STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont	)	GMCB-008-16rr
2017 Vermont Health Connect Rate Filing	)	
	)	
SERFF No. BCVT-130567350	)	
	)	

DECISION & ORDER

Introduction

On May 11, 2016, BCBSVT proposed an 8.2%[1] average annual rate increase for its health plans offered on the state's health benefit exchange, Vermont Health Connect (VHC), with coverage beginning January 1, 2017. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. The Patient Protection and Affordable Care Act of 2010 (ACA) requires that individuals and families have qualifying health insurance coverage or pay a penalty on their personal income tax returns. Qualifying coverage includes insurance provided by or through an employer, insurance purchased through the health benefit exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

2. Vermont Health Connect offers qualified health plans (QHPs) on Vermont's health benefit exchange (exchange) to individuals, families and small employers with rates based on a single risk pool that includes the individual and small group markets. 33 V.S.A. §§ 1803, 1811. For plan years 2014 and 2015, a "small employer" was defined as employing up to 50 employees. Beginning in 2016, Vermont law expanded the definition to include employers with 51-100 employees. 33 V.S.A. §1811(a)(3) (defines small employer to include up to 100 employees as of January 1, 2016).

3. Plans are offered to consumers in four "metal levels": bronze, silver, gold, and platinum. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.[2]

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[1] As explained in the decision, BCBSVT originally filed for an 8.17% increase (rounded to 8.2%) and later recalculated the increase to 8.6%. *See* Finding of Fact (Finding) ¶ 25.

[2] Catastrophic coverage is characterized by low premiums and high deductibles. Individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

4. To make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance, individuals enrolling for coverage through VHC may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan"). In addition, Vermont caps the percentage of household income that eligible individuals and families pay for health insurance premiums and offers subsidies for lower deductibles and copayments.

5. The ACA includes three risk spreading programs with mechanisms intended to stabilize costs and provide incentives for insurers to participate in the exchanges. The transitional reinsurance program, funded through fees levied on health insurance plans, ends with the 2016 plan year, as does the risk corridor program.

6. The third risk spreading program is permanent, and applies to ACA-compliant plans in both the individual and small group markets. Under the risk adjustment program, insurers with an enrolled population with lower than average actuarial risk will provide payments to insurers that have an enrolled population with higher than average actuarial risk. The program is intended to reduce incentives for insurers to structure plan offerings to make them most attractive to a healthy, low risk population, while unattractive to a less healthy population more in need of insurance services.[3]

Procedural History

7. On May 11, 2016, BCBSVT filed its 2017 Vermont Health Connect Rate Filing proposing an 8.17% average rate increase through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed exchange rates for coverage commencing January 1, 2017. Exhibit 1.

8. On May 20, 2016, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of Appearance as an interested party to the proceeding.

9. On July 8, 2016, the Vermont Department of Financial Regulation (DFR), the principal solvency regulator of this Vermont-domiciled insurer, issued an opinion and analysis of the impact of BCBSVT's rate filing on the company's solvency. DFR opined that the proposed rates are unlikely to materially impact the solvency of BCBSVT, contingent on a finding by the

[3] Additional information is available about the three risk spreading programs at https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8544-explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors1.pdf.

Board's actuary that such rates are adequate and maintain the company's surplus to keep pace with medical trend and anticipated membership growth. More specifically, DFR advised the Board that BCBSVT's risk based capital (RBC) decreased slightly in 2015, and the rate as proposed in this filing will put "further downward pressure on RBC." Exhibit 12 at 182.

10. Lewis & Ellis (L&E), the Board's contract actuary, conducted a review of the filing and issued an actuarial memorandum summarizing its analysis and recommendations. The memorandum was posted to the Board's website on July 11, 2016. Exhibit 13.

11. The Board held a public administrative hearing on July 20, 2016. Noel Hudson, Esq. served as hearing officer by designation of Board Chair Al Gobeille. Jacqueline Hughes, Esq. represented BCBSVT. BCBSVT's Chief Financial Officer (CFO) Ruth Greene and Actuarial Director Paul Schultz testified on the company's behalf. Lila Richardson, Esq. and Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Consulting. Ryan Chieffo, Esq., Assistant Director of Rates and Forms for DFR, testified regarding DFR's solvency analysis. Judith Henkin, Esq. General Counsel, represented the Board and conducted the examination of David Dillon, Vice President and consulting actuary for L&E.

12. The Board accepted public comments from May 11, 2016 through July 26, 2016,[4] receiving 133 total comments referencing rate filings for both insurers offering plans on the exchange. In addition, eleven members of the public spoke against BCBSVT's proposed rate increase at the July 20, 2016 public hearing. The public comments overwhelmingly address the issue of affordability for Vermonters and oppose any increase in premium rates.

13. Based on issues raised during the administrative hearing, the Board requested clarification and additional information from BCBSVT on June 28, 2016. BCBSVT responded in writing to the Board's request on August 2, 2016.

Findings of Fact

Nature of the Filing

14. BCBSVT is a non-profit hospital and medical service corporation that provides major medical, Medicare supplement, and prescription drug coverage to Vermonters. BCBSVT is one of two insurers offering coverage on VHC, insuring approximately 90% of its covered lives.

[4] Although the deadline for accepting comment expired on July 26, 2016, additional comments were received and reviewed by the Board subsequent to that date.

15. BCBSVT offers consumers in the exchange both standard and non-standard plans. The standard plans are not unique to the carrier and provide benefits approved by the Board, offer members access to a nationwide network of providers, and include coverage for all Essential Health Benefits (EHB).[5] The non-standard plans are carrier-specific but still must comply with all requirements for participation in the exchange.

16. As of March 2015, BCBSVT had approximately 70,000 covered lives in VHC plans. BCBSVT projects its membership will grow in 2017 by approximately 7,000 new members, the majority of whom (an estimated 6,500) will have been previously enrolled in Medicaid. The remaining projected membership is a result of the expansion of the small group market to include groups of from 51-100 members. Exhibit 1 at 17.

Summary of the Data, Analysis, and Testimony Presented at Hearing

17. BCBSVT developed its 2017 VHC rates using claims incurred from January 1, 2015 through December 31, 2015, and paid through February 29, 2016 (experience period), by its individual and small group QHP membership. Exhibit 1 at 15.

18. BCBSVT projected the experience period claims forward to the rating period using an allowed medical trend[6] factor of 4.3% and pharmacy trend of 10.2%. The medical trend comprised a 3.3% unit cost trend and a 1.0% utilization trend. Exhibit 1 at 25. To arrive at the 1.0% utilization trend, BCBSVT reduced the observed 1.7% trend based on its view that the trend was artificially skewed upward due to effects of greater utilization during the first two years of the exchange. Exhibit 1 at 24; Exhibit 10 at 164; ¶ 5.

19. BCBSVT proposes that administrative expenses, reallocated among plans based on results from an extensive cost accounting study, will increase PMPM premiums for members affected by this filing by 0.9%. BCBSVT calculates that the administrative costs average 6.91% of premium. Exhibit 1 at 12, 34, 74.

20. Based on its projections for increased 2017 enrollment as a result of the state's Medicaid eligibility reverification, BCBSVT calculates that it will require a 3.8% short-term

[5] The ten Essential Health Benefits under the ACA are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive care, and pediatric care (including pediatric dental and vision services).

[6] In basic terms, trend refers to the change in the cost of health care and consists of utilization (frequency of use of the product or service) and unit cost (price).

contribution to reserve (CTR) to maintain its risk based capital (RBC)[7] levels within its established target range. Exhibit 1 at 35. If BCBSVT were to assume that there is no migration to VHC from the Medicaid population, its calculation yields a lower short-term CTR of 1.7%. For this filing, however, BCBSVT proposes a 2.0% CTR, which it identifies as its long term target to manage fluctuations in membership and health care cost trend, and to maintain RBC levels within its established target range. Exhibit 1 at 35, 75.

21. At hearing, DFR Director Ryan Chieffo testified that DFR monitors insurers' solvency with a variety of tools, including RBC, to assess their financial health. Chieffo emphasized, consistent with DFR's written solvency opinion, that BCBSVT's current filing "builds in [a] decrease to risk based capital and builds in a risk to solvency as a result." Hearing Transcript (TR) at 93. Reminding the Board that the filing represents over 50% of BCBSVT's insured premium, he cautioned the Board not to further increase financial risk to the company by reducing the CTR. *Id*.

22. L&E actuary David Dillon also addressed the reasonableness of BCBSVT's CTR request, testifying that the company's "solvency metrics are right in line and are not excessive." Referencing the company's negative average CTR of -0.8% over a five-year period from 2011 to 2015, *see* Exhibit 13 at 193, Dillon opined that BCBSVT does not incorporate "implicit margins" in its rate filings, and that based on L&E's peer analysis of other Blue Cross plans nationwide, BCBSVT's RBC level falls in the "bottom third." TR at 123-125.

23. Donna Novak, testifying for the HCA, confirmed her written opinion that BCBSVT's proposed 2.0% CTR should be reduced to 1.3%, the same CTR utilized in a recent BCBSVT large group rate filing, to make rates more affordable for Vermont consumers. Novak opined that BCBSVT would require a 2.8% CTR to maintain its RBC levels in the short term, rather than the 3.8% calculated by BCBSVT, but acknowledged that some of the assumptions she used to arrive at the 2.8% figure "could be wrong." TR at 167-168. In addition, Novak offered calculations based on BCBSVT's 2011 through 2015 annual statements suggesting that it could maintain an RBC level safely within its target range of 500 to 700 if the CTR in this filing was reduced below 1.3%. TR at 150-157; Exhibit 14 at 203, 216, 2018.

[7] Risk-Based Capital is a method of measuring the capital required by an insurer to support its overall business operations in consideration of its size and risk profile.

24. Since 2014, BCBSVT has experienced medical loss ratios (MLRs)[8] for its VHC filings averaging approximately 90%, which is slightly above its expected MLRs, and higher than the 80% MLR required under the ACA. For this filing, BCBSVT projects a 90.9% loss ratio. Exhibit 1 at 78.

25. As of the date this rate request was filed, BCBSVT projected that it would receive a risk adjustment transfer payment from MVP, the only other carrier in the VHC market, and the effect of the payment was reflected in its proposed rate increase. After the Centers for Medicare & Medicaid Services (CMS) released final risk adjustment data on June 30, 2016, however, BCBSVT revised its calculation, resulting in its conclusion that it would make, rather than receive, a payment under the program. BCBSVT's revised calculation increased its proposed average rate change from 8.17% to 8.6%. Exhibit 10 at 164, 167, 168.

26. On review of the filing, L&E also recommends modifying the risk adjustment component of BCBSVT's rate based on the final CMS data. To arrive at a projected risk adjustment transfer amount for BCBSVT, L&E gathered data from both carriers in VHC, including confidential MVP data not available to BCBSVT, and determined that BCBSVT's assumed risk adjustment receivable would be reduced from the $1.36 PMPM shown in the carrier's initial rate filing, to $1.04 PMPM, slightly increasing the proposed rate change from 8.17% to 8.24%. Exhibit 13 at 193. BCBSVT has reviewed and agrees with L&E's recommended modification. TR at 30.

27. L&E recommends no other modifications to the filing, and has opined that after the risk adjustment modification, the filed rates would not be excessive, inadequate, or unfairly discriminatory. Exhibit 13 at 193.

28. At hearing, BCBSVT Actuarial Director Paul Schultz testified that BCBSVT's rates as filed are actuarially reasonable, adequate, and not excessive. When asked if the proposed rates are affordable, Schultz noted that 90% of the premium dollar is used to pay member claims, and that as a result, the proposed rates "can only be considered unaffordable if the underlying cost of health care is unaffordable." TR at 32.

29. Schultz also explained BCBSVT's methodology for determining the unit cost component of its medical trend, including how hospital budget review information is

[8] Medical loss ratio (MLR) is the amount of premium dollar an insurer spends on health care claims, as opposed to what it spends on administration, marketing and profit. The ACA requires that insurers covering individuals and small groups have an MLR of 80.0% or higher. Insurers failing to meet the standard must issue consumer rebates.

incorporated in the calculation. Schultz testified that the unit cost utilized by BCBSVT for provider reimbursement for 2017 exceeds the proposed 2.2% increase in commercial rates, as requested by Vermont hospitals in the current budget review process, because unit cost trends have risen and BCBSVT's calculation includes out-of-state providers and others not subject to Board regulation. TR. at 44-46; *see also* Exhibit 1 at 25 (Annual Reimbursement Changes due to Budget Increases and Contracting Season). Schultz acknowledged that as BCBSVT's actuary, he does not have input on how providers are paid, but those decisions nonetheless rest with BCBSVT through its provider contracting department. TR at 19-22, 48.

30. BCBSVT CFO Ruth Greene also testified about how the hospital budget process affects the unit cost component and calculation of medical trend. Greene explained that BCBSVT begins contract negotiations with providers in the fall once the Board issues hospital budget orders, and that BCBSVT's contracting process is an "ongoing cycle" through the end of the year, sometimes extending into the following year. TR at 80-82. Greene stated her belief, however, that if the Board were to reduce BCBSVT's requested rate, it would not achieve a reduction in the cost of health care services. *Id*. at 58. Greene explained that BCBSVT's "integrated health management practices," including prior authorizations, help control utilization by ensuring that providers "are providing [BCBSVT members] the right services at the right time and in the right combination." *Id*. at 59-60.

31. On July 28, 2016, Schultz provided a follow-up written submission to the Board regarding the increase in provider payments, as reflected in BCBSVT's unit cost calculation. Schultz explained that BCBSVT's unit cost trend differs from the 2017 proposed hospital budget commercial rates of 2.2% because BCBSVT's calculation includes a rate reduction for Rutland Regional Medical Center (RRMC) effective as of May 1, 2016; the 2.2% figure fails to account for the timing of rate increases and decreases; BCBSVT weights the rate change by both facility and by VHC membership; and last, BCBSVT's calculation includes a break-down by types of services provided to its members. BCBSVT Letter (Aug. 2, 2016), *available at* http://ratereview.vermont.gov/BCVT-130567350

Standard of Review

1. Vermont law provides that the Board shall review health insurance rate filings to ensure that rates are affordable, that they are not "excessive, inadequate or unfairly discriminatory," that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8

V.S.A. §§ 4512(b); 4062(a)(2), (3); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6). When approving rates for a non-profit hospital service corporation, the Board has authority under 8 V.S.A. § 4513 to attach supplemental orders necessary to ensure that benefits and services are provided at minimum cost under efficient and economical management of the corporation.

2. As part of its review, the Board will consider DFR's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, § 2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id*. § 2.104(c).

Conclusions of Law

In issuing our decision today, we initially note that BCBSVT's actuarial projections and those performed on our behalf by L&E are in alignment, and that BCBSVT's projections for preceding plan years have achieved a high degree of accuracy. In addition, the record demonstrates that BCBSVT has consistently and ably managed its finances to maintain company solvency, notwithstanding problems related to the implementation of VHC that caused it to experience unexpected costs of plan administration. Indeed, BCBSVT has been able to maintain a modest target RBC range of from 500-700%, while experiencing a negative contribution to its reserves—funds that are set aside to protect BCBSVT's membership from unforeseen events that could create a one-time shock to capital. Findings ¶¶ 21, 22. Further, BCBSVT has maintained loss ratios that have exceed federal requirements and has garnered a commanding market share of enrollees—90% of all covered lives—in Vermont's health benefit exchange. Findings ¶¶ 14, 24.

In light of its sizeable market share and its ability to carefully manage solvency, we reasonably believe that BCBSVT can and should exercise its considerable bargaining power in contract negotiations with health care providers to reduce the unit cost (pricing) component of the medical trend incorporated into the proposed rates. While we recognize that there are rating components over which the company has little to no influence, our findings demonstrate that BCBSVT can impact unit cost through the contracting process, and can exert downward pressure on the rates ultimately charged to its members. Based on its substantial market share, efficient

financial management, status as a non-profit entity operating in the best interest of its subscribers, and ability to influence both the timing and outcome of contract negotiations, we believe that BCBSVT must work to reduce premium growth by placing reasonable and measured limits on provider rate increases.

Accordingly, we conclude that BCBSVT, as the predominant insurer in our health benefit exchange, must use its leverage to reduce the portion of its unit cost assumption for 2017 that is attributable to providers under the ambit of our hospital budget review process. In doing so, we note that 2.2% is a provisional figure at this juncture, and does not account for any future commercial rate reductions ordered by the Board through its final hospital budget orders. Limiting BCBSVT's unit cost growth to the 2.2% commercial rate increase, as reflected in the current hospital budget submissions, provides the carrier with a clear and reasoned growth target, minimizes financial risk due to underestimation of trend, and further dampens growth of health care costs.

Next, we conclude that BCBSVT can and must reduce its utilization assumption from the 1.0% included in this filing to 0.5%, decreasing its overall medical trend and the rate increases experienced by Vermont health care consumers. As explained in the written record and in BCBSVT's testimony at hearing, the carrier selected a lower utilization trend than its observed trend of 1.7% to account for artificial increases in volumes during the first two years of Vermont Health Connect. Finding ¶ 18. Although we do not seek to replace BCBSVT's actuarial judgment with our own, we find that the carrier's ability to target a lower utilization level than reflected in recent member experience is indicative of its overall capacity to impact utilization levels; BCBSVT's "integrated health management practices" initiative, discussed at hearing, is one such example. Finding ¶ 30. Although our direction to reduce the utilization component of trend only minimally affects the proposed rates, we find that it encourages, and is consistent with, BCBSVT's stated interest to ensure that members receive, and providers provide, "the right services at the right time and in the right combination." *Id*.

We next address the HCA's request that the Board reduce the carrier's proposed 2.0% CTR for this book of business. In light of BCBSVT's actual CTR results over a five-year time span —on average, BCBSVT achieved a negative -0.8% CTR— and its confirmed need for a short-term CTR of 3.8%, we do not agree that any reduction in CTR is warranted at this time. Findings ¶¶ 21, 22. To the contrary, we conclude that the HCA's expert witness, Donna Novak, offered no cogent rationale for reducing the CTR, either in her hearing testimony in which she

acknowledged that some of her calculations may have incorporated erroneous assumptions, or in her written Report illustrating those calculations. *See* Finding ¶ 23; Exhibit 14. While it is axiomatic that reducing CTR without adjusting other rate components will always produce lower consumer rates in the short term, we do not agree that in this instance it can guarantee rates adequate to cover medical claims of BCBSVT's members, nor that the insurer can acquire needed reserves to protect those members against unusual and unforeseen occurrences such as a natural disaster or disease outbreak.

We are also unpersuaded by Ms. Novak's opinion that BCBSVT's RBC will remain comfortably within target range if the CTR were reduced below 1.3%. This statement is in clear contrast to the opinions and testimony of both DFR—the company's financial regulator —and our own actuary, which confirmed that a 3.8% CTR is needed in the short term, and a 2.0% CTR is reasonable in the long term. *See* Findings ¶¶ 21, 22. Based on the credible evidence in the record, we simply cannot conclude that our approval of a 2.0% CTR for this filing affords the carrier an unreasonably high RBC level, if that level were to increase at all once the approved rate is implemented.

This discussion necessarily leads us to respond to member Hogan's dissent in which he faults the majority for failing to more vigorously reduce BCBSVT's requested rate. Similar to Mr. Hogan's position, many of the comments we received from members of the public challenge us to deny the carrier any rate increase at all in this filing. We decline the invitations, and find that cutting or denying a rate increase as suggested would be unreasonable and contrary to our statutory obligation as a regulator of insurance rates. Indeed, if we were to deny BCBSVT any rate increase at all, we effectively deny it the ability to pay for its members' medical claims, and therefore do nothing to promote quality health care in Vermont, where only two insurers currently participate in the exchange, with BCBSVT covering the largest number of Vermonters by far. Based on our rudimentary calculations, we would expect that denying any increase at all would result in the carrier falling approximately $32 million short in its ability to pay member claims for 2017, a problem which is compounded in 2018 when it would need to implement rate increases of anywhere from 19% to 22% to make up for the shortfall, while never recouping its 2017 losses. We see no wisdom in sacrificing Vermonters' access to health insurance coverage, the company's solvency, or its continued ability and willingness to offer plans on the Exchange, by making unfounded cuts to rates that meet actuarial standards, in favor of short term gains in affordability.

Finally, we note that BCBSVT does not contest L&E's risk adjustment calculation, *see* Finding ¶ 26, and therefore include in our Order a requirement that BCBSVT implement the recommended modification.

Order

Based on the reasons discussed above, the Board modifies and then approves BCBSVT's 2017 Vermont Health Connect Rate Filing. Specifically, we order that BCBSVT: (1) reduce the FY2017 assumed increase in unit cost trend attributable to Vermont providers subject to hospital budget review from 2.9% to 2.2%; (2) reduce the assumed utilization component of medical trend from 1.0% to 0.5%; and (3) modify the risk adjustment receivable to reflect the $1.05 PMPM calculated by L&E.

As modified, the average annual rate increase is reduced from the proposed 8.2% to 7.3%.

So ordered.

Dated: August 9, 2016 at Montpelier, Vermont

s/ Alfred Gobeille	)	
	)	
s/ Jessica Holmes	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Betty Rambur	)	OF VERMONT

** Board Members Cornelius Hogan and Allan Ramsay have each filed a separate dissent to this decision, which is attached.*

Hogan, dissenting: Although I agree with the majority's decision to reduce the utilization assumption and to more closely align this filing with our most recent hospital budget submissions, I still believe that BCBSVT's rate request is too high. It is my opinion that the Board's decision does not adequately consider affordability of the rate request, which is paramount to our charge under Act 48.

Our actuary, L&E, has done an excellent job for the Board, but restricts its analysis to an actuarial comparison of rate filings from one year to the next, assessing whether each component is reasonable. Based on my background in business, I believe that controlling and shaping a business is best done through a broad balance sheet analysis, and any review of a rate filing should include a thorough review of the insurer's balance sheets.

Viewing BCBSVT through a wide lens, I believe that the company has maintained a healthy balance sheet over the last several years. The company has maintained a stable asset-to-liability ratio, and a sound level of surplus. In addition, the company's revenue-to-total membership ratio has been stable, and its net income has modestly increased. On the whole, BCBSVT is a healthy, well-managed company that I believe has remained isolated from much of the stress experienced throughout the rest of the health care world, and by the people who are served by it.

Over the last several years, BCBSVT's spending on administrative costs grew, while its membership also grew. While I agree with the company's actuary that much of the increase in administrative expenses stem from problems with Vermont Health Connect, my assumption is that those problems will progressively lessen over time, and that the carrier can therefore begin to lower its administrative expenses in 2017 and their impact on members affected by this filing. Furthermore, given that more than three-quarters of BCBSVT's administrative expenses are attributed to personnel costs scheduled to increase by 3.0% annually, I believe that the company must actively pursue administrative cost savings to ensure that other Vermonters do not experience negative wage growth as they struggle to pay for the ever-rising costs of health care coverage and services.

In addition, I would choose to cut BCBSVT's requested CTR from 2.0% to 1.0%. In three of the last four years, the Board has reduced CTR with minimal impact on capital, on surplus, or on the balance sheet as a whole. For its 2017 Vermont Health Connect filing, MVP—the only other carrier offering plans in the Exchange—requested and received a 1.0% CTR. Based on these reasons and those outlined in Board member Ramsay's dissent, I believe a 1.0% increase in CTR is sufficient.

Based on these several reasons, I respectfully dissent.

Ramsay, dissenting: Nonprofit entities offering health insurance to Vermonters, including BCBSVT, require careful examination related to reserves and surplus. Because they have an obligation to serve the public interest and are exempt from some taxes, they should restrict their reserves to only what is necessary to protect their solvency, and to protect themselves in cases of high claims. Nonprofit insurers should not be retaining excessive reserves simply to cover administrative costs, pay unreasonably high salaries, or provide other forms of compensation to their management. *See* Consumers Union, *How Much is Too Much: Have Nonprofit Blue Cross*

Blue Shield Plans Amassed Excessive Amounts of Surplus? (July 2010), *available at* http://consumersunion.org/wp-content/uploads/2014/04/surplus_report.pdf.

Contribution to reserve (CTR) is a significant component of the premium dollar. Although the concept of "rate stabilization" is the dominant theme of virtually every public comment received by the Board related to this 2017 BCBSVT rate request, there is no credible evidence that higher reserves lead to rate stabilization in the commercial health insurance market. To the contrary, a higher CTR achieves just the opposite by increasing the rates experienced by Vermont consumers.

This year, BCBSVT requested a 2.0% increase to its CTR, the same as its request for the 2016 rate filing. The record for this filing, however, as provided to us by BCBSVT, indicates that increases due to per member per month (PMPM) claims costs, standing alone, would only require a CTR of 1.7%. Exhibit 1 at 27. I am not persuaded that the carrier will experience substantial membership increases, as projected in this filing, as a result of from the State's Medicaid eligibility redetermination, which lead to its substantially higher total premium projections and elevated CTR requirement. In addition, the actuary for the Office of Health Care Advocate testified that BCBSVT maintains an RBC level in the upper quartile of its own targeted range, and that its CTR could safely be reduced below 1.3%. TR at 156; Exhibit 14 at 203. And notwithstanding our decision to reduce the CTR from a requested 2.0% to 1.0% for its 2016 filing, BCBSVT's financial stability remains strong.

For these reasons, I support reducing the CTR from 2.0% to 1.0%, in addition to the modifications approved by the majority, further lowering the requested rate increase. I also encourage BCBSVT to take measures to reduce its administrative costs to their lowest possible level.

I respectfully dissent.

Filed: August 9, 2016

Attest: s/ Janet Richard
Green Mountain Care Board, Administrative Services Coordinator

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail address: Janet.Richard@ vermont.gov). Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.