REPORT TO THE HOUSE COMMITTEE ON HEALTH CARE, HOUSE WAYS AND MEANS COMMITTEE, SENATE COMMITTEE ON HEALTH AND WELFARE AND THE SENATE FINANCE COMMITTEE
ON
HOW HOSPITALS AND HEALTH INSURERS FINANCE REGULATORY ACTIVITIES

GREEN MOUNTAIN CARE BOARD AND
VERMONT DEPARTMENT OF FINANCIAL REGULATION
FEBRUARY 1, 2013

Submitted by
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Section 5a of Act 171 of 2012 requires that no later than Feb. 1, 2013, the Vermont Department of Financial Regulation (formerly BISHCA) and the Green Mountain Care Board submit a **report "regarding the allocation of expenses among hospitals and health insurers to finance the department's and the board's regulatory activities pursuant to 18 V.S.A. §§ 9374(h) and 9415"** to the House Committee on Health Care, House Ways and Means Committee, Senate Committee on Health and Welfare and Senate Finance Committee. The report must address "the basis for the formula and how it is applied and shall contain the department's and the board's recommendations for alternate expense allocation formulas or models."

Act 171 authorized the Green Mountain Care Board (Board) to bill back to hospitals and insurance carriers costs of certain activities related to health care system oversight. 2011, No. 171 (adj. sess.), § 5. As part of that authorization, the Legislature required the Board and the Department to jointly submit this report. The General Assembly originally delegated identical bill back authority to the Department of Financial Regulation (Department) in 1996. 1995, No. 180 (adj. sess.), § 19.

Background on Department and Board bill back authority related to data and budgets

The initial authorizing legislation for this bill back was passed in 1996 to support the activities of the Health Care Authority (HCA)[1]. When the HCA moved into the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISCHA), the authority for this bill back transferred to BISHCA (now the Department).

While it is unclear why this was initially established as a "bill back" and not a fee, a report[2] filed in March, 2011 by the Commissioner of the Department of Finance and Management provides the distinction between these two funding mechanisms and why one would be chosen over the other. A bill back is appropriate when the amount of the charge needed to cover the cost of the service provided by the state cannot be determined in advance and is designed to recover the actual governmental costs of regulating a given industry. A fee is a specified amount required by statute to cover the costs of regulating when the cost of the service can be identified in advance. This report also noted that there are many instances of bill back authority in Vermont statutes.

[1] Session Law 180 of the Acts of 1995.

[2] http://www.leg.state.vt.us/reports/2011ExternalReports/267429.pdf

When the bill back was first passed in 1995, there was a consensus that regulatory activities categorized as data or budget can be billed back to the industry. While these two terms were not defined in statute, the consistent interpretation by both HCA and BISHCA is that costs, whether staff or contract, related to hospital budgets, expenditure analysis, certificate of need and data development could be billed back to the industry. [3]

In order to identify the costs, HCA and BISHCA looked to the General Assembly definition of 'cost': 'cost' shall be narrowly construed, but may include reasonable and directly related costs of administration, maintenance, and other expenses due to providing the service or product or performing the regulatory function."[4] The statute also requires matching State funds to control the growth of the bill back. The State is required to provide 40 percent of the funds for data and budget work, while the remaining amount is split among hospitals, non-profit medical service corporations, Health Maintenance Organizations and insurance companies.

This bill back has been administered in the same, consistent manner since passage. The annual amounts are based upon budget costs related to staff, contract and operating costs that provide the regulatory oversight for data and budget regulation. If the costs vary from budget during the year, the practice has been to apply a credit or debit in the following year. Current practice also limits the rate of budget growth to any corresponding increase in the overall Department budget, unless the law has been changed to require more oversight. The Department made an internal decision that the industry should not bear the full 60 percent burden of the regulatory processes spelled out in statute. For FY13, the bill back burden to the industry was $395,214. All of the regulatory activities for budget and data exceed $3 million annually and therefore a full 60 percent share of this would be at least $1.8 million.

Allocation of bill back costs

The sharing of costs under the bill back is defined in statute:

> 40 percent by the state from state monies, 15 percent by the hospitals, 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125, 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101, and 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.[5]

[3] For example, if three out of 10 employees are designated to work on tasks relating to data and budget, then 30 percent of the department's budget can be billable to the industry.
[4] 32 V.S.A. Sec. 603(2)
[5] 18 V.S.A. §§ 9374(h)(1), 9415(a)

Hospitals are responsible for one-quarter of the 60 percent industry share. The amount that each hospital owes currently depends on each hospital's number of acute admissions. For example, in FY13, Fletcher Allen Health Care was assessed $40,313. Appendix A includes a full chart of the FY13 assessments to the hospitals.

Non-profit hospital/medical service corporations are responsible for another quarter of the bill back. Blue Cross Blue Shield of Vermont (BCBSVT) is the only entity with this statutory designation. In FY13, BCBSVT was assessed $98,804.

Health insurance companies are responsible for one quarter of the bill back. Currently, to reduce the administrative burden, only health insurers who have $100 or more in revenue are billable. This includes all insurers who are licensed in Vermont. Appendix B includes a full chart of the FY13 assessments to health insurance companies.

Health Maintenance Organizations are responsible for the final quarter of the bill back. The Vermont Health Plan (TVHP) and MVP Health Care are the only licensed HMOs in the state of Vermont. TVHP and MVP Health Care were assessed $98,804 in FY13.

The portion that health care insurers pay is based on insurer earned premium.

Options for altering the allocation of bill back costs The Board and Department have identified three alternatives for structuring bill back as potential replacements for the formula above:

1. *Change the statutory formula*. The statutory formula requires that the State contribute 40 percent and the industry 60 percent. This formula could be changed so that the industry bears a greater burden than 60 percent and the state's share is reduced. This option can be used in conjunction with the second option below.
2. *Change the distribution of the industry share of the bill back*. Current practice is that the health insurance companies pay 75 percent of the bill back and hospitals pay 25 percent. This could be altered so that the bill back is split equally – or, for example, 65 percent/35 percent -- between health insurers and hospitals.
3. *Convert the bill back to a fee that would be reviewed by the General Assembly every three years*.

Recommendations

Having weighed the alternatives, the Board and Department recommend that this bill back and its formula remain as initially constructed in statute and as currently administered. We make this recommendation for the following five reasons: 1. This bill back has been consistently and fairly administered for the past 18 years; 2. The state staff and the industry are familiar with this bill back and report no confusion about its implementation; 3. This bill back is for a very small amount, $395,117 in FY13, compared with other bill backs and fees; 4. With the exception of MVP Health Care, the regulated industry does not object to the administration of this bill back; 5. Changing the structure of this bill back would require significant state staff training and implementation as well as having the capacity to cause confusion – and even more cost -- within the regulated industry.

Appendix A: Hospital Budget Assessment FY13

Hospital Name	Assessment
Brattleboro Memorial Hospital	$3,530
Copley Hospital	$3,735
Central Vermont Medical Center	$6,783
Grace Cottage Hospital	$426
Fletcher Allen Health Care	$40,313
Gifford Medical Center	$2,601
Mt. Ascutney Hospital	$923
North Country Hospital	$3,137
Northeastern Vermont Regional Hospital	$2,700
Northwestern Medical Center	$4,612
Porter Hospital	$3,346
Rutland Regional Medical Center	$13,671
Southwestern Vermont Medical Center	$8,080
Springfield Hospital	$4,947
TOTAL	$98,804

*Note that Grace Cottage Hospital, Mt. Ascutney Hospital, Porter Hospital, and Rutland Regional Medical Center all received adjustments in the FY13 assessment due to credits from the prior year's assessments.

Appendix B: Insurance Carrier Assessment FY13

Insurance Carrier Name	Assessment
Aetna	$3,140
American Heritage	$68
Blue Cross Blue Shield of Vermont-Medical Service Corporation	$98,804
Blue Cross Blue Shield- TVHP	$59,387
CIGNA	$76,316
John Alden Life Insurance Company	$110
MVP Health Insurance	$14,756
MVP- Health Maintenance Organization	$39,417
New York Life Insurance Company	$196
QCC Insurance Company	$763
State Farm	$274
United Health Care	$3,008
United States Life Insurance Company	$74
TOTAL	$296,313