STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2018 Vermont Health Connect Rate Filing SERFF No. BCVT-131037743	)	GMCB-008-17rr

DECISION & ORDER

Introduction

For the fourth consecutive year, this Board has reviewed major medical health insurance rates offered on Vermont Health Connect (VHC), the state's health benefit exchange. In this filing, Blue Cross Blue Shield Vermont (BCBSVT), one of the two carriers offering qualified health plans (QHPs) in Vermont, initially proposed a 12.7% average annual rate increase; it has subsequently reduced its request to 12.6%. 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 a 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 to individuals, families and small employers with rates based on a single risk pool, or "merged market." *See* 33 V.S.A. §§ 1803, 1811. Beginning with plan year 2016, Vermont law expanded the definition of "small employer" to include employers with up to 100 employees. *See* 33 V.S.A. § 1811(a)(3).

3. Health insurance plans on VHC are offered to consumers in four "metal levels": bronze, silver, gold, and platinum.[1] *See* 42 U.S.C. § 18022(d)(1). Under the ACA, each metal level corresponds to an "actuarial value" (AV), an expected percentage of claims for essential health benefits that a health insurer will cover on average. For example, a bronze plan with a 60% AV is expected to cover, on average, 60% of an insured's claims. Bronze plans are the least

[1] In addition to the metal level plans, catastrophic coverage, which is characterized by low premiums and high deductibles, is available primarily to persons under thirty years of age. *See* 42 U.S.C. § 18022(e).

"rich" of the four levels. Silver, gold and platinum plans respectively cover larger percentages of a beneficiary's claims.[2]

4. There are several mechanisms to make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance. The ACA includes a provision for federal premium assistance for some individuals, depending on their household income. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan").

5. The ACA also requires insurers to reduce out-of-pocket costs through "cost sharing reductions" (CSRs) for enrollees with incomes between 100% and 250% of the federal poverty level. *See* 42 U.S.C. § 18071(a)(2). The federal government offsets the added cost of CSRs by making payments directly to insurers. *See* 42 U.S.C. § 18071(c)(3). It is currently uncertain whether the federal government intends to continue to make these offset payments to insurers.[3] This filing assumes cost sharing reductions will continue.

6. Vermont law provides for additional health insurance premium assistance for eligible Vermonters purchasing coverage through VHC. 33 V.S.A. § 1812(a). The state also provides cost-sharing assistance to further reduce enrollees' deductibles and copayments. 33 V.S.A. § 1812(b).

7. As of May 2017, approximately 83% of individuals enrolled through VHC qualify for some sort of financial assistance, whether premium assistance, cost-sharing reductions, or both. *See* Vermont Health Connect May 2017 Dashboard, *available at* http://info.healthconnect.vermont.gov/sites/hcexchange/files/Coverage%20Dashboard-May2017.pdf

8. To help stabilize costs, the ACA includes a permanent risk adjustment program which 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 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.[4]

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[2] This discussion is solely intended to be illustrative. More detail concerning 2018 payment parameters and actuarial values is available at https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018.

[3] In 2016, a federal district court concluded that the cost-sharing program is unconstitutional and enjoined further payments. *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016). The Obama Administration appealed the ruling, and CSR payments were permitted to continue during the pendency of the appeal. The case, now titled *U.S. House of Representatives v. Price*, is currently being held in abeyance. More recently, the President threatened, via Twitter, to discontinue the CSR payments to insurers. *See, e.g.,* Michelle Hackman et al., *Trump Threatens Insurance Payments to Push Congress on Health-Law Repeal*, WALL ST. J., July 31, 2017 (reports on the President's tweet: "[i]f ObamaCare is hurting people, & it is, why shouldn't it hurt the insurance companies.").

[4] Additional information about the program is available at http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

9. Section 9010 of the Affordable Care Act imposes a Health Insurance Providers Fee based on a covered entity's premium revenue in the previous year. *See* 26 C.F.R. Part 57. In 2016, Congress imposed a moratorium on collection of the fee for plan year 2017. The fee is again in effect for 2018.

Procedural History

10. On May 12, 2017, BCBSVT filed its 2018 Vermont Health Connect Rate Filing with the Board 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, 2018. The filing proposed an average annual rate increase of 12.7%, with actual increases ranging from 5.8% to 14.7%. Exhibit 1 at 3.[5]

11. On May 22, 2017, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to the proceeding.

12. On July 11, 2017, 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 amended its opinion on July 18, 2017, to account for a correction made by BCBSVT to a calculation regarding its current risk based capital (RBC) level. In both its original and amended opinions, DFR opined that if BCBSVT's proposed rate increase is approved as filed, it would stabilize the company's RBC, and cautioned that any downward adjustments to the filing's rate components that are not actuarially supported will reduce surplus over time and negatively impact its solvency. Exhibit 12 at 3-4.

13. Lewis & Ellis (L&E), the Board's contract actuary, and Peter Horman, owner of HMA Solutions, the HCA's contract actuary, conducted reviews of the filing and issued actuarial memoranda summarizing their analyses and recommendations. The memoranda were posted to the Board's website on July 11, 2017. *See* Exhibits 11, 13.

14. The Board held a public administrative hearing on July 20, 2017. Noel Hudson served as hearing officer by designation of Board Chair Kevin Mullin. Jacqueline Hughes, Esq. represented BCBSVT. BCBSVT's Chief Financial Officer (CFO) Ruth Greene and Actuarial Director Paul Schultz testified on the company's behalf. Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Peter Horman of HMA Solutions. Jesse Lussier, DFR Insurance Examiner, testified regarding DFR's solvency analysis. Judith Henkin, General Counsel, represented the Board and conducted the examination of David Dillon, L&E's Vice President and consulting actuary.

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[5] The exhibits referred to in this decision were stipulated to by the parties. All documents, hearing transcript and public comments referenced in this Decision and Order are available at http://ratereview.vermont.gov/BCVT-131037743, and are described by their titles, rather than as numbered exhibits.

15. On the same day as the hearing, the Associated Press reported that BCBSVT is seeking $10.3 million from the Department of Vermont Health Access (DVHA) to reconcile 2016 VHC enrollment and claims. *See* http://www.vermontpressbureau.com/2017/07/20/blue-cross-blue-shield-of-vermont-seeks-10-3-million-from-state/. In response to a July 21, 2017 written request by the Board for additional information, BCBSVT advised the Board that the final amount of any recovery is "subject to a lengthy review," is not included in its financial information, and is not reflected in its 2018 rates other than having a minor impact on 2016 claims data. BCBSVT Response (July 24, 2017).

16. The Board accepted public comments on the proposed rates from May 12, 2017 through August 9, 2017.[6] The Board received 142 comments referencing rate filings for the exchange, the vast majority of which specifically reference BCBSVT's proposed increase. Additionally, the Board took comment from 15 members of the public at the close of the hearing testimony, continued the public comment period from 5:00 to 7:00 p.m. the following Thursday for members of the public unable to attend during the day, and accepted video comment from members of Vermont Workers' Center. The comments overwhelmingly address the issue of affordability for Vermonters and oppose any increase in premium rates.

Findings of Fact

Nature of the Filing

17. 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 over 80% of VHC customers.

18. The rates in this filing will be used for BCBSVT's Vermont Health Connect plan offerings for coverage beginning January 1, 2018 and ending December 31, 2018. BCBSVT covers approximately 70,000 lives in VHC plans. Exhibit 1.

19. BCBSVT requests an average annual rate increase of 12.7%. Actual rate increases across its members will range from approximately 5.8% to 14.6%. *Id.*

20. BCBSVT developed its 2018 VHC rates using claims incurred from January 1, 2016 through December 31, 2016, and paid through February 28, 2017 (experience period), by its individual and small group QHP membership. *Id.* at 16.

21. BCBSVT projected the experience period claims forward to the rating period using an allowed medical trend factor of 4.7% and a pharmacy trend of 8.9%. The medical trend comprised a 2.6% unit cost trend and a 2.0% utilization trend. BCBSVT derived the 2.0% utilization trend using calendar year 2016 over adjusted calendar year 2015 claims data to

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[6] Although the deadline for accepting comment expired on July 28, additional comments were received and reviewed by the Board subsequent to that date, including over three hundred comments received on August 2, 2017 that were identically formatted and forwarded from the Vermont Public Interest Research Group. The Board has included these comments in the record.

produce a starting point of 2.3%, then making adjustments for its benefits, fraud, waste and abuse programs. Exhibit 11 at 4-6.

22. BCBSVT proposes an administrative expense trend of 2.4% that includes an annual 3.0% increase to personnel costs accounting for 81.5% of the total administrative expense load. The carrier projects no increases for non-payroll administrative expenses. Exhibit 1 at 27-28.

23. Approximately 2.6% of the proposed rate increase is attributed to the return of the Federal Health Insurance Providers Fee for the 2018 plan year. *Id.* at 5, 30.

24. BCBSVT proposes a 2.0% contribution to reserves, which it states is consistent with its strategy of managing its reserves on a long-term basis. Exhibit 1 at 29. In its initial filing, BCBSVT indicated that it requires a 3.2% CTR to maintain its risk based capital (RBC) level, *id.*; it subsequently corrected and clarified the calculation to indicate that a 1.9% CTR would maintain its RBC "at the high end of our target RBC range." Exhibit 17 at 4.

25. If the federal government were to discontinue CSR payments to insurers and BCBSVT passed along the cost to all of its QHP membership, it projects that rates would increase by approximately 1.9%. Exhibit 6 at 4; Exhibit 11 at 13.

26. Since 2014, BCBSVT has experienced medical loss ratios (MLRs) for its VHC filings averaging approximately 90%.[7] For this filing, BCBSVT projects a 91.1% loss ratio. Exhibit 11 at 2.

<u>L&E Actuarial Analysis</u>

27. In its written report, L&E recommends only minor modifications to the proposed rates. First, L&E recommends that the Board consider the impact of 2018 hospital budgets on unit cost trends as the information becomes publicly available. Second, L&E recommends a slight reduction of 0.1% to BCBSVT's proposed risk adjustment calculation, taking into account BCBSVT's recalculation of its risk adjustment payment based on updated CMS data.[8] With these recommended changes, L&E opines that the filing, with an average annual rate increase of 12.6%, does not produce rates that are excessive, inadequate, or unfairly discriminatory. Exhibit 11 at 9-10, 13.

[7] Since 2011, insurance companies in the individual and small group markets have been subject to an 80% MLR, meaning they are required to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurers must report their MLR to the federal government on an annual basis, and starting in 2012, provide rebates to consumers if they do not meet MLR requirements.

[8] BCBSVT updated its risk adjustment calculation following CMS's final risk adjustment report on June 30, 2017, which it states would increase its rates by 0.2%. L&E recommends removing coding-based assumptions from both BCBSVT's and MVP's risk scores, decreasing BCBSVT's proposed rates by 0.3%. Exhibit 11 at 9-10.

HCA Actuarial Analysis

28. The HCA's actuary, Peter Horman of HMA Solutions, recommends that the Board reduce BCBSVT's proposed rates by four percentage points to approximately 8.7%. Horman identified four areas that he concludes would materially impact rates and collectively achieve the four percent reduction. First, Horman maintains that BCBSVT's demographic adjustment for aging was not supported in the filing. *See* Exhibit 13 at 5, 11-12.

29. Second, Horman contends that BCBSVT's utilization trend is inflated, and should be reduced to a "historical average or the competitor's utilization trend of 0.7%." *Id.* at 7, 11-12.

30. Third, Horman maintains that the CTR is excessive and should be adjusted downward. Horman contends that BCBSVT should target a 500% RBC, which he believes is "at the very top of the Department of Financial Regulation's target range." *Id.* at 10, 11-12. Horman estimates that BCBSVT would require a 0.8% CTR to maintain a target range of 700%. *Id.* at 17 (Appendix C).

31. Finally, Horman concludes that BCBSVT made "higher than necessary" adjustments to rates in three areas: dental trend, reinsurance, and administrative increase. Horman suggests replacing the pediatric dental trend with a national average; lowering the reinsurance estimate to account for reinsurers' "common practice" of overpricing, then issuing subsequent rebates; and adjusting BCBSVT's administrative expense component based on an assumption that the company has replaced its higher paid employees with lower paid ones. *Id.* at 7, 8, 9,11-12.

BCBSVT Hearing Testimony

32. BCBSVT actuary Paul Schultz described the assumptions used for determining each of the components of the rate filing. Schultz testified that the carrier considers historical data to determine demographic assumptions and described the process for calculating rate factors for administrative costs, risk adjustment payments, medical and pharmacy trend factors, and contribution to surplus. Hearing Transcript (TR) at 24-43.

33. To determine an adjustment for aging of the population, BCBSVT reviewed data for the company's QHP population from 2014 to 2017. Because 2014 was a transition year, actuary Schultz testified that the data is "suspect," and relied on the "extremely consistent" data from 2015 and 2016, which showed an aging trend of one-half of a percentage point per year. *Id.* at 24-25, 46.

34. Schultz explained that the company's personnel costs have increased an average of 7.3% over the past five years, with the number of full-time employees increasing by 5.8%, primarily due to one-time insourcing of IT functions. Personnel costs per full-time equivalent (FTE) have increased an average of 1.4% over five years, with employee benefit increases of 3.3% on average. Schultz anticipates a "more steady state" going into the future, and projects a 3.0% increase in personnel costs for this filing. *Id.* at 62-63; *see also* Exhibit 3 at 5.

35. Regarding the medical utilization trend, Shultz testified that the “uptick” in utilization starting in mid-2015 was due to three factors: the rise in prescription drug cost, an increase in preventive care, and a positive hospital intake trend. TR at 26-29. Taking these metrics into consideration, Schultz testified that a 2.0% utilization trend is justified.

36. Regarding the medical unit cost trend, CFO Ruth Greene testified that when negotiating prices for medical services with hospitals subject to the Board’s statutory budget review process, BCBSVT was unable to negotiate below the prices those providers included in their approved budgets. Greene testified that BCBSVT was hesitant to maximize further its bargaining leverage by using tactics objectionable to providers and disruptive to its membership, including increased use of prior authorizations, selective networks, or risking temporary exclusion of specific providers from the BCBSVT network if contracts are not timely executed. *Id.* at 127-29.

37. Schultz testified that if the company incorporated information from the hospitals’ 2018 budget submissions, filed with the Board on July 1, 2017, BCBSVT would need to increase its unit cost assumption from 2.6% to 2.9%. The company chose not to adjust its rates on this basis. *Id.* at 31.

38. When asked by the Board what the impact on BCBSVT will be if its competitor, MVP Health Plan, Inc. (MVP) increases its VHC membership by 50%, as it projects in its 2018 VHC filing, Schultz responded that he did not believe that it would impact BCBSVT’s rates and would “absolutely not” lead to an adverse selection spiral. *Id.* at 84-85. The migration would, however, reduce BCBSVT’s need for reserves. The filing does not assume any migration of BCBSVT members to MVP. *Id.* at 94-95.

39. Since 2014, BCBSVT has experienced a negative CTR of 1.5% for its VHC book of business. *Id.* at 39-40. The company had an underwriting loss of approximately $18 million on its QHP business in 2016, and $22 million over three years. *Id.* at 82, 124, 125.[9]

40. BCBSVT proposes a 2.0% CTR consistent with its long-term strategy of maintaining its target risk-based capital (RBC) level of 500-700%, without imposing unnecessary yearly rate volatility. Without disclosing its current RBC, Schultz testified, for illustration, that if the company were starting from a 700% baseline, it would need a 1.9% CTR in 2018 rates to maintain its RBC level; starting from a 600% baseline, the company would need a 1.5% CTR. Schultz noted that a 600% baseline and a 2018 CTR of 1.9% would likely increase the company’s RBC to 606%. *Id.* at 33-38.

L&E Hearing Testimony

41. Actuary David Dillon testified that L&E reviews the filing primarily to determine whether the rates are excessive, inadequate or unfairly discriminatory—the rate review standards that are “actuarial in nature”—and that its analysis assists the Board to make determinations under its full statutory charge. *Id.* at 152-153. Dillon explained that L&E performs independent

[9] BCBSVT’s Five-Year Historical Data from its 2016 Annual Statement indicates a net loss of $9.7 million, and net underwriting loss of $18.1 million.

calculations for rate components that are material, such as the carrier's utilization trend, and requests additional data and information from the carrier to test the accuracy of its rate assumptions. *Id*. at 150-151.

42. Dillon testified that L&E reviewed the information provided by BCBSVT in its initial filing relative to its aging assumption, requested additional supporting data, and once reviewed, concluded that BCBSVT's demographic adjustment was appropriate. *Id.* at 157.

43. Regarding BCBSVT's administrative costs, L&E first reviewed the assumptions in the filing for reasonableness then benchmarked BCBSVT's administrative costs against other Blue Cross plans nationwide. Of the 66 plans reviewed, BCBSVT was in the bottom tenth of Blue Cross plans nationwide, both on a PMPM and percentage of premium basis. *Id.* at 158-59; Exhibit 11 at 10.

44. L&E performed independent calculations using multiple methods, with a focus on "time series" approaches, to estimate a range of reasonable medical utilization trend estimates of approximately 1.0% to 2.5%. Dillon testified that although L&E agrees that BCBSVT's use of a 2.0% utilization trend is reasonable, a 1.0% utilization trend is also "a reasonable assumption" because it falls within L&E's calculated range. TR at 160-61.

45. When asked whether the 0.7% utilization range proposed by the HCA's actuary was reasonable, Dillon opined that it was not because it falls outside the range of reasonable trends, and was adopted from BCBSVT's competitor's filing, which covers a much smaller and less stable population. *Id*. at 161.

46. Dillon testified that in light of the information L&E obtained during its review of this filing, BCBSVT's requested 2.0% CTR is reasonable. Dillon further testified that if the company had proposed a 1.0% CTR, its RBC would remain within the "middle" of BCBSVT's target range of 500% to 700%. *Id.* at 161-165.

<u>DFR Hearing Testimony</u>

47. Insurance Examiner Jesse Lussier testified that DFR's general approach to insurer solvency is that all rates should "stand on their own"— meaning that each respective book of business should independently meet actuarial standards—and concurred that the carrier's RBC target range is reasonable. *Id.* at 224, 232. Lussier further testified that for 2016, BCBSVT had a net loss of approximately $9 million. *Id.* at 231.

<u>HCA Hearing Testimony</u>

48. Actuary Peter Horman explained that BCBSVT's adjustment for aging was not supported in the filing because the company had used a single data point to determine the adjustment. *Id.* at 185-86. Horman testified that "it's very difficult to review a rate filing," and claimed that BCBSVT's actuary had introduced "extra statistics" during the hearing to support the adjustment. TR at 189. On cross-examination, Horman acknowledged that these "extra statistics" were in the rate filing, but that he "didn't pick up on that." *Id.* at 219.

49. Horman recommended that BCBSVT reduce its medical utilization trend because "they misused the statistics" and "there's probably a better way to do this." *Id.* at 189-190. Horman explained that the methodology used by MVP to determine utilization trend was superior, although he had not independently reviewed the MVP calculation. *Id*. at 189-194, 208-214.

50. As to the three adjustments Horman attributes to "compounding conservatism," *see* Exhibit 13 at 12, Horman admitted that the dental trend he recommends to replace BCBSVT's pediatric dental trend is not specific to Vermont, not specific to pediatric dental, and does not consider the relative newness of the benefit. TR at 216-218. Regarding his conclusion that BCBSVT's reinsurance is overstated, Horman stated that although BCBSVT's reinsurance contract may not provide for "return of premium" at this time, BCBSVT might be able to change the terms of the contract in the future. *Id.* at 199-200; *see also* Exhibit 13 at 8; Exhibit 17 at 3. Last, Horman stated that the relevant increase in administrative costs for employee compensation is the 1.4% increase in employee costs over a five-year period, and that an increase in the number of employees over that time period should not be considered. TR at 199.

51. Horman recommends reducing the proposed CTR by 1.2% based on his calculation using a target RBC of 500%, which he described in his report as "the very top of the Department of Financial Regulation's target range." Exhibit 13 at 10. Horman would also "reallocate[] their investment income" based on his conclusion that BCBSVT "had other lines of business that were generating better profit." TR at 196.

Post-hearing Memoranda

52. In its post-hearing memorandum, BCBSVT requests that the Board modify the filing to adjust for the federal risk adjustment transfers, as recommended by L&E, and then approve a 12.6% average annual rate increase. The carrier requests that the Board reject the HCA's arguments and "provide no weight" to the recommendations and testimony of its actuary, and likewise reject L&E's calculation of range of utilization trend. BCBSVT Post Hearing Memorandum of Law (July 31, 2017).

53. The HCA's post-hearing memorandum reiterates its actuary's claims and requests that the Board disapprove or modify BCBSVT's filed rates on the basis that they are not affordable and do not promote access to health care. HCA Post-Hearing Memorandum (July 27, 2017).

54. BCBSVT filed a Motion to Strike Introduction of New Evidence on August 2, 2017 to contest introduction of data relating to wage growth, hypothetical calculations regarding affordability, and quotes from public comment in this docket. The motion was denied on August 3, 2017.

Standard of Review

With the passage of Act 48 (2011), the legislature conferred jurisdiction over major medical health insurance rates to the Board beginning January 1, 2012. 18 V.S.A. § 9375(b)(6).

The Board reviews 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)(3); GMCB Rule (Rule) 2.000, §§ 2.301(b), 2.401. 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). Although the first several terms—"excessive, inadequate or unfairly discriminatory"—are defined actuarial standards, other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16.

As part of its review process, the Board must consider the Department's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves, 8 V.S.A. § 4062 (a)(2)(B), (3), and any comments received from members of the public. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. Moreover, when approving rates for a non-profit hospital service corporation, the Board has authority to "make reasonable supplemental orders . . . [and] attach reasonable conditions and limitations to such orders" to ensure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. 8 V.S.A. § 4513(c). The burden falls on the insurer proposing a rate change to justify the requested rate. Rule 2.000, § 2.104(c).

Conclusions of Law

In issuing this decision and order, we first acknowledge the tension between two of our standards for review. On the one hand, there is an undeniable need for health insurance coverage that is affordable for all Vermonters. On the other, we cannot reasonably expect our insurers to continue to voluntarily participate in the health benefit exchange if it imperils their financial stability. If health insurance is not affordable, access to it will be restricted; if it is no longer financially viable for an insurer to remain in the marketplace, however, access will also be restricted. Our decision today seeks to strike a balance and achieve the leanest rates feasible, while protecting the insurer's financial health.

I.

First, we accept our actuary's recommendations, which BCBSVT does not contest, regarding the estimated 2018 risk adjustment transfer payment that BCBSVT will receive from its market competitor under the ACA's risk adjustment program. *See* Finding of Fact (Finding) ¶ 27. This modification results in a modest reduction of approximately 0.1%.

II.

Second, we accept our actuary's judgment that a 1.0% utilization trend is a reasonable assumption for BCBSVT's 2018 QHP population, and require that BCBSVT reduce its medical trend consistent with that assumption. *See* Finding ¶ 44. Although BCBSVT disputes the accuracy of L&E's calculation in its post-hearing memorandum, it has been amply demonstrated to this Board, in this rate filing and in others, that actuaries using identical data, and the same or

similar methodology, do not always produce identical results. Here, BCBSVT criticizes L&E's utilization trend projection because unlike its own actuary, L&E used a "statistical analysis" that assumes no trend. We find the assumption of no trend is appropriate, however, because BCBSVT's historical experience since 2014 has demonstrated non-increasing, or zero utilization trends, in addition to the recently increasing values.[10] We further find that BCBSVT developed its trend with no accounting for seasonality, and that its current advocacy for use of a 12-month cycle does not invalidate L&E's calculations based on three-month cycles. Contrary to BCBSVT's contention, historical trend can be analyzed over three-month rolling periods; in fact, "the three month pattern can be a leading indicator of trend direction." *See* D. Skwire, GROUP INSURANCE, 348 (7th ed. 2016). And while BCBSVT's rebuttal takes issue with L&E's development of best estimates of utilization trend across the various methods, it fails to address the inherent volatility and the projected range of values within the remaining eleven time series methods.

Even though the 1.0% figure represents the lower end of the actuarially reasonable range of 2018 utilization trends, it nevertheless remains within the range and produces more affordable rates for Vermonters enrolled in the company's QHP products. And as we discussed in last year's exchange rate decision, we believe that BCBSVT can and should influence and reduce its utilization, its overall medical cost trend, and ultimately the premium paid by its customers. *See In re: Blue Cross Blue Shield 2017 Vermont Health Connect Rate Filing*, docket no. 008-16-rr at 9, *available at* http://ratereview.vermont.gov/sites/dfr/files/2016/BCBSVT/008-16rr_BCBSVT_Final_2.pdf.

Last, beginning with the 2017 VHC rate submissions, this Board incorporated information gleaned from the hospital budget process to help establish consistency across hospital budget and insurance rate filings. By correlating the two processes, we can better track the benefit of decelerated hospital cost growth to proposed insurance premiums. In addition to using hospital budget information to inform insurance rates, however, we reasonably expect that insurers will vigorously negotiate rates with the hospitals, including those that are outside our borders, in a way that promotes parity in reimbursements between academic medical centers, community hospitals and independent providers. Provider reimbursements should reflect actual costs of care rather than site of service. In short, notwithstanding CFO Greene's testimony that the company is limited in its contractual abilities, *see* Finding ¶ 36, we are not persuaded that the state's largest health insurer cannot affect medical trend by maximizing its negotiating leverage, or that the hospital budget process inexorably mandates a predetermined negotiation result.

It is therefore ordered that BCBSVT reduce its medical trend as outlined above.

[10] BCBSVT assumed a 0.0% utilization trend in its 2015 VHC rate filing, a 2.0% utilization trend for 2016, and a 1.0% utilization trend for 2017, which the Board reduced to 0.5%. In denying BCBSVT's request for reconsideration of the reduction to the 2017 trend, we noted that the process of appropriately reducing utilization is not stagnant, but ongoing. Each of the Board's VHC decisions can be found on the Board's rate review website: http://ratereview.vermont.gov/bcbsvt-rate-review-decision-made.

III.

We next reduce the proposed CTR from 2.0% to 0.5%. In doing so, we first reference BCBSVT's recent[11] request to DVHA to recover $10.3 million for its 2016 VHC business, a year that otherwise produced net losses of more than $9 million, and an underwriting loss of over $18 million. Finding ¶ 15. BCBSVT did not disclose its reconciliation request in any of its filing documents or at hearing, even though any recovery towards the $10.3 million will offset 2016 losses, positively impact the company's RBC level, and likely would have altered L&E's and the HCA's actuarial analysis of the proposed CTR. While we recognize that the actual amount BCBSVT recoups may not be settled until some months into the future and may be less than the requested $10.3 million, we find that the potential for this sizeable recovery renders BCBSVT's financial stability less precarious than claimed in this filing and at hearing.

We also do not agree that the recent decline in RBC level, as may be derived from the company's annual statements, is as ominous as characterized by the insurer. BCBSVT's apparent belief that any RBC below midpoint of the target range forewarns financial difficulty ignores that the company's RBC has regularly fluctuated within the full span of its 500% to 700% target range for the last decade. Further, should MVP continue to grow its QHP membership as projected, BCBSVT's membership will inevitably decrease, and will require smaller reserves to cover the reduced number of lives. Finding ¶ 38.

In sum, we find that reducing the CTR to 0.5% helps to address valid concerns regarding affordability of the proposed rate, and will allow the carrier to remain within its RBC target range and significantly above the regulatory-action threshold, even if it receives less than the requested reconciliation amount.

IV.

Finally, we respond to the HCA's recommendations, which it contends will reduce the proposed average rate increase to approximately 8.7%. While we share the HCA's interest in making sure that rates are affordable for Vermonters and promote access to quality care, the HCA has offered no plausible basis for implementing any changes to the proposed rate, other than its unspecific recommendation that the utilization trend be calculated through regression analysis (which as discussed in Section II, above, was performed by L&E). There is no basis for adjusting the aging demographic because as he acknowledged at hearing, the HCA's actuary failed to consider information contained in the filing and supplemented by the carrier during the course of the review. Finding ¶ 48. We also do not agree with the HCA that BCBSVT's experienced-based pediatric dental trend is unreasonable and should be replaced with a dissimilar, generic national trend. Finding ¶ 50. In addition, the HCA's recommendations about BCBSVT's reinsurance adjustment and its allocation of employee pay increases are speculative and based on supposed "common" business practices rather than on actual contractual terms and factual information. *See* Findings ¶¶ 31, 50. And while we do not reject the HCA's arguments out of hand as suggested by BCBSVT—whose critique of the HCA's actuary is more

[11] The Board learned from information publicly available, *see* Finding ¶ 15, and from a memorandum sent from the Commissioner of DVHA to the Joint Fiscal Office and provided to the Board by BCBSVT, BCBSVT sent its reconciliation request to DVHA on July 6, 2017.

inflammatory than probative—we conclude that the HCA's actuarial report and testimony at hearing fail to raise any credible rationale for implementing the proposed changes to the filing.[12]

Conclusion and Order

The availability of affordable health insurance remains at the forefront of national debate. As we issue our decision today, we are mindful of the uncertainties surrounding provisions of the Affordable Care Act, and the difficulties that many Vermonters—particularly those who do not qualify for premium assistance or cost-sharing reductions—face as health insurance premiums continue to rise faster than other economic indicators. This filing in particular generated sincere and impassioned input from members of the public, each requesting that we decline to increase rates as requested. We give great weight to their concerns in our decision, which recognizes that the insurer retains some levers, and should have the incentive, to cut costs to their minimum while providing this crucial service for Vermonters. Moreover, today's decision reflects our dual interests to approve rates as lean as possible, while ensuring that the company remains solvent and therefore willing to continue to participate in our health insurance marketplace.

Based on the reasons discussed above, the Board modifies and then approves BCBSVT's 2018 Vermont Health Connect Rate Filing. Specifically, we order that BCBSVT: (1) reduce the proposed rate by 0.1% to account for the most recent federal risk-scoring data and the removal of coding intensity assumptions from the risk adjustment transfer calculation; (2) reduce the utilization trend assumption from 2.0% to 1.0%; and (3) reduce the CTR from 2.0% to 0.5%.

As modified, the average annual rate increase for 2018 QHP rates is reduced from the proposed 12.7% to approximately 9.2%.

[12] Remarkably, the HCA faults L&E for not including affordability in the definition of "excessive." HCA Post-Hearing Memorandum at 2. As David Dillon explained at hearing, L&E primarily analyzes *actuarial* review standards—which are terms of art—for the Board. Under Actuarial Standard of Practice No. 8 (*Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*), "rates may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins." Affordability is not included within this definition, and constitutes a separate and distinct component of the Board's review. 8 V.S.A. § 4062(a)(3).

SO ORDERED.

Dated: August 10, 2017 at Montpelier, Vermont

s/ Cornelius Hogan	)	
	)	
s/ Jessica Holmes	)	
	)	
s/ Robin Lunge	)	GREEN MOUNTAIN
	)	CARE BOARD
s/ Kevin Mullin	)	OF VERMONT
	)	
s/ Maureen Usifer	)	

Filed: August 10, 2017

Attest: s/ Erin Collier, Administrative Services Coordinator
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (email address: Erin.Collier@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.