OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

Health Insurance Rate Review Standards in Vermont

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Issue

Describe Vermont's health insurance rate review standards.

Summary

Generally, health insurance rate-review refers to the process by which a designated regulatory official or agency reviews health insurance rates to determine whether to approve, change, or deny an insurer's rate change request. In Vermont, the Green Mountain Care Board (GMCB) is responsible for regulating health insurance and conducting rate reviews. Prior to approving a rate, Vermont law requires the board to determine whether the rate, among other things, is affordable; promotes the quality of, and access to, health care; and protects insurer solvency (Vt. Stat. Ann. Tit. 8, § 4062).

Vermont Health Insurance Rate Review

Green Mountain Care Board

The GMCB was created in 2011. It reviews hospital budgets and major capital expenditures and it reviews and approves rate filings for comprehensive major medical health insurance plans. Major medical health insurance plans may not be sold in Vermont unless the premium rates are approved by the board. In general, the board has 90 days after an insurer files a proposed rate to approve, disapprove, or modify it.

Review Criteria

In approving, disapproving, or modifying an insurer's proposed rate, the board must determine that it is:

1. affordable;
2. promotes quality care;
3. promotes access to health care;
4. protects insurer solvency; and
5. not unjust, unfair, inequitable, misleading, or in violation of Vermont law (Vt. Stat. Ann. Tit. 8 § 4062).

According to the GMCB, many of these standards, including affordability, are "general and open ended," and are not defined in statute (re MVP Health Insurance Co., 2016 VT 111, ¶ 16).

The proposed rate also cannot be excessive, inadequate, or unfairly discriminatory. These are generally actuarially defined terms. According to the Actuarial Standards Board, a rate may be considered:

1. unfairly discriminatory if it results in different premiums for individuals with similar risk profiles and the class of individuals is protected by law or the difference in premium does not correspond to the difference in risk, and
2. excessive or inadequate if it exceeds or fails to meet the rate necessary to pay claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins. (In Connecticut, excessive is interpreted to mean rates that are disproportional to the benefits provided and inadequate rates are interpreted as rates low enough to endanger the insurer's solvency).

Reviewing Rates

In making its determination, the board must consider:

1. legal requirements;
2. changes in health care delivery, payment methods, and costs;
3. an analysis of the proposed rate's impact on the insurer's solvency and reserves; and
4. any other issues the board determines relevant (GMCB's Rule 2.00 and Vt. Stat. Ann. Tit 18, § 9375(b)(6)).

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