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Expert Witness Report

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Contents

Qualifications	1
Methodology	1
Act 48	2
<i>Background</i>	2
<i>The Legislative History of Act 48</i>	3
Expert Opinion	7

Qualifications

I served as a Vermont State Representative for fourteen years (2001–2014). During that time, I served in a variety of leadership roles including three years as Chair of the House Health Care Committee, one year as Vice-Chair of the House Health Care Committee, and six years as Vice-Chair of the House Human Services Committee. As one of the key legislators who assisted in navigating Act 48 through the whole legislative process, I have extensive knowledge of the politics and policies that led to the creation of the Green Mountain Care Board and Vermont’s current rate review process. I also have knowledge of the legislative process and the records documenting it.

I am currently Chief Advocate for the Office of the Health Care Advocate. I have held the position since January 2017.

Methodology

As Vice-Chair of the House Health Care Committee in 2011, I was at the table for many conversations about H.202 both in committee, in planning meetings about the bill, and as a member of the conference committee. In order to ensure that I am accurately relating the events from six years ago, I have spent considerable time reviewing the recordings from the committees of jurisdiction for the rate review section of the bill. My review focused on testimony from witnesses before the legislature who spoke about insurance rate review, including insurance executives, and on bill markup and committee discussions. Finally, I reviewed the amendments to Act 48 offered by members of both houses.

Specifically, I reviewed the State Archives’ recordings from 2011 from House Health Care, the Senate Health and Welfare and Senate Finance Committee Hearings of Act 48 with a specific focus on the sections of the bill that addressed insurance rate review. I referred to the meeting agendas on file to determine which recordings pertained to Act 48. I also reviewed notes from 2011 House Health Care Committee meetings.

Act 48

Background

The Vermont statutes contemplate a more comprehensive evaluation of proposed insurance rate increases than most other states.¹ In almost all other states, individual insurance rates are lawful as long as they are actuarially justified--the statutory language typically requires that rates not be “excessive, inadequate, or unfairly discriminatory.” That is the only standard the insurer must meet, and only a person who is knowledgeable about actuarial principals has the expertise necessary to determine whether that standard is met.

In Vermont, the Green Mountain Care Board (the Board) must similarly determine whether a proposed rate is actuarially justified when determining whether the rate is lawful.² Vermont is different, though, in that the Board must also determine whether the proposed rate meets other standards: whether it is affordable; whether it promotes quality care; whether it promotes access to health care; whether it protects insurer solvency; and whether it is not unjust, unfair, inequitable, or misleading.³ It is important for us to remind ourselves how those standards became part of Vermont law.

My purpose in offering this statement is not to advise the Board on what those standards mean, or on how to apply them. Rather, my purpose is to outline the legislative history of this one particular part of Act 48. I draw on my experience as the Vice-Chair of the House Health Care Committee when Act 48 (H.202) of 2011 was drafted, moved through the legislative process, and passed. I also draw on my fourteen years of experience as a Vermont legislator and my review of the legislative history of Act 48 to do this.

My hope is that a description of this process, based on my knowledge of the development of the bill, my experience on the Health Care Committee, my experience in navigating the legislative process, and my detailed review of the legislative materials, will assist the Board in understanding the evidence introduced at the hearing and in making the determinations required by statute.

¹ See Consumers Union, *50 State Overview: Statutes, Types of Rate Review and Public Participation*, <https://consumersunion.org/wp-content/uploads/2014/06/AppendixA.pdf> (2016).

² GMCB Rule 2.301(b); GMCB Rule 2.401; *see also*, 8 V.S.A. §4062(a)(3).

³ *Id.*

The Legislative History of Act 48

Act 48 (H.202) of the 2011 legislative session was introduced by the Chair of the House Health Care Committee. This original draft was a proposal from the Shumlin administration.⁴ The bill framed up the creation of Vermont's health insurance exchange, the creation of the Green Mountain Care Board, and laid out the steps that would need to take place to move toward a single payer financing system.⁵ As it is widely known, the third part of the bill hit significant roadblocks and a single payer system did not come to be in Vermont.⁶

H.202 touched on many parts of the health care system here in Vermont. Most importantly for this proceeding, it made important changes to the standards for insurance rate review and the process for conducting that review.⁷

The original draft language of the insurance rate review section of the bill included the new criteria that a rate be affordable, promote quality care, and promote access to care. These provisions remained in the bill throughout the legislative process.⁸ Additionally, on March 16, 2011, the House Health Care Committee accepted an amendment offered by Representative Poirier that made the rate review process more transparent by requiring plain language summaries and comment periods.⁹ These additional rate review standards and the Poirier transparency amendment eventually were codified in Vermont statute as part of Act 48.¹⁰

H.202 also amended Vermont's Nonprofit Hospital Service Corporations and Health Maintenance Organizations statutes. These two statutes had previously stated that the commissioner may refuse approval if the rates submitted are excessive, inadequate or unfairly discriminatory.¹¹ H.202 added, to both statutes, another set of criteria, namely, that the commissioner may refuse approval of the rates submitted if they "*fail to meet the standards of*

⁴ H.202, *An Act Relating to a Single-Payer and Unified Health System* (As Introduced February 8, 2011).

⁵ Id.

⁶ E.g., Sarah Wheaton, *Vermont Bails on Single-Payer Health Care*, Politico, <https://www.politico.com/story/2014/12/vermont-peter-shumlin-single-payer-health-care-113653> (2014).

⁷ Fn. 4.

⁸ Id.

⁹ House Health Care Committee, March 16, 2011, *H.202 (As Passed By the House): An Act Relating to a Single-Payer and Unified Health System*, 126-127.

¹⁰ Vt. Act No. 48, 2011.

affordability, promotion of quality care, and promotion of access...” (emphasis added).¹² This added language clarified the pre-existing language of these two statutes that such entities, unlike other insurers, must operate so that “subscriber benefits are provided at minimum cost under efficient and economical management.”¹³

When describing the rate review section of the bill to Senate Finance on April 19, 2011, Robin Lunge, a representative from the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), described the new rate review standards as being based on Rhode Island’s rate review process, which includes a number of factors including an assessment of affordability.¹⁴

On that same day, BISHCA’s general counsel, Cliff Peterson, presented an amendment to Senate Finance regarding which types of insurance products should be included in the new rate review process and which products should remain in the former process at BISHCA. Peterson described the new rate review process as a “higher level of scrutiny” than the previous process. Peterson noted that this was true both because of the Board’s role as well as the public disclosure provisions.¹⁵

The concept of affordability was a major theme in the discussion and the development of Act 48. This concept appears 17 times in the bill (not including references to the Affordable Care Act).¹⁶ During the development of H.202, the legislature heard from numerous consumers about issues they faced with health care affordability, and the resulting challenges to getting needed health care services.

There is one particular exchange in the legislative record where the affordability standard in the rate review process was clearly articulated. On April 19, 2011, Senator Brock addressed the tension between actuarial soundness and affordability and anticipated a scenario in which a

¹² 8 V.S.A. §4512(b); 8 V.S.A §5104(a)(2); *H.202 (As Enacted): An Act Relating to a Single-Payer and Unified Health System*, 118.

¹³ 8 V.S.A. §4584(c); see 8 V.S.A. § 4512(c).

¹⁴ Senate Finance Committee, April 19, 2011, *H.202: An Act Relating to a Single-Payer and Unified Health System*, Testimony of Robin Lunge, Assistant General Counsel, BISHCA.

¹⁵ Senate Finance Committee, April 19, 2011, *H.202: An Act Relating to a Single-Payer and Unified Health System*, Testimony of Clifford Peterson, Counsel, BISHCA.

¹⁶ Vt. Act No. 48, 2011.

rate is actuarially sound but unaffordable to the average consumer.¹⁷ Then Senator Brock asked a representative of BISHCA a question about the tension between the rate review criteria:

You can envision a situation in which you can design a plan that meets all of the cost targets, in other words it is an appropriate charge given what it is that is being insured against, but it simply isn't affordable by anyone other than someone who is earning far more than the average wage. How do you meet both tests?

Cliff Peterson, general counsel for BISHCA at the time, responded to this question by noting that actuarial soundness includes a range. He then stated:

The Green Mountain [Care] Board, which has general responsibility for cost containment elsewhere in the statute... might look at those [proposed rates] and say these may be actuarially sound but they do not promote affordability, you are squeezing Vermonters for every last penny your actuaries will allow. The Board may have a view on that.

At no point in the legislative process was it discussed that affordability refers to actuarial soundness or that simply filling out forms as to actuarial reasonableness would meet the affordability criterion.

I did not find any legislative discussion that explored the meanings of the promote quality of care and promote access to care language of the rate review standard section of the bill. I note, however, that the purpose of the bill, as defined in statute, is “to promote the general good of the state by: (1) improving the health of the population; [and] 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.”¹⁸

House and Senate members in the committees of jurisdiction and on the House and Senate floors largely did not discuss the addition of the “affordable, promotes quality care and promotes access to care” language to the insurance rate review standards. The addition of this language was presented to legislators and adopted without controversy. After a review of all relevant recordings, other than the events described above and a number of additional hearings where the relevant sections of the bill were walked through by legislative council, there were no questions or expressions of concern about the new rate review standards or process.

¹⁷ Senate Finance Committee, April 19, 2011, *H.202: An Act Relating to a Single-Payer and Unified Health System*, Exchange between Clifford Peterson, Counsel, BISHCA, and Senator Randy Brock.

¹⁸ 18 V.S.A. §9372.

The rate review standards were similarly not objected to by third parties. Both Don George and Kevin Goddard of Blue Cross Blue Shield of Vermont and William Little of MVP Healthcare testified in front of the House Health Care, Senate Health and Welfare, and Senate Finance committees.¹⁹ The comments made by insurance representatives at the time did not address the new rate review process or standards. Instead, they commented on whether the small group definition in Vermont should be for businesses under fifty or under one hundred as well as the question of how many insurers should be allowed to participate in the exchange.

Additionally, on April 5, 2011, Don George from Blue Cross Blue Shield of Vermont testified in front of the Senate Health and Welfare Committee. At this hearing, the committee was chaired by the then Vice-Chair of the Committee, Kevin Mullin. George made three comments suggesting changes to the bill that would require the state to include insurer perspectives before making key decisions laid out in the bill.²⁰ Acting Chair Kevin Mullin asked George whether there was anything else Blue Cross objected to in the bill. George responded that Blue Cross was committed to being a productive partner in the reform effort.²¹

H.202 had many significant policy areas that demanded a great deal of focus from witnesses, from members of the administration, and from legislators. However, the addition of the standards of affordability, promotion of access to care, and promotion of quality of care to rate review were adopted without controversy.

It is also clear from the legislative record that the additional rate review standards would apply to either a single-payer health care system or the existing Vermont health care system. Legislators discussed that a single-payer health care system was one possible path to health care reform, but certainly not the only path considered at the time.

The Legislature did not tie the rate review process to the implementation of the single-payer health care system that was discussed in Act 48. Further, five legislative sessions have occurred since Governor Shumlin announced his decision not to pursue a single-payer health care system in Vermont, and the Legislature has not changed the rate review standards.²² As

¹⁹ Senate Health and Welfare Committee, April 5, 2011, *H.202: An Act Relating to a Single-Payer and Unified Health System*, Testimony from Don George, Blue Cross & Blue Shield of Vermont.

²⁰ *Id.*

²¹ *Id.*

²² *Fn. 2.*

Robin Lunge (then of BISHCA) testified, the expanded rate review process was designed to apply to all existing health insurance plans, well before any single-payer health care system would have been implemented.²³

Expert Opinion

Based on my review of the historical legislative record detailed above and my experience as a legislator during the passage of Act 48, it is my opinion that:

1. The inclusion of the affordability standard in the rate review process was a recognition that a lack of affordability interferes with Vermonters' ability to get the care that they need.
2. Among the criteria the Board must consider in rate review, the terms affordable, promote quality care, and promote access to health care are independent standards, separate from a traditional actuarial analysis that considers whether proposed rates are "excessive, inadequate or unfairly discriminatory" and an analysis of insurer solvency.

²³ Fn. 11.