STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield Vermont	)	
2017 Qualified Health Plan Rate Filing	)	GMCB-08-16-rr
	)	

MOTION FOR RECONSIDERATION

Blue Cross and Blue Shield of Vermont (BCBSVT) moves for reconsideration of the Board's decision in this docket with respect to its ordered reductions to the FY2017 assumed increase in unit cost trend attributable to Vermont providers subject to the GMCB hospital budget review from 2.9% to 2.2% and to the assumed utilization component of medical trend from 1.0% to 0.5%.

BCBSVT has carefully reviewed the Board's decision and is concerned that the decision is not based on differences of actuarial opinion but rather on assumptions that are not supported by the evidence. The actuaries opining on the filing agreed that each and every one of BCBSVT's underlying assumptions were actuarially appropriate and actuarially supported. Further, the GMCB found and the record demonstrates that BCBSVT has a long track record of a high degree of accuracy with its rate projections. GMCB August 9, 2016 Decision (revised), p. 8. Rather than rely on the actuarial conclusions of the three actuaries who reviewed the filing, the Board instead has based its decision on assumptions that BCBSVT can achieve much greater medical cost containment in 2017 than was demonstrated in the filing or the hearing. The average commercial rate increase of 2.2 percent cited by the Board is *equivalent to or slightly higher than* the 2.9 percent unit cost trend assumed by BCBSVT in its rate filing. By limiting BCBSVT to a 2.2 percent 2016 to 2017 unit cost trend for providers and facilities under the GMCB hospital budget process, the GMCB is effectively ordering BCBSVT to achieve a 1.5 percent commercial increase as calculated using hospital budget methodology. The Board's reduction in the utilization assumption means that BCBSVT must more than double the savings of its utilization management programs in 2017.[1]

[1] Part of BCBSVT's mission is to ensure comprehensive networks to provide responsible access to its members for medically necessary care. BCBSVT has integrated health management programs in place to ensure that providers are providing the right services at the right time. BCBSVT's efforts to manage costs are not and cannot be done unilaterally and, in fact, are routinely met with resistance by providers who have been effective in advocating to limit such management.

With respect to the FY2017 assumed increase in unit cost trend attributable to Vermont providers subject to the GMCB hospital budget review, BCBSVT made adjustments in its initial filing for the expected outcome of the FY2017 hospital budget process tempered with its knowledge of the local market and past bargaining results. Then, when the actual hospital budget submissions were filed with the Board (many weeks after the initial rate filing but shortly before the hearing), BCBSVT reviewed the publicly available information on those submissions. BCBSVT concluded that its assumptions were actually too low. Tr. 22. BCBSVT responded to the Board's questions during the hearing on the effect of the hospital budget submissions and its relative market power as well as to the Board's July 28, 2016 post-hearing written questions concerning the 2.9 percent increase attributed to the providers under the ambit of the GMCB hospital budget approval process. Without repeating the detail here, BCBSVT explained in its August 4, 2016 Post Hearing Response that the 2.2 percent commercial increases the GMCB calculated from hospital budget submissions is *equivalent to or slightly higher than* the 2.9 percent unit cost trend calculated by BCBSVT in its rate filing, due to multiple differences in scope, timing, weighting and base data used for the two calculations. The Board's decision does not recognize these critical differences. By limiting BCBSVT to a 2.2 percent unit cost trend for providers and facilities subject to the GMCB hospital budget process, the GMCB is effectively ordering BCBSVT to achieve a 1.5 percent commercial increase when calculated using methodology employed in the hospital budget review process. The unit cost assumption reduction has the effect of going well beyond "limiting BCBSVT's unit cost growth to the 2.2% commercial rate increase," as stated in the GMCB decision. See, GMCB August 9, 2016 Decision (revised), p. 9.

BCBSVT appreciates the Board's vow to reduce hospital budgets from the "provisional" 2.2 percent requested. BCBSVT further appreciates the Board's confidence in BCBSVT's ability to negotiate even lower increases than projected. However, both of these outcomes are not only speculative but more importantly are not properly supported by the evidence. As aptly explained by the GMCB's actuary David Dillon at hearing, there is a surprising amount of medical trend that a company cannot control. Testimony of David Dillon, Tr. 133. "[S]ince we have been here in 2014, we have specifically seen . . . one hospital chain really impact things where the carriers could not do much to prevent it. . . it does vary by year, and . . . it varies based on the leverage of the hospitals. But . . . in a state like [Vermont that] doesn't have a

whole lot of metropolitan areas, and . . . certain hospitals or provider groups that have more power than others, it can be very difficult for carriers to negotiate even if they do have a lot of membership." Id. While overall cost increases are kept lower in Vermont than elsewhere in the United States due to the merged market and a hospital budget process, id., that does not guarantee that BCBSVT as a dominant issuer of QHPs will have unilateral power to reduce its provider costs. There is limited competition among the state's hospitals, which decreases issuer bargaining power. In addition, due to the rural nature of the state, BCBSVT cannot simply narrow its networks or otherwise decrease access to care for its members to reduce provider costs. Members across Vermont expect access to comprehensive networks, and in fact "access to care" is another key element of the GMCB's own standards of review.

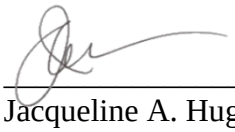
The Board's decision also orders a reduction in the assumption for the utilization component of medical trend from 1.0 percent to 0.5 percent. The Board has cited no evidence in the record to support this reduction but rather concludes that because BCBSVT made an adjustment to account for non-recurring utilization spikes in 2014 and 2015 that BCBSVT can be ordered to further cut its utilization assumption in half using unidentified mechanisms. Decision finding 18 and p. 9. BCBSVT is confident in its expertise and ability to impact medical utilization in ways that preserve providers' abilities to maintain high quality medical care. In fact, the combined efforts have produced an estimated reduction of $2.94 PMPM, which is already reflected in our rate request. However, due to the compounding, two-year impact of the utilization trend assumption, the Board's decision orders an *additional* $3.75 PMPM savings—more than doubling the current reduction—presumably incorporating new management mechanisms that would have to begin to accrue on January 1, 2017 but as of now do not exist. While BCBSVT is always working to develop new cost-effective utilization management programs, we would expect a lag in positive outcomes as providers take time to integrate the changes into their practices even if a new program was conceived and implemented between now and January 1, 2017.

While the Board characterizes its utilization reduction as "minimally" affecting the rates, BCBSVT's assumptions were grounded in the Actuarial Standards of Practice (ASOP) #8, which requires an actuary to use assumptions that are reasonable in the aggregate and for each assumption individually. See, BCBSVT August 4, 2016 response to Post Hearing Question #2. As explained there, BCBSVT's assumption of one percent "represents the lowest possible

assumption that is both reasonable based upon our review of relevant information and produces a result that is reasonable and adequate when aggregated with all other assumptions, consistent with ASOP #8. L&E agreed with our approach, including our adjustments for induced utilization, aging population, the unexpected seasonal patterns in 2014, and the potential up-take in 2015, finding it to be reasonable and appropriate." Id. (italics omitted) (citing to finding in L&E August 11, 2016 Opinion, p. 5). The Board's order is both well in excess of any reasonable assumption regarding the magnitude of medical cost management savings and is unsupported in the record or by the Board's findings.

We acknowledge and appreciate the Board's discussion and conclusions with respect to CTR and RBC. Nonetheless, while the Board nominally approved BCBSVT's request for a CTR of 2 percent, the reductions ordered by the Board as described above effectively reduce BCBSVT's CTR to 1 percent. As we have demonstrated in our filing, responses to the inquiries of the Board's and the HCA's actuary and in testimony, the rates ordered by the Board will be inadequate to cover fully the costs of QHPs in 2017. We ask that the Board reconsider and revise its decision to eliminate the two reductions to the rates contained in its August 9th Order.

Dated at Berlin, Vermont, this 16th day of August, 2016.



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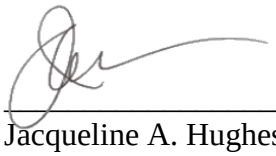
CERTIFICATE OF SERVICE

I hereby certify that a copy of this Motion for Reconsideration has been duly served upon Judith Henkin, General Counsel to the Green Mountain Care Board, Noel Hudson, GMCB appointed hearing officer, and Lila Richardson and Kaili Kuiper, Office of Vermont Health Advocate, by electronic mail, return receipt requested, this 16th day of August, 2016.



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