STATE OF VERMONT

GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield Vermont 2018 Qualified Health Plan Rate Filing	)))	GMCB-08-17-rr

POST HEARING MEMORANDUM OF LAW

Blue Cross and Blue Shield of Vermont (BCBSVT) requests the Board approve its 2018 qualified health plan rate filing request after making the modification for federal risk adjustment transfers recommended by Lewis & Ellis (L&E), the Board's actuarial firm. That recommended modification would decrease BCBSVT's average request from 12.7 percent to 12.6 percent. BCBSVT opposes all of the adjustments suggested by the Health Care Advocate's report and requests that they be denied. Other than the agreed modification for federal risk adjustment, BCBSVT requests that the Board make no other change to the filed rate.

Once again, the Board's actuary has performed a thorough review of every component of BCBSVT's rate filing as well as BCBSVT's data underlying the request. L&E found that:

> BCBSVT provided the methodology used to calculate the proposed 2018 individual and small group premiums. [BCBSVT] provided exhibits and support for each component of the premium development, including trend, network changes, morbidity adjustments, federal programs, administrative costs, and taxes and fees.

July 11, 2017 Lewis & Ellis opinion, binder p. 246. L&E further found that each of the components of BCBSVT's requested rate increase, with the exception of the calculation relating to the federal risk adjustment program which we discuss separately below, was reasonable, appropriate and supported in the filing and responses to information requests. L&E Opinion, *passim*. L&E opined that, after modification for federal risk adjustment, the filing met the

statutory standards for approval and that "L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory." Id. P. 259.

BCBSVT agrees with L&E's recommendation with respect to calculation of the final federal risk adjustment program payments. Specifically, L&E recommended removing coding growth for both BCBSVT and MVP from the calculation and calculating the risk adjustment payment using the final federal report released June 30, 2017. Id. pp. 255-6. L&E's recommendations increase BCBSVT's final receivable and thereby decrease BCBSVT's requested rate from 12.7[1] percent to 12.6 percent. Id. p. 259

We respectfully request that the Board provide no weight to the testimony of Peter Horman, FSA, AAA, the HCA's consulting actuary, in light of his lack of experience with reviewing rate filings and his immediate past employment as chief actuary for Neighborhood Health Plan, which was financially troubled throughout his tenure.[2] Tr. 205-208. Furthermore, it was demonstrated at hearing that Mr. Horman's conclusions are based on inaccurate interpretation of data, inappropriate methodology, erroneous calculations, or a combination of the three. L&E had considered all of the issues raised by Mr. Horman in their conclusions that

[1] BCBSVT did not amend its rate request after May 11, 2017, to reflect new information on the federal risk adjustment program. The higher 12.9 percent figure found in L&E's recommendation with respect to risk adjustment was solely L&E's calculation and was never requested by BCBSVT. Id., p. 259; Tr. 44 and 156.

[2] This is the first and only review of an external rate filing ever performed by Mr. Horman (compare that with the experience of L&E who have performed over 500 such reviews on QHP filings alone); by his own admission, this was Mr. Horman's first experience reviewing rates. Mr. Horman was the chief actuary of the Neighborhood Health Plan (NHP) in Massachusetts while it suffered significant losses (at least $221 million in losses in three years). About the time Mr. Horman ceased in his role as acting chief actuary for NHP, the Commonwealth of Massachusetts placed NHP under a corrective action plan due to its poor financial condition. While Mr. Horman testified that he was a victim of NHP's circumstances from June 2013 until October 2016, elsewhere Mr. Horman characterizes his role differently. "At [NHP, Mr. Horman] led all actuarial and underwriting functions, including financial forecasting, risk based capital planning, and design of provider risk contracts." Horman CV, Binder page 289. See also Horman CV description specific to NHP tenure. p. 290. Mr. Horman's recommendations here will lead to grossly inadequate rates (similar to those experienced by his former company). Unlike Neighborhood Health Plan, BCBSVT does not have any parent company, let alone one that could bail out hundreds of millions in losses over 3 short years.

BCBSVT filed rates, after modification to the risk adjustment calculation, are not excessive, inadequate or unfairly discriminatory. Tr. 171 (Dillon).

Medical (Medical Utilization and Cost) Trend

BCBSVT's and L&E's best estimates of 4.7 percent for medical trend were equal. Id. p. 252. L&E expressly found that the BCBSVT's total allowed medical trend is reasonable and appropriate. Id. Further, L&E found that BCBSVT "provided sufficient evidence to support the 2.0 percent utilization trend." Dillon, p. 167.

With respect to utilization trend, we note that L&E departed from its past practice of disclosing its conclusions in the report it submits to the Board and testified at hearing that it had calculated a range for medical utilization trend of 1 percent to 2.5 percent. L&E's results and data considered to support this range were shared with BCBSVT the week after the hearing and are derived from the application of a software package employed by L&E. While we agree with L&E's best estimates, we disagree that a 1 percent utilization trend is a reasonable assumption.

Both L&E and the actuary for the HCA used a very statistical approach to selecting utilization trend. While BCBSVT informs their trend selection with statistical analysis, we find that it is more important to analyze and assess drivers of trend. Nonetheless, close scrutiny of the statistical analyses of both L&E and the HCA lead to the same conclusion as that derived from the BCBSVT trend driver approach: that is, the best estimate is a 2 percent utilization trend , and that there is no evidence for a utilization trend significantly less than this amount.

L&E used an approach based on fitting 16 time series and six regressions to historical data. In doing so, L&E erred in two ways. First, they included five time series that assume that

there is no underlying trend.[3] Irrespective of the fit of these models, it is clearly inappropriate to select a trend assumption by using a model that assumes no trend. Second, they include four additional time series[4] that inappropriately chose a best fit of 3 months for the seasonality assumption, leading to artificially skewed results. It is well-established in the actuarial literature that health care claim seasonality runs on a 12-month cycle. See, e.g., *Group Insurance, 7th Edition*, D. Skwire, editor. p. 324. When the software is appropriately adjusted to use a 12-month seasonality, the four time series that resulted in trends of between 0.22 percent and 0.24 percent in the L&E analysis (results that are outside of L&E's own reasonable range) instead yield utilization trends ranging from 1.86 percent to 2.49 percent. In fact, once corrections are made, the *lowest* utilization trend predicted by the remaining 11 time series and six regressions modeled by L&E is 1.86 percent. L&E's development of a best estimate trend assumption is sound, but a 1% utilization trend is clearly well below the reasonable range of assumptions.

The actuary for the HCA testified at hearing that the methodology used by MVP was superior to that used by BCBSVT. Tr.. 193-194. L&E testified at hearing that it is not appropriate to "utilize a different company's trend assumption, especially one that is much smaller and not as stable, for [setting utilization trend]." Tr. 161 (Dillon). However, while it is unreasonable to use another company's trend assumption, it is reasonable to apply the MVP methodology to the BCBSVT data. BCBSVT has done so, and has found that the predicted utilization trend is 2.0 percent, with R-squared values in excess of 90 percent, demonstrating excellent fit well in excess of MVP's fit. "You'd need a statistical regression methodology with

[3] Seasonal Additive, Seasonal Multiplicative and Single Moving Average time series assume that there is no trend. See https://docs.oracle.com/cd/E12825_01/epm.111/cb_predictor_user/frameset.htm?copyrite.html.

[4] The following four time series using 24 months of data: Damped Trend Seasonal Additive, Damped Trend Seasonal Multiplicative, Holt Winters Additive, and Holt Winters Multiplicative.

a good fit to be predictive, but it doesn't imply that that regression methodology is predictive." Tr. 216.

Mr. Horman asserts that we should use statistical regression that are predictive based on statistical best practices, and that a backcast is an effective means of measuring predictiveness. Horman, Tr. 192; 208-209; and 215. BCBSVT has performed this analysis as well, and found that the methodology predicted 2016 utilization trend of 1.9 percent to 2.5 percent, depending on whether inpatient utilization is taken to be zero or positive (the regression suggests 2.3 percent, but with poor fit). These results bracket the observed utilization trend of 2.3 percent, meaning that the model has both good fit and is predictive. Again, the result of this methodology that produces a "better estimate," tr. 194, is 2.0 percent.

As stated above, BCBSVT informs their trend selection with statistical analysis, but finds that it is more important to analyze and assess drivers of trend. Fully 75 percent of 2016 utilization trend is explained by three drivers, of which two, pharmaceuticals dispensed in a clinical setting and preventive services, have trends that are not expected to abate in the near-term, while the third, inpatient trend, reflects the cessation of a negative trend and is also expected to continue at the now-flat level. Schultz, p. 28-29. These three discrete drivers alone yield 1.5 percent utilization trend, while additional trend beyond these main drivers has been observed and informs BCBSVT's filed trend of 2.0 percent.

Nothing in the evidence supports a utilization trend of less than 2.0 percent. BCBSVT's discrete and evidence-based methodology yields 2.0 percent. L&E assessed a wide variety of time series and regression methodologies that, upon correction, yield a mean and median trend in excess of 2.0 percent, and no results of less than 1.86 percent. The preferred approach of the

HCA's expert witness has good fit, is predictive, and also yields a utilization trend of 2.0 percent. BCBSVT requests that the Board approve as filed its utilization trend of 2.0 percent.

Contribution to Reserve

BCBSVT has requested the Board approve a two percent CTR. CTR supports the long-term solvency and overall financial health of the company for the benefit of all members, including QHP members. CTR is required in order to maintain an adequate level of members' surplus,[5] which is a critical consumer protection that allows members to receive needed care and providers to continue to receive payments in the event of unforeseen adverse events that may otherwise impact BCBSVT's ability to pay claims. CTR is designed to deal with uncertainty. Tr. 162 (Dillon). BCBSVT's actual CTR results have been an average (-1.8) percent for the last five year period. Binder p 257. This means that BCBSVT's rates have been inadequate.

BCBSVT believes that CTR should be managed to an adequate long-term level, rather than fluctuating significantly from year to year. At this point in time, we believe a two percent CTR represents the long-term level necessary to maintain Risk-Based Capital (RBC) levels that are within our established, modest target range in the face of short-term membership fluctuations, the constant increases in health care cost trend, and potential adverse events. A long-term CTR of two percent represents an adequate, yet not excessive, CTR. While two percent may fall below or above the amount required to maintain RBC at current levels, consistently maintaining an adequate long-term assumption allows BCBSVT to avoid rate shocks in years of high growth in membership or high increases in health care cost trend.[6] While a one percent CTR would allow BCBSVT to stay between 550 percent and 650 percent RBC, the

[5] BCBSVT's current surplus is about $640 per member—the cost of one ER visit, without the cost of associated tests such as labs or xrays.

[6] Should BCBSVT fall below 500 % RBC it would increase the CTR percent requested and above 700 %, it would decrease the CTR requested. Tr. 39.

same is true of a four percent CTR, which the Board's actuary testified would also be a reasonable number. Tr. P. 163. Rather than fluctuate between extremes with *higher* CTR requests when other factors in the filing might also be high or when RBC is trending downward as it has been but is still within range, BCBSVT has selected a reasonable long-term assumption. Both DFR and L&E agree that a CTR of two percent was appropriate and reasonable for this filing. Binder p. 257; Tr. 162-163.[7]

In testimony and in the Commissioner's solvency opinion, the Department of Financial Regulation (DFR) made clear that the DFR actively monitors BCBSVT's surplus and solvency as well as potential threats to surplus and solvency, using all available tools. Tr. 223; Department of Financial Regulation Solvency Opinion, July 18, 2017 (amended), Exhibit 19, p. 1. The Commissioner further determined that the range of surplus targeted by BCBSVT is reasonable and necessary for the protection of its members and that BCBSVT is within the range determined to be necessary. Id. The Commissioner also made the point that [t]here is significant risk that the sufficiency of BCBSVT's surplus erodes due to factors described [in his solvency opinion] unless applicable rates are adequate and set at a level that maintains adequate surplus to keep pace with those trends.[8] Id. The commissioner noted that "[t]he primary factor in an insurer's ability to maintain adequate solvency is whether the insurer consistently charges adequate premium rates." Id. p. 2. The Commissioner also observed that "BCBSVT's current rate filing

[7] Mr. Horman, the only witness to argue that a lower CTR percentage was appropriate, incorrectly asserted that BCBSVT's requested CTR was based on a calculation. Binder, p. 286; cf. BCBSVT actuarial memorandum, binder p. 37 and Exhibit 17, p. 4-5. BCBSVT's approach is explained above and Mr. Horman's assumption is simply false.
[8] BCBSVT's target RBC range of 500-700% is equivalent to about 21%-29% of surplus as a percent of revenue. If BCBSVT's surplus had been 12.5% of revenue at the end of 2016, our RBC ratio would have been well below the level where enhanced BCBSA monitoring and corrective action begin. Adequate surplus levels are also a key BCBSA metric that allows our participation in the Blue Card network which provides Vermonters buying BCBSVT coverage, including QHPs, access to quality provider networks nation-wide (and worldwide). We also note that formulas that use surplus as a percent of revenue are flawed because they necessarily lead to lower a RBC position over time, given inflation.

contains a 2.0 percent contribution to reserves. If the proposed rate is approved as filed it will stabilize BCBSVT's RBC ratio, which has been *trending downward* over the last three years." Id. p. 3 (emphasis supplied).

While DFR must depend on the Board's actuary to assess the various components of the rate filing for adequacy, it is nonetheless DFR's purview to assess the impact of rate inadequacy on BCBSVT. DFR was clear that the Board should take care not to approve inadequate rates because over the long term, BCBSVT could face a material and direct threat to its solvency. Exh. 19, p. 2. While the Board's general counsel focused on the Commissioner's conclusion as a truism, she glossed over the other cogent points made in the Commissioner's solvency opinion, including the long term effects of premium underfunding, the need for stability and the effects of adverse utilization. The Board should not discount the Commissioner's opinion.

There is no wisdom in sacrificing Vermonters' long term access to health insurance coverage, BCBSVT's solvency, or BCBSVT's continued ability and willingness to offer plans on the Exchange, by making unfounded cuts to rates that have been shown to meet the actuarial standard of adequacy, in favor of short term "affordable" underpricing. BCBSVT has long been committed to Vermonters and Vermont's insurance marketplace. The important role that the company plays requires an unwavering financial foundation such that BCBSVT can be the safety net as other carriers come and go from the Vermont marketplace; so BCBSVT can support important changes like the implementation of the ACA which included providing access to care to members through the roll out of the flawed Vermont healthcare exchange; and so it can provide through its BlueCard network access to 96 percent of hospitals across the nation.

BCBSVT has managed to support its 220,000 members with world class service while also providing $8 million in annual funding to the Blueprint program, $7-8 million for the

Vermont health care claims tax through which BCBSVT's members fund Medicaid, Vermont Health Connect and VHCURES, $2 million for VITL and $1.5 million to fund the GMCB. BCBSVT has been a collaborative partner with Vermont providers in developing innovative programs to address the healthcare needs of Vermonters including supporting Vermont's ACOs in payment reform efforts since 2014. BCBSVT will be seeing Vermont through future changes to the ACA including for example the precarious funding of the federal cost share reduction program. BCBSVT is fully committed to individuals and small businesses in Vermont and the last thing we would propose for our customers is a double-digit rate increase unless it was essential to protect the financial foundation on which we all rely.

BCBSVT must remain financially sound in order to continue to provide Vermonters with outstanding member experiences, responsible cost management and access to high value care. A CTR of 2 percent, coupled with adequate rates on other components of the rates, is key to long term stability of QHP rates and the QHP market.

Affordability

BCBSVT is a local Vermont nonprofit hospital service corporation. It has no shareholders, no parent company, no presence outside of Vermont and it exists solely for the benefit of its members. BCBSVT QHP products protect members from the potentially ruinous cost of significant illness or injury, are very high quality, are delivered by robust global networks of providers, and, most significantly, reflect the expected cost of health benefits that will be accessed by 2018 QHP participants.

The 2018 QHP rates filed by BCBSVT were developed to cover the cost of health services, taxes, fees, administrative costs and a CTR of 2 percent for the protection of its members. It is the responsibility of the actuaries to develop rates that are neither excessive nor

inadequate, are reasonable in relation to the benefits provided and are not unfairly discriminatory. Actuaries for BCBSVT and the Board agree that the 2018 QHP rates requested by BCBSVT, after the modification for federal risk adjustment is made, meet all of these criteria. Given that the rates are neither excessive nor inadequate, the only way the rates are unaffordable is if the underlying cost of health care in unaffordable. Tr. 67.

Beyond the actuarial work, BCVSVT takes very seriously its charge of promoting affordability. Based on management guidance, BCBSVT has established a proven track record of using actuarial assumptions that produce estimates erring on the low side. Tr. 40 (Schultz). Actual results over the three years of QHPs have generated losses.

BCBSVT has taken and continues to take many actions to promote the affordability of all of its products for its members. BCBSVT will not re-file QHP rates to reflect the higher-than-anticipated hospital budget unit cost trends that L&E opined should be considered by the Board in making their decision. Tr. 31 (Schultz); Binder p. 259 (L&E). BCBSVT continues to file for a modest, 2.0 percent contribution to member reserves, in contrast to testimony from the GMCB's actuary that a CTR of up to 4.0 percent would have been unsurprising. Tr. 163 (Dillon). BCBSVT targets an MLR of 91.1 percent, binder, p. 183, which is higher than that targeted by "most companies," tr. 150 (Dillon), meaning that more of the dollars BCBSVT collects go directly toward paying for the cost of care for members than is typical in the industry.

Furthermore, BCBSVT has implemented a number of programs that generate real savings in order to keep rates as low as possible. BCBSVT's fraud, waste and abuse audits saved 1.0 percent of premiums last year, tr. 88 (Schultz), while its PBM contracting will save 0.6 percent in 2018, tr. 42 (Schultz). Its clinical management programs across its book of business save another

$40 million, or 3.7 percent of premium.[9] Tr. 113-114 (Greene). It is clear from this evidence that BCBSVT is fully engaged in strategies that lead to rates that are affordable while maintaining access to quality provider networks.

BCBSVT carefully weighed its filed assumptions and recent financial results and determined that fully funding the QHP market is of paramount importance in 2018. Tr. 82-83 (Schultz). Fully funding QHP rates will not result in an adverse selection spiral. Tr. 47-51.

The Board, which controls about 45 % of health care costs in the state through the hospital budget process, is charged with implementing health care reform measures that will transform our care delivery system and its associated costs. BCBSVT continues to support the Board's efforts in that regard. Board success in holding down healthcare costs will translate to lower plan costs for BCBSVT members. This is an outcome we are eager to have the Board achieve.

Rather than underfunding rates in favor of short-term, modest gains in affordability, BCBSVT looks forward to working with the GMCB, HCA and other stakeholders to create meaningful change within the system. This could include the pursuit of a federal 1332 waiver similar to the Alaska waiver that is expected to save 20 percent of premium[10], or discussion with stakeholders to assess the potential for introduction of limited age-rating to the Vermont QHP market, which could meaningfully reduce premiums for young working families. BCBSVT has embarked on meaningful payment reform initiatives through partnership with Vermont ACOs, and has noted that rates must be fully funded for shared risk/savings models to be effective. Tr. 108.

[9] http://ratereview.vermont.gov/sites/dfr/files/2017/BCVT-130935599_SERFF_Final_070317.pdf , p. 246-248.
[10] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf

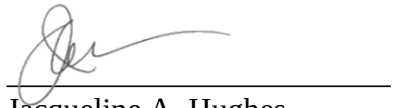
We note, however, that the Board has not adopted any standards defining or measuring affordability. Rather, it applies ad hoc determinations each year in a good-intentioned attempt to lower the cost of QHP products. This has been at the expense of BCBSVT and its members and has contributed to inadequate rates (negative actual CTRs) in four of the last five years, and an RBC that is trending downward trend. Exh. 19, p. 3.

Given that there are no standards which define affordability, and furthermore given BCBSVT's focus and efforts on enhancing affordability, BCBSVT requests that the Board find that it has met the applicable standards for approval of its rates.

Conclusion

After modifying the filing for the agreed federal risk adjustment, we request the Board approve the filed rates without any further modification. Further downward modification is without any support in the record, would be contrary to the actuarial opinions expressed by BCBSVT's and the Board's actuaries, and would lead to the underfunding QHP rates again. This Board should accept its actuaries' opinion. It should reject the recommendations made by the HCA for further reduction of the rates as unfounded, unsupported and/or erroneous. The Board should further find that the rates filed by BCBSVT are as affordable as possible, given the cost of the underlying health care services that are covered by them.

Dated at Montpelier, Vermont, this 31st day of July, 2017.



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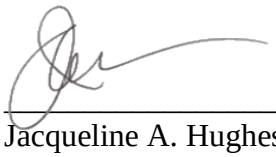
CERTIFICATE OF SERVICE

I hereby certify that a copy of this Post Hearing 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 Kaili Kuiper, Office of Vermont Health Advocate, by electronic mail, return receipt requested, this 31st day of July, 2017.



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