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

REPLY MEMORANDUM OF LAW

Blue Cross and Blue Shield of Vermont (BCBSVT) files this Reply Memorandum to correct several overstatements and inaccuracies in the July 28, 2016 Post Hearing Memorandum filed by the Office of Health Care Advocate (HCA).

The HCA Memorandum requests that the medical trend and pharmacy trend each be reduced to the lowest figure in Lewis & Ellis's (L&E) "best estimate" range. L&E's opinion, however, makes clear that L&E agrees with BCBSVT's trend pick of 4.3 percent for medical trend and 10.2 percent for pharmacy trend. L&E Opinion, page 5 ("*Our best estimate of the total allowed medical trend is equal to the Company's estimate of 4.3 % . . .* We consider the allowed medical trend [of 4.3%] to be reasonable and appropriate." "*Our best estimate of the total allowed [pharmacy] trend is equal to the Company's estimate of 10.2 % . . .* The Company's proposed value of 10.2 % fits comfortably within our estimated range of actual results. We consider the Company's requested allowed pharmacy trend to be reasonable and appropriate.") Modifications of the trends are simply not supported by the record (or even apparently by the HCA's own actuary, who did not recommend any change to trend in her report).

The HCA also misunderstands BCBSVT's testimony and approach to contributions to reserve. First, the HCA repeatedly asserts that BCBSVT has a "target RBC of 600 %." HCA Memorandum, p. 6 (assertion made four times) and p. 4. As BCBSVT's chief actuary testified, Tr. 54 (and HCA's own actuary acknowledged, Tr. 152), BCBSVT uses a range for RBC of 500 to 700 percent of Authorized Control Level Capital. The midpoint of the range (600) was mentioned for illustrative purposes because BCBSVT is prohibited by law from publicizing its RBC. Binder Exhibit 7B, page 75. Moreover, the 3.8 percent result would not be materially

different if BCBSVT were to illustrate using a different point in the range. HCA then compounds its error by "calculating" a fictitious increase of .7 percent that it argues would be sufficient to maintain RBC. HCA Memorandum, p. 6. This section of the HCA memorandum is, at its best, mathematically inaccurate. BCBSVT manages to a range of 500 to 700 percent, not "600" percent, and 3.8 percent is the amount needed to *maintain* the current level of RBC for health care cost trend and expected membership growth for 2017 QHPs.

Furthermore, CTR values are not interchangeable across filings as the HCA also seems to argue. In other words, the requested CTR in one filing may be both wrong and totally inappropriate as a guide for another filing. Each filing is based on the market segment covered and the data underlying that particular filing and is not intended to be made applicable to other segments of the market nor to data that does not underlie the filing. HCA then justifies its unsupportable calculation and arguments by further arguing that the CTR approved in a different filing will provide an "additional margin of surplus." HCA Memorandum, p. 6. This argument shows that the HCA fails to understand what the 1.3 % figure meant in that earlier filing. As Mr. Schultz testified, "[t]his exhibit was a demonstration of the contribution to reserve that was required only for increases in health care cost trend. This did not contemplate membership increases or any other causes of premium increases." Tr. 170.

The HCA has also mischaracterized testimony by the Department of Financial Regulation (DFR). In its opinion and testimony, DFR made clear that it did not support reduction of the requested 2.0 percent CTR. In point of fact, DFR emphasized its concern that, with the relative size of QHP business coupled with the reduction of RBC in 2015, the 2.0 percent CTR requested for 2017 is expected to have further downward pressure on RBC. DFR opined that "further downward adjustments to any rate components of this filing should not be made unless GMCB's consulting actuary explicitly opines that the filed rates . . . are excessive." DFR Opinion, p. 2. BCBSVT's RBC has been relatively stable and has not hit the top of the range that Mr. Chieffo testified about and his theoretical remarks were taken out of context.

Finally, the HCA quotes from the Board's decision on BCBSVT's 2016 QHP rate filing as support for its proposition that the Board can (and should) cut rates to make them more affordable even if that means ignoring the expert testimony and underfunding QHP rates as has happened for three years. Rate reduction that underfunds required premiums is not cost

containment. Tr. 58. It is clear from testimony that BCBSVT is losing ground on this market with a *negative* average actual CTR of 0.8 percent over the last five years. QHP rates have been inadequate over the time frame. Tr. 25.

Dated at Berlin, Vermont, this 2nd day of August, 2016.

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CERTIFICATE OF SERVICE

I hereby certify that a copy of this Reply Memorandum of Law 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 2nd day of August, 2016.

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