from the Board's regulatory processes. It would no longer matter when the QHP rate filings occur in relation to the hospital budget process. As noted in the white papers, this group does not have a large impact on hospital or ACO budgets,[2] so setting rates for this group should not threaten hospitals' financial stability. In addition to helping Vermonters and increasing regulatory alignment, making these plans more affordable through rate setting would likely reduce the amount that hospitals absorb in bad debt and free care for uninsured and underinsured Vermonters.

Affordability and Changes to the Hospital Budget Regulatory Timeline

The white papers noted that insurance plans regulated by the Board do not have a significant impact on either the hospitals' budgets or the ACO's budget. Although this population may not be a significant driver of cost growth statewide, regulatory changes may have a significant impact on affordability for the individuals on those plans.

It bears noting that Vermonters on individual QHPs who do not qualify for subsidies pay the full cost of their premiums and cost sharing without assistance from employers or the government. And small businesses that purchase QHPs generally have tight margins that make it difficult to

[1] GMCB Reg. Alignment White Paper, Part 1 at 11.
[2] GMCB Reg. Alignment White Paper, Part 2, Page 11: "Only about 73,000 people are insured by these plans (12% of the VT population and 23% of the privately insured population), so, as noted in the first white paper, this market has a small impact on APM TCOC and on hospital budgets."

absorb large cost increases each year. Vermonters on individual and small group plans report that they are being crushed by premium increases.[3]

The second white paper states that "ideally" hospital commercial rates would be set before the Board reviews commercial health insurance premium filings.[4] Due to the vulnerability of Vermonters and small businesses on QHPs, we have concerns about any plan that would move the Board's hospital budget review prior to the QHP rate review process. If the hospital budget review process took place before the QHP rate review process, the Board would set hospital commercial rates without knowing their impact on Vermonters with QHPs. To determine the impact of hospital commercial rates on QHP rates, the Board would need the QHP-specific hospital utilization trends. There also may not be an opportunity for the Board to see if there is alignment between the carriers' reported utilization trends and the hospitals' budgeted commercial utilization trends. In this scenario, a hospital's requested commercial rate increase could look reasonable and affordable only because the hospital is projecting an unreasonably low utilization increase. To improve affordability, the Board needs to know both the insurers' and the hospitals' recent unit cost and utilization trends as well as their utilization projections prior to setting the allowed hospital commercial rates. As stated above, the Board can reconcile this issue by setting hospital commercial reimbursement rates for QHPs.

At the same time, we do not think it is sustainable for the Board to set health insurance rates in isolation from hospital budget review. The HCA therefore supports the Board staff recommendation to shift the hospital budgets to the calendar year to align with the ACO year and QHP year, only under the condition that the Board must also use its rate setting authority to set affordable hospital commercial reimbursement rates for QHPs.

General Comments on Regulatory Alignment White Papers

Hospital Commercial Charge

The first white paper discusses approved hospital commercial rates in the context of the hospital budget review process and in the context of how the approved hospital commercial rates impact fully-insured insurance premiums. The white paper describes approved hospital budget commercial rates as an upper limit and notes that actual rates charged to consumers are negotiated based on the approved upper limit. Based on statements made by various parties subject to Board regulation, it is clear that the approved hospital commercial rates rarely serve as a ceiling and are instead the *de facto* rates that hospitals implement. While it might be desirable and/or the Board's intent for the approved hospital commercial rates to be upper limits, in the current state, the rates do not function as an upper limit and therefore should not be described as such.

[3] See Public Comment on BCBSVT and MVP Individual and Small Group Rate Filings.
[4] GMCB Reg. Alignment White Paper, Part 2 at 6.

Risk and Reserves

We urge the Board to increase transparency of health care system risk and reserves, including how risk and reserves are distributed among the ACO, the hospitals, and the insurers. We ask the Board to use the regulatory alignment process to move toward identification and elimination of reserve duplication across the health care system. We believe this is one of the greatest areas of opportunity in the regulatory alignment process. To achieve greater transparency and eliminate reserve duplication, the Board must collect data that are consistent and comparable (see above, *Data Alignment Across and Within Regulatory Processes*). Additionally, when the issue of reserves is discussed in terms of both the current state and future planning, it critical to acknowledge that the source of health care system reserves is patient and taxpayer monies.

Evaluation of ACO Population Health Investments

The first white paper states that the ACO must "provide details of how it measures the return on investment in the short- and long-term, and justification for the continuation, scaling up, or sunsetting of population health investments."[5] To our knowledge, a method for such an evaluation by the ACO or the Board has not been developed or implemented to date. We support development and implementation of a method for evaluation of ACO population health investments. However, as it is not currently implemented, we ask the Board to change the language in the white paper to accurately reflect the current situation.

ACO Stabilization

In the Board's discussions of altering the timeline of regulatory processes, there seemed to be an assumption that significantly less information about the ACO can be projected than for the other regulatory processes. For example, there was discussion that the final attribution numbers must be known before the budget can be reviewed. Based on this logic, it was concluded that the ACO regulatory timeline was not very flexible. If the ACO is going to be successful, most aspects of its budget, including attribution, should eventually stabilize. In time, we believe that it could be reasonable to review the ACO Budget with projections of data, such as attribution, based on recent years' experience. Although it would be premature to make those assumptions right now, this might be an aspect of the regulatory timeline that would be worth revisiting in a few years.

Thank you for considering these comments. Please feel free to contact hcapolicystaff@vtlegalaid.org with any questions or concerns.

Sincerely,

Julia Shaw, MPH	Eric Schultheis, Ph.D., Esq.	Kaili Kuiper, Esq.
Health Care Policy Analyst	Staff Attorney	Staff Attorney

[5] GMCB Reg. Alignment White Paper, Part 1 at 20.