Health Insurance Premium Rate Review

VERMONT
GREEN MOUNTAIN CARE BOARD

Summary

The Green Mountain Care Board (GMCB) is tasked with reviewing major medical health insurance premium rates in the large group and individual and small group insurance markets.[1] In its review, the Board must determine whether a rate is **affordable, promotes quality care and access to health care, protects insurer solvency**, and **is not unjust**, **unfair**, **inequitable**, **misleading**, or **contrary to Vermont law**.

8 V.S.A. § 4062 and 18 V.S.A. § 9375

Green Mountain Care Board

The purpose of the Green Mountain Care Board is to promote the general good of the State by:

1. Improving the health of the population;
2. Reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
3. Enhancing the patient and health care professional experience of care;
4. Recruiting and retaining high-quality health care professionals; and
5. Achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

What is Rate Review?

The Green Mountain Care Board is tasked with reviewing major medical health insurance premium rates in the large group and individual and small group insurance markets. The review process supports health system reform by providing the opportunity to assess how changes in health insurance keep Vermont moving toward higher quality care while controlling costs. In 2019, these markets included 92,290 Vermonters, about 15% of the state's total population (pg. 3).

Individual and small group plans cover individuals who purchase major medical health insurance on their own (the individual market), as well as individuals who are insured by a plan sponsored by an employer with 100 or fewer employees (the small group market). Qualified Health Plans (QHPs) are sold through Vermont's state-based health insurance exchange, Vermont Health Connect (VHC), which is managed by the Department of Vermont Health Access (DVHA), and through licensed insurance brokers. Reflective plans may be purchased directly from the insurance carriers (no subsidies are available for individuals purchasing plans directly from a carrier).[2] All individual and small group plans cover Vermont's essential health benefits and meet the standards of the Affordable Care Act. Two insurance carriers currently offer these plans in Vermont, Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Plan, Inc. The annual timeline for rate review for these plans is:

February	March-June	May-July	August-September
• GMCB approves plan designs with recommendations from DVHA	• Form Review (Department of Financial Regulation)	• GMCB Individual and Small Group Rate Review • May: Rates filed • Mid-July: Public hearings • August: Decisions Issued	• QHPs certified and selected (DVHA) • Vermont Health Connect preparation and testing (DVHA)

[1] Act 25 of 2021 unmerges the individual and small group markets for the 2022 plan year. These changes will not impact how individuals, families, and small businesses purchase health insurance plans. *See* DVHA FAQ.
[2] Currently, only silver-level nonqualified health benefit plans are offered outside of VHC. These plans are similar in their design to the "silver-loaded plans" offered on VHC. However, unlike the VHC plans, reflective silver plans do not include any funding to offset the loss to carriers of federal cost sharing reduction (CSR) payments. *See* 33 V.S.A. § 1813.

Rates for **large group** plans – plans sponsored by employers with 101 or more employees – are reviewed and approved throughout the year on a rolling basis, within 90 days of filing. The number of filings varies year to year.

During the Board's review, insurers provide an actuarial analysis, a mathematical assessment which looks at how much it will cost to care for the insured population and to administer the plan, as well as the appropriate contribution to the insurer's surplus or reserves. Generally, within 90 days of submission, the Board must determine whether a proposed rate meets the **review criteria**.

Review Criteria

The Board must consider whether a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State" (8 V.S.A. § 4062(a)(3)). The Board also must consider whether a proposed rate is excessive, inadequate, or unfairly discriminatory (Rule 2.000, § 2.301(b)); these are actuarially defined terms.

> *"An affordable rate may not promote quality care or protect insurer solvency, and in turn limit access to care, while an unaffordable rate may limit access to quality care, and will ultimately erode insurer solvency, thereby limiting access to care. …[W]e must strike the appropriate balance between affordability and solvency."*

As the Board noted in its 2019 BCBSVT QHP rate decision, quoted above, these standards are often at odds – the Board must always have an eye to consumer affordability and access, but it must also protect insurer solvency and consider the adequacy of the rate (i.e., whether it provides for payment of claims, administrative expenses, taxes, and regulatory fees and reasonable contingency or profit margin).

The **Department of Financial Regulation (DFR)** supports the Board's review of insurers' rate filings. DFR is charged with ensuring insurer solvency and reviewing the reserves of each insurer. Generally speaking, *solvency* is a measurement of whether an insurer has enough funds – *reserves* – to cover the relevant risks and costs associated with the insurer's business, including the risk that members need more health care services than expected. DFR uses several tools to assess whether insurers have sufficient reserves. DFR also reviews insurer forms and contracts, and ensures plans meet State standards for consumer protections, network adequacy, quality improvement activities, and other subjects. The Board is required to consider DFR's opinion regarding the effect a proposed rate will have on an insurer's solvency.

Public Comment

Once a rate filing is posted to the GMCB website, a public comment period begins. Any member of the public may comment on the filing on the GMCB rate review website, by email to GMCB.Board@vermont.gov, by phone at (802) 828-1972, or by mail. All public comments received by the Board are "public records" under Vermont law: absent a specific exemption to the Vermont Access to Public Records Act, any member of the public may access public comments by contacting the Board. The Board must consider public comments before making a decision on a proposed rate.

Key Terms

Benefits includes what medical services are covered (hospitals, doctors, pharmacy, lab, and other patient care) but also the amount of a deductible and cost-sharing (coinsurance and copays, and when you must pay them).

A **premium** is what consumers pay each month for their health coverage.

A **rate** is the change in premiums from year to year.

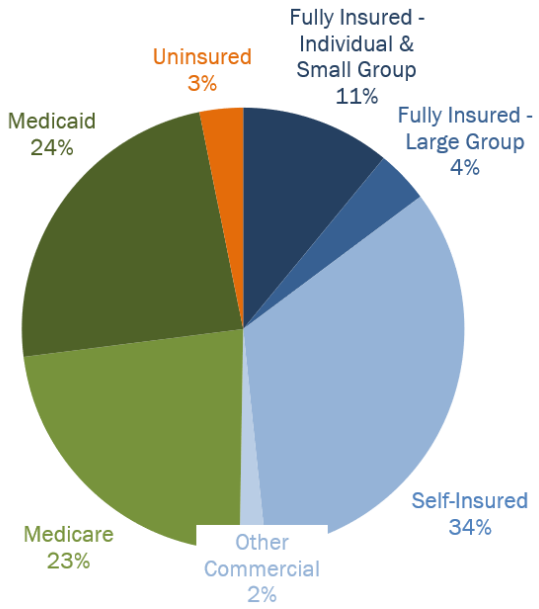
Vermont's Insurance Market (2019)

Governmental Coverage: About 47% of Vermonters are covered by the major government-administered programs, ***Medicare*** (23%) and ***Medicaid*** (24%).

Commercial Insurance: Half of Vermonters (50%) have commercial insurance. Types include:

- Individual: Plans individuals purchase for themselves and their families.
- Small Group: Insure 100 or fewer people.
- Large Group: Insure 101 or more.

Self-Insured: An organization pays the actual cost of care used by their employees or other plan members, rather than purchasing an insurance plan. The federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured plans.



Uninsured: A small number of Vermonters are uninsured (~3%).

Since 2013, the number of Vermonters covered by GMCB-regulated plans has decreased by nearly 40%. Rate Review continues to have a significant impact on premiums for the Vermonters who purchase Individual and Small Group or Large Group plans (15% of Vermonters).

How to Enroll in a Qualified Health Plan

To enroll in a QHP, visit Vermont Health Connect or call 1-855-899-9600 to sign up during an enrollment period. Open enrollment – when anyone can enroll – typically starts November 1 each year and lasts for 6 weeks. During this time, any Vermonter can sign up for health coverage or make changes to an existing plan.

To enroll outside of the open enrollment period, you must have a qualifying event, and must apply and select your plan within 60 days. Qualifying events are changes in life circumstances, including:

- Loss of employer- or government sponsored health insurance or a qualifying student health plan
- Aging off of a parent's health plan, or out of foster care
- Loss of coverage due to divorce, annulment, dissolution of civil union, or due to domestic violence
- Marriage, pregnancy, birth, or adoption
- Change in immigration status
- Move to Vermont

Vermont has periodically created special enrollment periods for uninsured Vermonters due to the COVID-19 pandemic. Check the Vermont Health Connect website for up-to-date information about enrollment.

Additional Resources

- GMCB Rate Review Website
- Department of Financial Regulation – Insurance Division
- Vermont Health Connect
- Vermont's Office of the Health Care Advocate

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