STATE OF VERMONT

GREEN MOUNTAIN CARE BOARD

In re: BCBSVT 2018	)	
Vermont Health Connect Rate Filing	)	GMCB 08-17rr
	)	

HCA POST-HEARING MEMORANDUM

The Office of the Health Care Advocate (HCA) asks the Green Mountain Care Board (Board) to reject Blue Cross Blue Shield of Vermont's (BCBSVT) request for a 12.7% rate increase for its QHP line of business.[1] We ask the Board to reduce the increase by 4% due to BCBSVT's excessive cost predictions and make any further modifications it deems necessary to bring the rates in line with current hospital budget information and to maximize affordability and access to care for Vermonters.

I. Standard of Review

Health insurance organizations operating in Vermont must obtain approval from the Board before implementing changes to health insurance rates.[2] When "deciding whether to approve, modify, or disapprove each rate request, the Board shall determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[3] In addition, the Board must take into consideration "the requirements of the underlying statutes, changes in health care delivery, changes in payment methods and

[1] GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing.
[2] 8 V.S.A. §4062(a).
[3] GMCB Rule 2.000 §2.301(b); GMCB Rule 2.000 §2.401; *see also* 8 V.S.A. §4062(a)(3).

amounts, protecting insurer solvency, and other issues at the discretion of the Board."[4] BCBSVT has the burden of justifying its proposed 12.7% rate increase.[5]

II. Background

BCBSVT has requested to increase its premium rates for its Qualified Health Plan (QHP)s by 12.7% for 2018.[6] Currently, about 70,000 Vermonters are enrolled in these plans.[7]

HCA entered an appearance in this matter pursuant to GMCB Rate Review Rule 2.000, §2.105(b). The HCA hired an independent actuary, Peter Horman,[8] to review the filing. Mr. Horman submitted an expert report on July 11, 2017, which recommended a 4% reduction to BCBSVT's requested rate increase.[9]

Also on July 11, 2017, Lewis and Ellis (L&E), the Board's contracted actuarial firm, issued an actuarial opinion and the Department of Financial Regulations (DFR) submitted a solvency analysis.[10] L&E recommended a modified rate increase of 12.6%. L&E's review was limited to whether the rates were excessive, inadequate, or unfairly discriminatory.[11] However, L&E's definition of "excessive" does not consider affordability for consumers.[12]

DFR's opinion was limited to the subject of solvency and stated that if BCBSVT does not bring in sufficient money to cover its costs, over the long-term BCBSVT will risk insolvency.[13]

---

[4] 18 V.S.A. §9375(b)(6); *see also* GMCB Rule 2.000 §2.401.
[5] GMCB Rule 2.000 §2.104(c).
[6] *Id*.
[7] GMCB 08-17rr, Ex. 11: July 11, 2017 Lewis & Ellis Actuarial Opinion, p. 247.
[8] GMCB 08-17rr, Ex, 14: July 11, 2017 HCA Expert Witness Disclosure & CV, p. 297.
[9] GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report.
[10] GMCB 08-17rr, Ex. 11: July 11, 2017 Lewis & Ellis Actuarial Opinion; GMCB 08-17rr, Exhibit 19: July 18, 2017 Dep't of Fin Regulation Solvency Opinion.
[11] GMCB 08-17rr, Ex. 11: July 11, 2017 Lewis & Ellis Actuarial Opinion, p. 259.
[12] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 252, 253.
[13] GMCB 08-17rr, Ex. 11: July 11, 2017 Lewis & Ellis Actuarial Opinion, p. 259.

DFR did not independently assess BCBSVT's proposed rates and L&E did not independently analyze BCBSVT's solvency.[14]

The Hearing for this filing was held before the Board on July 20, 2017.[15] The Board heard testimony from Paul Schultz and Ruth Green, employees of BCBSVT; from David Dillon on behalf of L&E; from Peter Horman for the HCA; and from Jesse Lussier, on behalf of DFR.[16] Members of the public also commented.[17]

III. Analysis and Argument

To increase the accuracy of the rate projections and the affordability of health insurance, the Board should adopt Mr. Horman's recommendations which lower the requested rates by 4%. We also ask the Board to make any further adjustments it deems necessary to increase the accuracy of BCBSVT's projections and to bring health insurance costs down to a more affordable level for Vermonters. This may include adjustments related to BCBSVT's provider payment projections associated with the Board's hospital budget oversight, and adjustments related to BCBSVT's contributions to reserve.

A. The Proposed Rate is not Affordable

As one Vermonter commented, "At some point it will no longer be a choice for us as to whether or not we buy insurance, it will simply be beyond our financial means. The current trend is not sustainable."[18] Besides causing individual hardship and household insolvency, unaffordable rates could cause plan participation to fall thus impacting BCBSVT's solvency.[19]

---

[14] *See* GMCB 08-17rr, Ex. 11: July 11, 2017 Lewis & Ellis Actuarial Opinion; *see* GMCB 08-17rr, Exhibit 19: July 18, 2017 Dep't of Fin. Regulation Solvency Opinion; *see* GMCB 08-17rr, July 20, 2017BCBSVT Exchange Filing Hearing Tr., p. 161.
[15] GMCB 08-17rr, July 20, 2017BCBSVT Exchange Filing Hearing Tr., p. 1.
[16] *Id* at p. 3.
[17] *Id* at p. 4.
[18] GMCB Public Comments: John Dunham, July 19, 2017.
[19] GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report, p. 274.

This section first examines BCBSVT's proposed rate in light of macroeconomic indicators. Next, we explain how BCBSVT's proposed rate increase will be detrimental to individual-level affordability. The rate of Vermont health care cost growth is unsustainable and without the Board's intervention will undermine insurer solvency and the solvency and health of Vermonters.

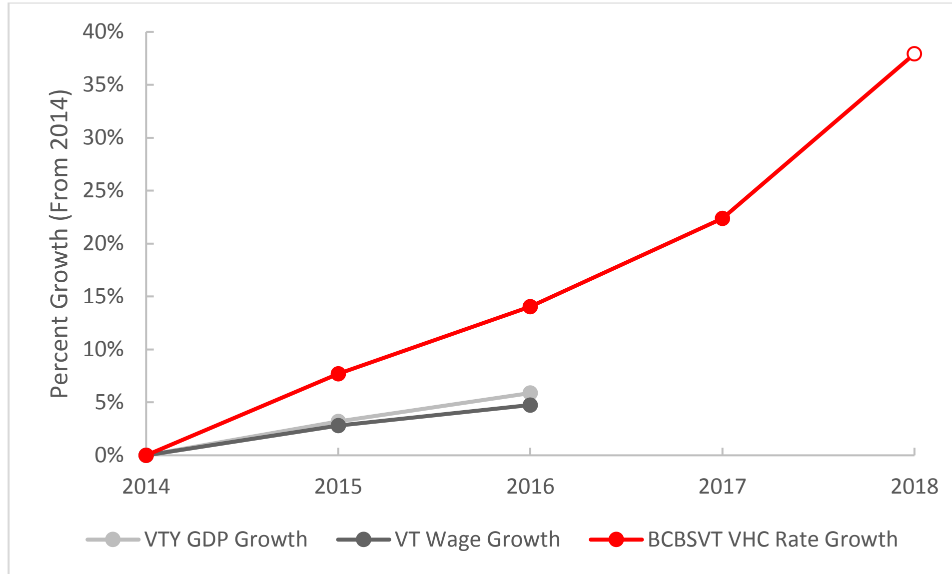
1. *The Proposed Rate is not Affordable at the Macro-Level*

The affordability of BCBSVT's proposed increase cannot be reviewed in isolation. The growth of BCBSVT's QHP premiums compared to Vermont's Gross Domestic Product (VTGDP) exposes the increasing unaffordability of BCBSVT's QHP premiums. Between 2014 and 2016,[20] BCBSVT's premium growth was 239% of VTGDP growth.[21] BCBSVT's QHP premium growth also outpaced Vermont wage growth (VTWG) during the same period. BCBSVT's premium growth for 2014-2016 was 294% of VTWG.[22]

BCBSVT's QHP premiums have continued to increase at an alarming rate. Between 2014 and 2017, BCBSVT's QHP premium has grown by 22.4%.[23] If the proposed 12.7% increase is approved, between 2014 and 2018, BCBSVT's QHP premium will have grown by 37.9%.[24]

[20] 2014 – 2016 is the period starting when BCBSVT began selling QHPs and ending at the most recent year for which VTGDP and VTWG data is available.
[21] U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Vt., retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/VTNGSP; GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing; August 9, 2016 GMCB 08-16rr Decision & Order; August 13, 2015 GMCB 08-15rr Decision & Order; September 2, 2014 GMCB 18-14rr Decision & Order.
[22] Vt. Dept. of Labor, Year to Date Wage tables, http://www.vtlmi.info/indnaics.htm#mqa; August 9, 2016 GMCB 08-16rr Decision & Order; August 13, 2015 GMCB 08-15rr Decision & Order; September 2, 2014 GMCB 18-14rr Decision & Order.
[23] August 9, 2016 GMCB 08-16rr Decision & Order; August 13, 2015 GMCB 08-15rr Decision & Order; September 2, 2014 GMCB 18-14rr Decision & Order.
[24] GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing; *Id.*

Chart 1. BCBSVT QHP premium growth compared to VTGDP growth and VTWG.[25]



Macro indicators only tell part of the affordability story. The impact of BCBSVT's QHP premium growth on Vermont households must also be considered.

2. *The Proposed Rate is not Affordable at the Individual-Level*

The Affordable Care Act (ACA) provides one method for measuring individual-level premium affordability. Under the ACA, a 2017 premium is unaffordable if an individual would be required to pay more than 9.69% of their income towards the premium.[26]

The ACA standard does not take into account the substantial financial burden of a plan's deductible on a Vermonter. The State of Vermont Department of Financial Regulation Insurance Division, however, provides a measure for deductible affordability in its Vermont Household

[25] *Id*. Vt. Dept. of Labor, Year to Date Wage tables, http://www.vtlmi.info/indnaics.htm#mqa; U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Vt., retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/VTNGSP.

[26] 26 U.S.C § 5000A(e)(1); 26 U.S.C. §36B; I.R.S. Rev. Proc. 2016-24, 2016-18 I.R.B. 677. The 9.69% captures the top end of premium cost burden for individuals who qualify for premium subsidies and is the metric for assessing affordability of employer based coverage.

Health Insurance Survey. The survey defines a deductible as unaffordable if a household would have to pay more than 5% of their income towards the deductible.[27]

One way to approach an analysis of individual-level affordability is to combine the ACA premium affordability and Vermont's deductible affordability standards. Using this measure, a plan is affordable only if a household does not (1) pay more than 9.69% of their income for the premium or (2) have a deductible greater than 5% of their income.

BCBSVT's 2017 Standard Silver Plan (13627VT0340004) (Standard Silver) is projected to be the most popular BCBSVT QHP plan in 2018.[28] The 2017 Standard Silver is unaffordable to large swaths of Vermonters using the above-described, two part affordability test, even after accounting for subsidies.[29] The 2017Standard Silver is unaffordable to single individuals whose annual income is between $23,760 and $64,500. The plan is unaffordable to couples whose

---

[27]Robertson and Noyes (2015), 2014 Vermont Health Insurance Survey Research Findings, p. 79, http://hcr.vermont.gov/sites/hcr/files/pdfs/survey/2014-VHHIS-Legislative-Presentation.pdf. Note: We discuss the first prong of the affordability test used in the Vermont Health Insurance Survey. The complete affordability test used in the survey has separate affordability analyses for the ratio of deductible to income and the ratio of actual out-of-pocket expenses to income. The use of just the ratio of income to deductible can only undercount whether a specific plan is affordable and is appropriate when examining specific plan affordability as opposed to making a population estimate of health care affordability.

[28]GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 46.

[29] To estimate subsidy eligibility, we used Vermont Health Connect's QHP Subsidy Estimator, http://info.healthconnect.vermont.gov/Subsidy_Estimator as the basis for our subsidy calculations. We can provide spreadsheet calculations on our affordability analysis if requested by the Board. We made three assumptions when determining the impact of subsidy eligibility and plan deductible on plan affordability. First, at some lower incomes, a household is eligible for BCBSVT silver plans with a smaller deductible than the Standard Silver. In these instances, we used the lower deductible plan to calculate plan affordability. Second, if a family might be eligible for Dr. Dynasaur coverage as indicated by the Subsidy Estimator, we assumed that the family was eligible for Dr. Dynasaur and that they purchased a couple QHP. Third, the Standard Silver has a stacked deductible and a separate prescription drug deductible. We include the full household unit deductible (incl. prescription drug deductible) in the affordability calculation. We also note that BCBSVT's 2018 plan design increases the cost burden on consumers. GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 95. Our affordability test does not include all 2018 plan design changes thus making the Standard Silver appear more affordable than it will be in 2018.

annual income is between $32,200.20 and $129,020.[30] The plan is unaffordable for families[31] whose annual income is between $0 and $181,274.[32]

The 2017 Standard Silver is particularly unaffordable for households at 401% of the Federal Poverty Level (FPL) whose incomes are slightly above what is required to receive a premium tax credit. Individuals, couples, and families at 401% FPL have to pay 17.95%, 27.32% and 22.59% of their income respectively to maintain coverage for a year and reach their deductible.[33] If an individual, couple, or family at 401% FPL has to pay both their premium and the maximum yearly out of pocket costs they would have to pay 28.44%, 43.54%, and 33.01% of their incomes respectively.[34]

An individual-level affordability measure must also be tested against the lived experience of Vermonters. Overwhelmingly, the public comments submitted to the Board called attention to QHP plan unaffordability.

- "As a self-employed clinical social worker I am paying almost $600/month for coverage for myself. This is already outrageous. If the rates rise I will be forced to go without insurance, taking another healthy Vermonter (who supports the unhealthy population) out of the system."[35]

- "Last week, I cancelled an MRI that my neurologist ordered because I just can't afford it, even with insurance. It is outrageous that an insurance plan that already costs 10% of my income doesn't provide the coverage I need to make important procedures affordable.

[30] *See* subsidy eligibility assumptions at fn. 28.
[31] We assumed that a family consists of two adults and two children under 19 years of age.
[32] *See* subsidy eligibility assumptions at fn. 28.
[33] *See* subsidy eligibility assumptions at fn. 28.
[34] *See* subsidy eligibility assumptions at fn. 28. Standard Silver has a stacked maximum out of pocket (MOOP) for couples and families and a separate prescription drug MOOP. We assume that a couple or family must pay their full household unit MOOP (incl. prescription drug MOOP) for this calculation.
[35] GMCB Public Comments: Joanne Case, July 17, 2017.

An increase in rates would also increase the burden on my family as we struggle to pay for our medical care."[36]

- "Though I do not make much and work two jobs, I don't qualify for much of a subsidy and currently pay a lot for health insurance -1/4 of my monthly mortgage. A rate hike would make it impossible for me to continue to have health insurance."[37]

The Board should scrutinize the rate filing to ensure affordability for all Vermonters.

B. The Proposed Rate Does not Promote Access to Health Care

The Board must set rates to promote access to health care.[38] At a basic level, access to health care has two necessary components. The first component relates to the adequacy of the provider network which has not been an issue for Vermont QHPs. Plan affordability is the second component of access to health care.

It makes no difference how adequate BCBSVT's provider network is if Vermonters cannot afford to use it. BCBSVT's current QHP plans are unaffordable for too many people. The documented lack of affordability directly and negatively impacts access to health care.

The Board should either disapprove or modify BCBSVT's proposed rate downward to promote access to healthcare.

C. BCBSVT did not Meet its Burden to Justify its Requested Rate Increase

There are six areas in the rate filing where BCBSVT fails to meet its burden of proof to justify its requested rate increase.[39] These points are: aging, utilization trend, contribution to

[36] GMCB Public Comments: Caitlin Gildrien, July 19, 2017.
[37] GMCB Public Comments: Samantha Langevin, July 19, 2017.
[38] GMCB Rule §2.301(b); GMCB Rule §2.401; *see also* 8 V.S.A. §4062(a)(3).
[39] GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report.

reserves, dental, reinsurance estimates, and administrative costs.[40] Together, these items make up roughly 4% of the requested rate increase.[41]

1. Aging

BCBSVT cannot justify a premium increase by offering a generic claim about Vermont's aging population. BCBSVT stated that population aging is a significant factor in this year's cost increase: "1 percent of the increase is simply the result of Vermonters getting older." [42] All parties agree that it is appropriate to consider demographics when developing rates. However, BCBSVT has failed to justify the appropriateness of an adjustment for demographic shift, and then compounded the problem by applying an overly simplistic and actuarially unsound adjustment. Therefore the Board should reject it.

BCBSVT's witness testified that aging membership contributed to cost increases by about 0.25% in 2014 and about 0.5% per year in 2015 and 2016.[43] BCBSVT used 2014-2016 data plus one data point from March 2017 to predict that the average age of its members will increase costs by 1% from 2016 to 2018. When BCBSVT was asked what modeling or other evidence it has to support the 2018 increase, BCBSVT responded simply that it is aware that the percentage of the Vermont population over 65 has increased and under 18 has decreased since the 2010 census and that state-wide GDP is lower than the national average.[44] There are many other

[40] *Id*.
[41] BCBSVT's pre-hearing memorandum included statements and arguments regarding Mr. Horman's findings about IBNR conservatism, Reflections of Capitation, and BCBSVT's Administrative Ratio. GMCB 08-17rr, Exhibit 17: July 17, 2017 BCBSVT Letter to GMCB. However, Mr. Horman did not incorporate his findings on these three topics into any of his rate reductions. They therefore have no bearing on Mr. Horman's recommendation to reduce rates by 4%, and we are not addressing BCBSVT's statements and arguments on those points.
[42] May 15, 2017 BCBSVT Press Release. *Blue Cross Blue Shield of Vermont Files 2018 Rate Request with the Green Mountain Care Board*, available at http://www.bcbsvt.com/wps/wcm/connect/41228cfc-0f44-4fbd-a385-018eac611af0/bcbsvt-2018-qhp-rates-may2017.pdf?MOD=AJPERES.
[43] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 46-47. It appears the actual aging factor from 2014 to 2016 was 0.77%. GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 29 (2016 factor of 1.2581 ÷ 2014 factor of 1.24854 = 1.0076569).
[44] GMCB 08-17rr, Ex. 6: June 27, 2017 BCBSVT response to L&E Inquiry #4, p. 219, 220.

significant factors that BCBSVT did not analyze, including the portion of Vermont's population that is on Medicaid, the movement of young and healthy people from Medicaid to QHPs as their income grows, the fact that the federal risk adjustment program reimburses BCBSVT for demographic differences between the carriers that impact claims costs, and the number of Vermonters over 65 who will leave commercial plans for Medicare. In fact, because of the shift to Medicare, Census statistics showing that a greater proportion of Vermont's population is over 65 compared to 2010 could support a claim that the average age of BCBSVT's members will decrease.

BCBSVT has not supported its conclusion that the average age of its members will increase in 2018, and that this requires a 1% premium increase above that requested for increased claims, service utilization, family size, and unit cost.[45] BCBSVT did not demonstrate a long-term reliable trend or conduct a sufficiently robust analysis of new information to validate its prediction that aging costs will increase. BCBSVT should be required to conduct a more comprehensive analysis before imposing millions of dollars in additional costs on its members. We therefore ask the Board to decrease BCBSVT's requested increase due to aging by 0.5%.

2. Utilization Trend

BCBSVT's projected utilization trend is not supported by sound actuarial science.[46] BCBSVT's costs related to medical claims have fluctuated in recent years. It had significantly higher than average medical claims costs towards the end of 2016. BCBSVT uses this increase to

---

[45] BCBSVT captures future cost increases due to population morbidity elsewhere in its filing. The plain language statement lists several categories driving the cost increase including the 2016 claims increase (1.9%); the increase in service utilization and cost (2.8%), aging, and an increase in family size (2.1% together with aging). GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 42; May 15, 2017 BCBSVT Press Release, *supra* n. 42 (noting 1% of the requested increase is due to aging).
[46] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 190, l. 15; GMCB 08-17rr, Exhibit 13: July 11, 2017 Mr. Horman Actuarial Report, p 275.

forecast higher claims costs for 2018. However, BCBSVT did not demonstrate that this prediction is sound.[47] Mr. Horman tested BCBSVT's trend methodology and found that BCBSVT's predicted trend did not explain recent past experience data.[48] This demonstrated that BCBSVT's predicted utilization trend is invalid and not a reliable predictor of future claims.[49] The updated claims information BCBSVT submitted in response to questions from L&E further demonstrate that BCBSVT's proposed utilization trend does not predict future costs.[50]

As part of Mr. Horman's analysis of BCBSVT's utilization trend, he reviewed MVP's methodology for developing its 0.7% utilization trend.[51] He found that MVP used a more sophisticated approach to develop its trend than BCBSVT's approach. MVP separately analyzed the unit cost and utilization for each category of medical services.[52] Paul Schultz testified on behalf of BCBSVT that any difference in the level of health needs between BCBSVT and MVP populations is accounted for by the federal risk adjustment program.[53]

L&E's witness testified at the hearing that a 1% utilization trend is within L&E's calculated range of reasonableness for this filing.[54] As Mr. Horman testified, his recommendation on the utilization trend did not change in response to BCBSVT's hearing testimony or its response memo.[55] BCBSVT claimed at the hearing that Mr. Horman failed to adequately adjust for the low claims that resulted from individuals switching from Catamount to Medicaid in 2014.[56]

---

[47] GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report, p. 6.
[48] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 192; GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report, p. 6.
[49] *Id*.
[50] *See* GMCB 08-17rr, Ex. 3: June 7, 2017 BCBSVT response to L&E Inquiry #2, p. 173.
[51] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 193.
[52] *Id*.
[53] *See* GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 48, l. 1-8.
[54] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 160, 161.
[55] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p.194-195.
[56] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 54-55.

However, Mr. Horman's calculations do not materially change when estimating the results on the post-2014 subset of data that BCBSVT referenced at the hearing.[57] BCBSVT has failed carry its burden to prove the magnitude of its future utilization trend increase. As such, BCBSVT should not be permitted to impose costs on its members in excess of its historical 1% trend.

3. Contribution to Reserves

The requested increase for contribution to reserves (CTR) is excessive. BCBSVT claims that it should be permitted to charge an ongoing 2% contribution to reserves to their membership, regardless of actual need. BCBSVT claims that this will "allow us to avoid rate shocks in years of high growth in projected claims costs, such as 2018." BCBSVT admits that the 2% is not tied to a specific calculation.[58]

In response to Mr. Horman's report, BCBSVT provided revised calculations purporting to support a CTR need of 1.9%.[59] BCBSVT targeted this CTR calculation to 700% of Risk Based Capital (RBC), which is the top of their reasonable RBC range.[60] In light of the proposed double-digit rate increase for 2018, BCBSVT should target the low end of its reasonable RBC range. This would bring the CTR down to 0.8% and reduce the requested rate increase by 1.2%.[61]

BCBSVT should be required to justify its CTR request in the same manner that it is required to justify all other rate increase components. This is consistent with the statute and is especially

---

[57] Mr. Horman can provide updated calculations on this point at the request of the Board. Also, Mr. Horman's original analysis relied on data that BCBSVT provided in its filing to support its utilization trend. If the data is inappropriate, BCBSVT should not have included it in the filing.
[58] GMCB 08-17rr, Exhibit 17: July 17, 2017 BCBSVT Letter to GMCB, p. 4.
[59] Initially, BCBSVT incorrectly provided premium costs instead of claims costs for an exhibit that purported to demonstrate their actual CTR need. GMCB 08-17rr, Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 76. When Mr. Horman pointed this out, BCBSVT corrected the mistake, which brought its calculated CTR need down from 3.2% to 1.9%. Fn.56.
[60] Fn. 56.
[61] GMCB 08-17rr, Ex. 13: July 11, 2017 Mr. Horman Actuarial Report, p. 280.

important in years such as this one where they have requested a double-digit rate increase. The HCA asks the Board to set BCBSVT's CTR no higher than 0.8%.

4. Compounding Conservatism: Dental, Reinsurance, and Administrative Costs

Mr. Horman found excessive projected costs in BCBSVT's dental trend, reinsurance estimates, and administrative costs.[62] BCBSVT has not provided an adequate response to these findings. First, pediatric dental benefits have been in place for QHPs since 2014. While BCBSVT asserts that a high number of people will continue to learn about the benefit for the first time in 2018, it identified little evidence to support this assumption.[63] Similarly, BCBSVT claims that its reinsurance contract is "best-in-class,"[64] but it has provided no evidence to back up the claim that BCBSVT has negotiated the best possible deal for its consumers. Finally, although BCBSVT argues that its administrative costs are as low as they could possibly be, BCBSVT's average PMPM administrative costs for Exchange plans has increased from $27.22 proposed in its 2015 filing to $36.06 proposed for 2018, a 32.5% increase in three years.[65] We ask the Board to reduce BCBSVT's proposed increase by 1%, as recommended by Mr. Horman, to remove the combined excess in these areas.

5. HCA Expert Peter Horman is Qualified to Evaluate the Filing and the Board Should Adopt his Recommendations

Mr. Horman has nearly 20 years actuarial experience in the field of healthcare and health insurance rates. At the hearing and in its prehearing memo, BCBSVT attempted to distract from the weaknesses in its filing by implying that Mr. Horman is responsible for the recent financial performance of his former employer, Neighborhood Health Plan (NHP). BCBSVT did not make

---

[62] *Id* at p.276-278, 280-281, 287-288.
[63] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 58-60.
[64] GMCB 08-17rr, Exhibit 17: July 17, 2017 BCBSVT Letter to GMCB, p. 3.
[65] GMCB 08-17rr, Ex.1: May 12, 2017 BCBSVT SERFF Filing, p. 73; GMCB-018-14rr, ex.7A: June 2, 2014 SERFF Filing.

any connection between NHP's financial performance and the quality of Mr. Horman's actuarial work setting commercial rates. In reality, NHP's issues began before Mr. Horman worked there.[66] Further, although NHP's annual statement included separate information on the financial performance of NHP's commercial line, BCBSVT instead quoted annual statement numbers that refer to NHP's full book of business.[67] This was negatively impacted by NHP's Medicaid line.[68] As BCBSVT should be aware, NHP's Medicaid rates were set by the state of Massachusetts, not Mr. Horman. Finally, it is absurd for BCBSVT to blame one actuary for the financial performance of an entire company without any evidence connecting the two, when the whole of BCBSVT takes no responsibility for its own recent financial losses.

6. BCBSVT Provides Weak Justification for Additional Assertions in its Filing

i. Increases due to Preventive Care are not Justified

BCBSVT argues that preventative care, a significant factor in its utilization trend, is unlikely to level off.[69] As evidence of this, BCBSVT points to statements made in public comments that indicated to BCBSVT that many individuals are not aware of their preventative care benefits.[70] First of all, BCBSVT has provided no evidence that it will improve its outreach to consumers. Second, many consumers are aware that preventative care benefits do not guarantee that any single visit will not result in out of pocket costs due to the narrow definition of preventive care.

ii. BCBSVT does not Analyze Care Management and Cost Containment Programs

BCBSVT states that they do not try to estimate future savings from care management and cost containment programs. Rather, the savings comes out in claims costs resulting in lower

[66] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 206.
[67] Annual Statement for the Year 2013-2016 of the Neighborhood Health Plan, Inc., Analysis of Operations by Line of Business.
[68] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p 207-208.
[69] GMCB 08-17rr. Ex. 1: May 12, 2017 BCBSVT SERFF Filing, p. 13.
[70] GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p. 72. 73.

trends. If BCBSVT believes it is more prudent to wait for claims results than to try to estimate savings, it should apply the same logic to potential cost increases that are difficult to estimate. Further, if BCBSVT truly does not have any way to estimate how much it is savings from its care management programs year to year, then it has no way of knowing if these programs are worthwhile. They could be adding extra administrative costs without any benefit to consumers.

iii. Comparisons to Other Blue Cross Associations are not Relevant

BCBSVT highlighted where they compare favorably to Blue Cross associations nationwide.[71] It is illogical for them to encourage the Board to compare them to other insurers nationally on specific points, while cautioning the Board against making national comparisons in other ways because Vermont is a unique state.[72] Further, the suggestion that BCBSVT should be commended for looking better than other Blue Cross organizations is only true to the extent that we assume other Blue Cross organizations are being held to the Board's statutory standards including affordability. We have no evidence of this.

IV. Conclusion

For the reasons explained above, the HCA respectfully requests that the Board reduce BCBSVT's requested rate increase by approximately 4% and that the Board consider additional adjustments as warranted to increase the accuracy of the rate projections and affordability for Vermonters.

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

/s/ *Kaili Kuiper*
Kaili Kuiper
Staff Attorney
Office of the Health Care Advocate
Vermont Legal Aid, Inc.

[71] *See eg*. GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p 158, l. 6-17.
[72] *See eg*. GMCB 08-17rr, July 20, 2017 BCBSVT Exchange Filing Hearing Tr., p 79, l. 8-12.

CERTIFICATE OF SERVICE

I, Kaili Kuiper, hereby certify that I have served the above Memorandum on Judith Henkin, General Counsel to the Green Mountain Care Board, Noel Hudson, Health Policy Director of the Green Mountain Care Board, and Jacqueline Hughes, representative of Blue Cross Blue Shield of Vermont, by electronic mail, return receipt requested this 31st day of July, 2017.

/s/ *Kaili Kuiper*

Kaili Kuiper
Staff Attorney
Office of the Health Care Advocate
P.O. Box 606
Montpelier, Vt. 05601
Voice (802) 223-6377 ext. 329