Health Insurance Rate Review: A Critical Part of Health Care Reform in Vermont

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Abbreviations Guide

ACA
Patient Protection and Affordable Care Act

HCA
Office of the Health Care Advocate

BCBSVT
Blue Cross Blue Shield of Vermont

MLR
Medical loss ratio

CON
Certificate of Need

NAIC
National Association of Insurance Commissioners

DFR
Department of Financial Regulation

RBC
Risk Based Capital

ERISA
Employee Retirement Income Security Act of 1974

SERFF
System for Electronic Rate and Form Filing

GDR
Generic dispensing ratio

VHC
Vermont Health Connect

GMCB or the Board
Green Mountain Care Board

VHHIS
Vermont Household Health Insurance Survey

Introduction

Vermonters who purchase individual health insurance policies and employers who purchase policies as part of the compensation for their employees are very concerned about the cost of health insurance. This paper describes the process that the state of Vermont uses to review requested rates for commercial major medical policies to ensure that the rates insurers charge are affordable and adequate, but not higher than needed. It also highlights the ways in which members of the public can be involved in the rate review process.

Rate review is one of the major regulatory jobs assigned to the Green Mountain Care Board (the Board or GMCB), a five-person independent board created by the Vermont legislature in 2011. The Board is generally charged with working to improve the health of Vermonters, reduce the rate of growth in health care expenditures, enhance both the patient's and the health care professional's experience of care, recruit and retain high-quality health care professionals, and achieve administrative simplification.[1] The Board's publication explaining its work emphasizes the importance of its role in regulating health insurance rates: "Of all GMCB's jobs, reviewing insurance rates affects Vermonters' budgets most immediately. Each rate increase means that some Vermonters could soon be paying more for their health insurance."[2]

Overview of Vermont Insurance Market

Health insurance organizations offering comprehensive major medical insurance coverage in Vermont must file a request and obtain approval from the Board before implementing new health insurance rates.[3] The Board reviews filings related to plans offered to individuals or to employers in the small group (groups with 50 or fewer employees) or large group (groups with more than 50 employees) insurance market. Employer-sponsored self-insured plans are not subject to state regulation due to the Employee Retirement Income Security Act of 1974 (ERISA).[4]

Some filings request a change in the rates charged for a particular health insurance plan offered by the carrier. Other filings are "factor filings" that set specific components of the premium rate

[1] 18 V.S.A. §§9371-9392

[2] The Green Mountain Guide to Vermont's Health System Reform (June 2013), 3.

[3] In the 2014 session of the legislature, 8 V.S.A. § 4062(h) was amended to clarify that the rates reviewed by the Board "shall apply only to the rate review process for policies for major medical insurance coverage and shall not apply to the policy forms for major medical insurance coverage or to the rate and policy form review process for policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, student health insurance coverage, or other limited benefit coverage; to Medicare supplemental insurance."

[4] ERISA is a federal law that requires any private employer that establishes an employee pension or welfare benefit plan to meet certain requirements. It also sets limits on the state's ability to regulate certain plans. An ERISA plan is any employee welfare benefit plan offered by a private employer or union (except churches), including those offered through insurance carriers and self insured plans. Self-insured plans that bear primary insurance risk are not subject to regulation by the state. 29 U.S.C.§1144(b)(2)(B).

rather than the entire rate. For example, a filing can be made to set medical trend, administrative costs and surplus or to set the methodology for determining a set of "benefit relativities" - the relative value of insurance plans with varying benefits. The recent Blue Cross Blue Shield of Vermont (BCBSVT) Third and Fourth Quarter 2014 Trend Factor Filing[5] and BCBSVT Fourth Quarter 2014 through Third Quarter 2015 Administrative Expense and Contribution to Reserve Filing[6] are examples of factor filings.

The Board is also responsible for related regulatory functions that affect the cost of health care and therefore affect the prices paid by insurers for medical services that are incorporated in the cost of insurance premiums. It regulates hospital budgets[7] and reviews major capital expenditures through the Certificate of Need (CON) process.[8]

In 2012, 61.4% of the Vermont population (381,183 people) were covered by private insurance, according to the Vermont Household Health Insurance Survey (VHHIS) Data Compendium.[9] The remainder were covered by Medicare or public programs or were uninsured. An estimated 19% of the population covered by private insurance was in self-funded ERISA plans that, as noted above, are not subject to state regulation.[10] Vermont has relatively few private insurance companies. The major insurers that file rates reviewed by the Board are BCBSVT and its wholly-owned subsidiary, the Vermont Health Plan; MVP Health Care (MVP); and two subsidiaries of Cigna Corporation (Cigna). BCBSVT, MVP and Cigna account for over 77% of the major medical insurance business administered by commercial insurance companies in Vermont, according to the 2012 Annual Statement Supplement Report.[11]

Individual and small group policies have been community rated in Vermont since the early 1990s. Community rating of health insurance policies is a method of setting premiums that spreads risk evenly across the entire population of people insured under the policy regardless of age, health status, or claims history. The federal Patient Protection and Affordable Care Act (ACA) requires a form of modified community rating where premiums can vary up to a maximum based on selected characteristics. In some states, this has caused a major change in

[5] GMCB 012-14-rr

[6] GMCB 016-14-rr

[7] 18 V.S.A. § 9375(b)(7); GMCB Rule 3.00: Hospital Budget Review.

[8] The Green Mountain Care Board has authority to decide CON applications pursuant to 18 V.S.A. §§ 9375(b)(8), 9380, 9431(b) and 9433. The purpose of CONs is to prevent unnecessary duplication of health care facilities and services, promote cost containment, guide the establishment of health facilities and services which will best serve public needs, ensure the provision of high quality services and resources, and ensure access to and equitable allocation of such facilities and services in Vermont.

[9] "Is the person covered by private health insurance?" Table. *2012 VHHIS Data Compendium*. Vermont Department of Financial Regulation, 23 May 2014. Web.http://www.dfr.vermont.gov/insurance/health-insurance/vermont-household-health-insurance-survey-vhhis

[10] Vermont Department of Financial Regulations—Insurance Division. *Commercial Health Insurance in Vermont*, 4. http://www.dfr.vermont.gov/sites/default/files/ASSR_2012_Commercial_Health_Insurance_in_Vermont.pdf

[11] Id. at 12.

the health insurance market as insurers change the rating system, but Vermont's market was not affected since it had already been adjusted for community rating.[12]

Large group products are experience rated in Vermont. Rates are developed based on a particular group's own claims history, without blending that history with the experience of other groups. A healthier group will therefore pay lower rates than a sicker group.

The health insurance marketplace and the regulation of rates charged by health insurance companies in Vermont have undergone significant changes since 2010 as a result of the ACA and three Vermont statutes: Act 48, relating to a universal and unified health system, which was passed in 2011; Act 171, relating to health care reform implementation, which was passed in 2012; and Act 79, relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board, which was passed in 2013.

The ACA requires each state to create a Health Benefit Exchange, which is an online marketplace for health insurance products, or to use the federal exchange. In 2011, the Vermont legislature created the Vermont Health Benefit Exchange [now called Vermont Health Connect (VHC)] as part of Act 48.[13] Enrollment in the VHC plans began October 1, 2013 and coverage began as early as January 1, 2014.

Act 171 requires individuals and small groups with 50 or fewer employees to purchase health insurance through VHC. Products sold on VHC must offer a set of benefits called "essential health benefits" and must be structured to provide different levels of "actuarial value"[14] with different amounts of cost sharing. Because the products offered on VHC are more standardized, it is easier for consumers to compare different plans offered than it is to compare other types of insurance plans not in the VHC marketplace.

Rate Review Process

Until January 2012, the Department of Financial Regulation (DFR), which was then called the Department of Banking, Insurance, Securities and Health Care Administration, had sole authority for reviewing health insurance rates to ensure that they were not excessive, inadequate or unfairly discriminatory. With the passage of Act 48, the Legislature gave the Board responsibility for making final rate decisions. Under the system in place from January 1, 2012

[12] Kapel, Steven, Policy Integrity, LLC (March 25, 2011). Community Rating: The Basics. Vermont Legislative Joint Fiscal Office. http://www.leg.state.vt.us/jfo/healthcare/2011_Community_Rating_Basics.pdf

[13] 33 V.S.A.§§1801-1812

[14] "Actuarial value" of a plan represents the percentage of total average costs for covered benefits that the plan will cover. A plan with an actuarial value of 70% will cover on average 70% of the covered benefits. The remaining 30% will be paid by the policy holder through deductibles, co-insurance and co-payments. Any policy holder could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on his/her actual health care needs. Policy holders often have additional health care costs for services that are not covered by the plan. Health plans in VHC are offered at four levels of actuarial value: Platinum (90%), Gold (80%), Silver (70 %), and Bronze (60%)

through December 31, 2013, DFR reviewed rate filings and made a recommendation to the Board about whether to approve, disapprove or modify requested rates. The Board reviewed the recommendation and the record, including an opinion from an actuary[15] who contracted with DFR to offer an independent actuarial analysis of the filing.

In 2013, Act 79 eliminated the two-step review process. Under the current system, the Board has jurisdiction over each filing as soon as it is submitted, and there is no longer a review by and a recommended decision from DFR. Filings are reviewed by the Board and an actuary hired by the Board. The Board must approve, modify or disapprove requests for health insurance rates within 90 days of receiving a filing.[16]

The rate review process is described in detail in the Board's Rule for Health Insurance Rate Review on its website. It begins when an insurance carrier submits a filing using a web-based electronic filing system called the System for Electronic Rate and Form Filing (SERFF) to the Board. The filing must include a plain language summary of the basic features of the filing, which is posted on the State's rate review website.[17]

During an initial period lasting up to 60 days, the Board's actuary reviews the filing, poses questions to the carrier requesting additional information needed to analyze the rate request and prepares an opinion.[18] The Office of the Health Care Advocate (HCA) also has the right to propose questions to the Board for its actuary to pose to the insurer.[19] The answers to questions posed during the review period may include information that the insurance carrier claims is confidential. The Board rules require the insurer to provide detailed information about why the material should be treated as confidential, and the Board determines whether to grant any requests for confidentiality. Any information found to be confidential must be provided to the Board and the parties, but is redacted from the public record.[20] The questions and non-confidential portions of the carrier's responses are added to the SERFF filing on the Board website.[21] Unfortunately, due to the design of the SERFF system and the way supplemental material is inserted, it is difficult to know when new material has been added to the original

[15] An actuary is a specialist in analyzing risk who studies health trends, predicts changes that influence the costs of medical care and analyzes the factors that affect insurance rates. The insurance carriers use actuaries to develop their proposed rates and independent actuarial firms may be used by the Board and other parties in a filing to review and analyze this work.

[16] 8 V.S.A. §4062(a); 18 V.S.A. §9375(b)(6)(*as amended by* 2013, No. 79 §5c); GMCB Rule 2.00:Health Insurance Rate Review 2.301(a).

[17] GMCB Rule 2.00 § 2.104(b).

[18] GMCB Rule 2.00 §§2.202(d), 2.304.

[19] GMCB Rule 2.00 § 2.202(c).

[20] GMCB Rule 2.00 §2.305.

[21] GMCB Rule 2.00 §2.202(e).

filing. At the end of the review period, the Board receives an opinion from its actuary, which is posted on the website.[22]

During the initial 60-day review period, DFR prepares an analysis of the carrier's solvency (ability to meet its long-term financial obligations) and the potential impact of the rate change requested in the filing on that solvency.[23] This solvency opinion is posted on the Board website.[24]

"Parties" to the rate filings are those who have a close interest in the filing. The insurer submitting the filing is a party.[25] The HCA may choose to become a party to a rate filing to represent the interest of Vermont consumers by filing a Notice of Appearance with the Board.[26] People or organizations that can show that they have a substantial and direct interest in the filing may also apply to the Board for "interested party" status. Being covered by the insurance policy at issue in the filing is not enough in itself to give an individual the right to participate in the filing as an interested party.[27] As of July 2014, there have been no cases where the Board has allowed an individual or organization other than the HCA to participate as an interested party.

Parties have a substantial role in the review process. A party can present evidence at hearing, make arguments, provide responses to all issues introduced to the Board regarding the filing in question and can appeal the Board's decision to the Vermont Supreme Court.

The Board may allow an individual or organization to participate as an amicus curiae (friend of the court) if it finds that the applicant "will be able to render material assistance to the Board by providing nonduplicative evidence relevant to the Board's review." An amicus curiae is not a party to a rate review proceeding. However, an individual or organization with amicus curiae status will be copied on all non-confidential materials in the rate case, can introduce information into the official record for the case and can receive copies of confidential materials by signing a confidentiality agreement with the Board.[28]

Once the actuarial opinion and solvency analysis are posted on the Board's public website, the Board has 30 days to issue a decision on the filing.[29] A public hearing may be held[30] or may be waived by the parties with the Board's approval.[31] In addition, the Board may decide to make its

[22] GMCB Rule 2.00 §2.202(d).
[23] GMCB Rule 2.00 §2.202(d).
[24] GMCB Rule 2.00 §2.202(d).
[25] GMCB Rule 2.00 §2.105(a).
[26] GMCB Rule 2.00 §2.105(b).
[27] GMCB Rule 2.00 §2.105(c).
[28] GMCB Rule 2.00 §2.105(d).
[29] 8 V.S.A. §4062(e)(3).
[30] GMCB Rule 2.00 §2.307.
[31] GMCB Rule 2.00 2.309(a)(1).

decision without holding a hearing if the proposed rate increase is not more than 10% and affects only a small number of lives or the rate increase is no greater than 3%.[32]

If a hearing is held, it is conducted by the Chair of the Board or by a person the Chair designates. At the hearing, the Commissioner of DFR or designee and the Board's contracting actuary will be called as witnesses, unless the parties agree to waive this testimony. There is an opportunity for sworn testimony to be presented by the carrier, the HCA and any other interested party. The hearing will also include an opportunity for members of the public to comment orally on the filing.[33]

The public also has an opportunity to comment on the filing outside the public hearing process. Comments may be made via the Board's rate review website, by email, telephone, and U.S. mail. Comments are accepted from the first day the filing is posted on the Board website until midnight on the fifteenth day after the actuarial and solvency opinions have been posted.[34]

The record for rate review includes the entire SERFF Filing submitted by the insurer; questions posed by the Board to its actuaries; questions posed to the insurer by the Board, its actuaries and DFR and responses to these questions; DFR's Solvency Analysis; and the actuarial opinion from the Board's actuary.[35]

Decisions and documents connected to the filing for rate review cases from January 2012 through December 2013 are found on the Board website. Related documents for filings decided from January 2014 on are found on the State's new rate review website.

Components of Rate Filings

Medical and pharmacy trends, administrative expenses, and contributions to surplus are the major components of health insurance rate filings.

A **trend factor** represents the percentage by which the insurer expects its per capita medical or pharmaceutical costs to increase for policyholders who enroll or renew coverage during the period covered by the filing. It is based on a historical experience period and changes that the carrier expects during the future rating period. A trend factor is applied as a multiplier to the medical or pharmaceutical claims from the experience period to determine the price the insurer will need to charge for comparable services during the prospective period covered by the rate filing.

[32] GMCB Rule 2.00 §2.309 (a)(2) and (3).

[33] GMCB Rule 2.00 §2.307(d)(1) -(3).

[34] GMCB Rule 2.00 §2.201.

[35] GMCB Rule 2.00 §2.403.

Trend rates are based in part on the **unit cost trend**, a measure of the changes in the rates paid by the insurer to different health care providers. They are also based on predictions about the future utilization and mix of services of the insured group. They measure changes in the number of services that will be used, the intensity of the services and the number of treatable conditions that the population is expected to have. The expected **morbidity** (health status) of the insured population is important in predicting the amount of utilization that will contribute to medical trend. This can be especially hard to predict for new insurance products or products with little historical experience data such as the 2014 and 2015 VHC filings.

Predictions about pharmacy trends depend heavily on the expected **Generic dispensing ratio (GDR).** This figure refers to the number of generic drug prescription fills divided by the total number of prescriptions. Because generic drugs are less expensive than brand name drugs, higher GDRs produce lower prescription drug costs.[36]

An **administrative expense** factor sets forth the company's basic administrative expenses on a per member per month basis and the percentage by which the company expects those expenses to increase on an annualized basis during time period covered by the filing.

Rate requests also include the carrier's proposed **contribution to reserve** or **contribution to surplus**. Insurance companies typically build a contribution into their proposed rates. Maintaining an adequate amount is an important protection for health insurance consumers because this ensures that there is enough money to pay claims if the plan's actual costs for health care claims are higher than estimates of medical and pharmacy trends in the filing. It also provides protection in case there are unanticipated high medical costs due to an epidemic or other unusual event, although such events are by their very nature almost impossible to predict.

Other costs may also contribute to insurance premium rate increases. These include fees that the insurer must pay, the cost of including new benefits in a plan and changes in federal and state policy. For example, in its 2015 VHC filing, BCBSVT estimated that an increase in the federal insurer fee established by the ACA to provide subsidies required a .9% premium increase. It also estimated that a change in coverage for children's dental benefits which provides certain services with no cost-sharing raises the premium from the prior year by .5%. Most significantly, it estimated that a reduction in the subsidy available from the federal Transitional Reinsurance Program (which provides funding to insurers that incur very high claims costs for people enrolled in the plan) would require a 4% increase in premium costs.[37]

[36] GMCB 012-44-rr Decision, FN 4.

[37] GMCB 018-14-rr Plain Language Summary.

Legal Standard for Reviewing Rate Filings

Vermont's statute establishing procedures for rate filings lists a number of factors that the Board must consider when it reviews a rate filing. "In deciding whether to approve, modify, or disapprove each rate request, the Board shall determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[38]

The Board must consider the requirements of the underlying statutes, changes in health care delivery, changes in payment methods and amount, the Solvency Analysis prepared by DFR in connection with each filing and other issues at the discretion of the Board.[39] The Board "shall consider any [public] comments received on a rate filing and may use them to identify issues."[40] The carrier has the burden of justifying its requested rate.[41]

The terms "excessive," "inadequate" and "unfairly discriminatory" have been defined by DFR in its Recommended Decisions on rate filings from 2012 to 2013. Rates are generally considered excessive if they are likely to produce unreasonably high profits or if expenses are unreasonably high in relation to services rendered. Rates are considered inadequate if they are insufficient to sustain projected losses and expenses in the class of business to which they apply. Rates are unfairly discriminatory if price differentials for groups of insureds do not reflect the differences in projected losses and expenses for those groups in an equitable manner.[42]

The concept of medical loss ratio (MLR) is a basic financial measurement that can help to highlight rate requests that have excessive administrative and other non-claims costs. It compares the amount of each premium dollar that is used to pay for the customers' medical claims and activities that improve the quality of care to the amount used for other expenses such as administrative costs, salaries and profits. If a company has a medical loss ratio of 80%, it is using 80 cents of every premium dollar for the claims expenses and the remaining 20 cents for other costs. Section 2718 of the ACA sets minimum MLRs of 80% for small group plans and 85% for large group plans. Insurers must pay consumer rebates if they fail to meet these minimum standards. Cigna was required to provide rebates to Vermont consumers because it did not meet the minimum MRL requirement in 2011 and 2012.[43]

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[38] 8 V.S.A. 4062(a)(3), GMCB Rule 2.00§ §2.301 and 2.401.

[39] GMCB Rule 2.00 2.401: see also 18 V.S.A. §9375(b)(6).

[40] GMCB Rule 2.00 §2.201(d).

[41] GMCB Rule 2.00 §2.104(c) .

[42] *See, e.g.,* GMCB 001-12-rr Recommendation, 2.

[43] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/mlr-issuer-rebates-20121126.pdf; http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-issuer-rebates-06042013.pdf

Affordability is extremely important to consumers who buy health insurance products. According to the latest Vermont Household Health Insurance Survey conducted in 2012, "cost remained the primary barrier to health insurance coverage among the uninsured," who represent 6.8% of the Vermont population. Of the 42,760 uninsured, 49.9% cited cost as the only reason they were not insured, and an additional 22.4% indicated that it was a main reason.[44]

In a 2013 decision reviewing The Vermont Health Plan 3Q13 and 4Q13 Trend Factor Filing, the Board expressed concern that the medical and pharmacy trends used by The Vermont Health Plan in that filing and prior filings "exceed growth in other sectors, and exceed consumer expenditures on health care costs." Examples of other rates of growth cited by the Board in support of its reduction in the trend factor were the U.S. Bureau of Labor Statistics, *Consumer Price Index Summary,* the U.S. Bureau of Economic Analysis' report on *Widespread Economic Growth Across States in 2011* and The Centers for Medicare and Medicaid Services' *National Health Expenditure Projections 2011 – 2021.*[45]

Similar sources were cited in an earlier Board decision for the MVP Individual Indemnity Rate Filing covering the first and second quarters of 2013. In that decision, the Board stated that "proposed double-digit increases warrant heightened scrutiny because they raise serious questions about affordability, are unsustainable, and exceed recent growth in other areas of spending and projected national trends in health care expenditures."[46]

In a 2012 case, the Commissioner of DFR recommended that the Board modify the rates requested by MVP by reducing the rate increases below 10% to promote affordability. A 10% rate increase is the threshold that requires a review for reasonableness under the ACA. DFR noted that in the MVP case, "the proposed average annual rate increase exceeds the 10.0% reasonableness threshold established in the Affordable Care Act. Given the Department's directive to help keep rates affordable for Vermonters and the company's track record of enjoying strong capital support from other entities in the MVP corporate group, the Department recommends the further reduction of the proposed rates … to 9.9%."[47]

The Board expressed concern about the affordability and sustainability of the requested rates and reduced the carrier's requested trend factors. However, it was not willing to reduce the rates below 10% based on the DFR Commissioner's reasoning: "[B]ecause we have chosen the low end of the reasonable and actuarially justified, range of medical trends, we do not conclude that it is necessary or appropriate to adopt the Commissioner's recommendation to reduce rates so that they fall below the 10% ACA [reasonableness] threshold."[48]

[44] 2012 Vermont Household Health Insurance Survey, 10 and 19.

[45] GMCB 014-13-rr, 4.

[46] GMCB 033-12-rr Decision, 6.

[47] GMCB 033-12-rr Commissioner's Recommendation, 5.

[48] GMCB 033-12-rr Decision 7..

In several of its decisions, the Board has reviewed trend ranges that were independently calculated by the actuaries hired either by DFR (before January 2014) or by the Board itself to review the carriers' trend projections. In some cases, it has modified insurers' requests based on the lowest end of independently calculated trend ranges.[49] However, in one recent decision, the Board chose a trend rate at the middle of the independently calculated trend range rather than the lowest end, based on its actuary's opinion that this was the best estimate of medical trend; "the most likely actual trends do not fall at points on either end of the continuum, but in the middle."[50]

Solvency Review

As described above, DFR provides the Board with an opinion as to the solvency of the insurance carrier for each rate review filing. In addition, some information about the insurers' financial condition is available to the public.

All domestic insurance companies in Vermont have an annual independent financial statement audit. In addition, DFR performs financial examinations at least once every five years on all domestic insurance companies licensed to conduct business in the state. The most recent financial examination of BCBSVT was completed in 2010. The state does not conduct these financial reviews of MVP or Cigna because they are not headquartered in Vermont.

Risk Based Capital (RBC) Reports are designed to demonstrate the solvency of an insurance company. In order to monitor the strength of the businesses, the State of Vermont requires each domestic insurance company doing business in Vermont to submit an annual RBC report to DFR and The National Association of Insurance Commissioners (NAIC)[51] The NAIC explains that RBC is significant to insurance company regulation because the analyses involved measure "the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile." The NAIC cautions that minimum RBC standards are "not necessarily the full amount of capital that an insurer would want to hold to meet its safety and competitive objectives" and that RBC is only one measure used to assess the financial solvency of an insurance company. RBC is one of the tools that give regulators legal authority to take control of an insurance company if the amount of capital is too low.[52]

The State of Vermont chooses to treat RBC Reports as confidential because the reports "constitute information that might be damaging to the insurer if made available to its

[49] GMCB 014-13-rr Decision; GMCB 035-13-rr Decision; GMCB 036-13-rr Decision.

[50] GMCB 012-14-rr Decision 4.

[51] 8 V.S.A. §8302.

[52] (NAIC, *Risk Based Capital*, http://www.naic.org/cipr_topics/topic_risk_based_capital.htm, last viewed July 15, 2014).

competitors."[53] The Board Decisions and the DFR Commissioner Recommendations in 2012 and 2013 regularly discuss the RBC reports of health insurance companies proposing a rate increase but do not specify the actual RBC values.[54]

However, it is possible to calculate an insurance carrier's RBC from two figures contained in the Chart of the Five-Year Historical Data in its annual financial statement.[55] These statements are public documents filed with DFR or the regulating entity in the carrier's home state, but they are not posted on DFR's or the Board's website.

Conclusion

As this paper has shown, the decision of the Green Mountain Care Board to approve, modify or disapprove requested rates from health insurers in Vermont is based on a careful review of each filing and supplemental material requested by or otherwise provided to the Board. The Board, with the input of an independent actuary, scrutinizes the filing and its many component parts; reviews DFR's analysis of the insurer's solvency; and considers evidence and arguments presented by the HCA and other interested parties.

The Board and State rate review websites provide useful information about past and pending rate reviews and the rate review process. The public has opportunities to participate in the review of individual filings and comment on specific rate requests or the process in general. The rate review process and the public's role in it continue to evolve in Vermont.

[53] 8 V.S.A. §8308(a).

[54] *See, e.g.*, GMCB Decisions: GMCB-015-12-rr; GMCB-031-12-rr; GMCB-026-12-rr; GMCB-006-12-rr; GMCB-013-12-rr; and DFR Commissioner Reports: August 23, 2012 (SERRF Tracking number BCVT-128395160); July 30, 2012 (SERFF Tracking Number BCVT-128394283); April 26, 2012, (SERRF Tracking number BCVT-128100658); June 11, 2012, (SERFF Tracking No. MVPH-128099157).

[55] To calculate an insurance carrier's RBC for a given year, divide the total adjusted capital (line 14) by the authorized control level risk–based capital (line 15).