VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05633-3601
802-828-2177

INDIVIDUAL AND SMALL GROUP RATE REVIEW GUIDANCE REGARDING AFFORDABILITY DATA

Purpose

The purpose of this document is to assist the Parties to health insurance rate review proceedings by describing data that the Green Mountain Care Board plans to request and consider as part of its review of individual and small group filings.

Background

As part of its review of health insurance rate filings, the Board must determine whether rates are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of Vermont; and are not excessive, inadequate, or unfairly discriminatory.[1] The Applicant – the insurer filing a rate request – bears the burden of justifying its proposed rates under this standard.[2] With respect to the "affordability criterion," the Board's task has historically been hampered by an evidentiary record that lacks quantitative data regarding the ability of individuals to afford an insurer's rates. This guidance seeks to address this deficiency.

Guidance

Individual Rate Filings

In reviewing an individual rate filing, the Board plans to ask the Applicant to provide data on the net premium[3] that must be paid by different households at different income levels for each of the Applicant's in-force plans,[4] as well as how these amounts compare to the required contribution percentage[5] established by the Internal Revenue Service (IRS).[6] The Board plans to develop a form for reporting this data.

[1] 8 V.S.A. § 4062(a)(3); GMCB Rule 2.301(b).
[2] *See* GMCB Rule 2.104(c).
[3] "Net premium" means the premium that must be paid after accounting for any federal or state premium assistance.
[4] "In-force" plans means the plans currently offered by the Applicant. For example, in reviewing an Applicant's proposed plan year 2025 rates, the Board plans to request information regarding the Applicant's plan year 2024 rates.
[5] The required contribution percentage was established for 2014 at 9.5 percent, which, at the time, was the upper limit of premium tax credits for individual plans covering households with an income between 300 and 400 FPL. The required contribution percentage has since been annually indexed to the rates of premium growth relative to the rates of income growth in National Health Expenditures data. *See* Internal Revenue Code, § 36B(c)(2)(C).
[6] *See* Internal Revenue Service, Rev. Proc. 2023-29, https://www.irs.gov/pub/irs-drop/rp-23-29.pdf (stating that the required contribution percentage for plan years beginning in calendar year 2024 is 8.39%).

Small Group Rate Filings

In reviewing a small group rate filing, the Board plans to ask the Applicant to provide data on the expected premium contribution to be paid by different households at different income levels for each of the Applicant's in-force plans,[7] as well as how these amounts compare to the required contribution percentage established by the IRS.[8] The "expected premium contribution" will be determined using the average share of premiums borne by employees at private-sector establishments in Vermont with less than 50 employees, as published in the most recent Medical Expenditure Panel Survey.[9] The Board plans to develop a form for reporting this data.

Generally

The required contribution percentage referenced above should not be understood as a "rate cap."

Parties to a health insurance rate review proceeding may present arguments regarding what weight, if any, the Board should give the data described above and may also present other evidence and argument on the issue of affordability.

[7] *See supra* n.5.
[8] *See supra* n.7.
[9] Medical Expenditure Panel Survey, Insurance Component, https://datatools.ahrq.gov/meps-ic/#table-series (showing that, on average, 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).