STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing	)	GMCB-009-18rr
	)	SERFF No. BCVT-131497882

DECISION AND ORDER

Introduction

On May 11, 2018, Blue Cross and Blue Shield of Vermont (BCBSVT), one of the two carriers offering qualified health plans in Vermont, proposed an average annual rate increase of 7.5% for the individual and small group market for coverage beginning January 1, 2019. On July 18, 2018, BCBSVT amended the filing to request an average annual rate increase of 9.6%.

Based on our review of the record, the testimony and evidence presented at hearing, and our statutory directives and commitment to approve the most affordable rates possible without threatening the carrier's financial stability, we modify the rates downward as explained below, and then approve the filing.

Findings

Background:

1. The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, fundamentally changed the federal government's role in regulating health insurance and required the establishment of state health insurance exchanges where individuals, families and small businesses could shop for qualified health insurance coverage. In 2011, the Vermont Legislature enacted Act 48 which, among other reforms, created Vermont Health Connect (VHC), the state's health benefit exchange. VHC allows Vermonters to compare qualified health plans (QHPs) for individuals, families and small employers (up to 100 employees) with rates based on a single risk pool, or "merged market." *See* 33 V.S.A. §§ 1803, 1811.

2. Health insurance plans on VHC are offered to consumers in bronze, silver, gold, and platinum metal levels, as well as catastrophic coverage for qualifying individuals.[1] *See* 42 U.S.C. § 18022(d)(1). Each of the four metal levels corresponds to an "actuarial value" (AV)—the expected percentage of claims for essential health benefits that a health insurer will cover on average. The bronze plans have the lowest AV and least generous coverage, while the platinum plans, with the highest AV, have the most generous coverage.

[1] 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).

3. The ACA and state law incorporate several mechanisms to make health insurance plans offered on the exchange more affordable for individuals without employer-sponsored insurance. Taxpayers may be eligible for premium assistance, based on a percentage of their household incomes and calculated relative to the second lowest cost silver plan, through federal advanced premium tax credits (APTCs)[2] that can be applied to the cost of any metal level plan. *See* 26 U.S.C. § 36B ("Refundable credit for coverage under a qualified health plan").

4. The ACA also requires insurers to reduce out-of-pocket costs for enrollees earning from 100% to 250% of the federal poverty level (FPL) through cost sharing reductions (CSRs). *See* 42 U.S.C. § 18071. Until this past year, the federal government offset the cost of CSRs by making CSR payments directly to insurers. In October 2017, however, the federal government announced that it would no longer make CSR payments to insurers, notwithstanding the insurers' continued obligation to offer CSRs to enrollees. *See* Letter from Eric Hargan, Acting Secretary, U.S. Dep't of Health & Human Services, to Seema Verma, Administrator, Centers for Medicare & Medicaid Services (Oct. 12, 2017), *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

5. To date, the federal government has not resumed making CSR payments to insurers. On March 18, 2018, BCBSVT commenced a lawsuit in federal court to recover the payments. *See Blue Cross & Blue Shield of Vermont v. United States of America, Case No*. 1:18-CV-00373-MBH (Fed. Cl. 2018).

6. In addition to federal premium assistance, Vermonters at or below 300% of the FPL who purchase coverage through VHC are eligible for Vermont premium assistance that reduces their premium contribution by 1.5% below the amount available under the federal law, *see* 33 V.S.A. § 1812(a), and Vermont cost-sharing assistance that further reduces enrollees' deductibles and copayments. 33 V.S.A. § 1812(b).

7. As of March 2018, approximately two of every three individuals enrolled through VHC receive federal premium tax credits. Many also receive additional state or federal assistance such as CSRs to reduce their premiums and out-of-pocket costs. *See* Dep't of Vermont Health Access (DVHA) Health Coverage Map (July 11, 2018), *available at* http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q1.pdf.

8. To counter the financial impact from the federal defunding of CSRs, the Vermont Legislature enacted Act 88 (2018), effective February 21, 2018. The Act allows health insurers to offer silver-level nonqualified health benefit plans, called "reflective silver plans," off the exchange. These plans must be similar to silver plans on VHC ("silver-loaded plans") with one variation in benefit, but unlike the VHC plans, do not include any funding to offset the loss of the CSR payments, and are therefore significantly less expensive. *See* 33 V.S.A. § 1813. Because

[2] Taxpayers can choose to have the estimated credit computed and paid to the insurance company to lower monthly premiums or can claim the benefit when filing their tax return for the year. APTCs must be reconciled with actual income when the taxpayer files his or her annual tax return. *See* IRS Questions and Answers on the Premium Tax Credit, *available at* https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

subsidies for eligible Vermonters increase relative to the rise in cost of the second lowest cost silver plan on VHC, eligible Vermonters can use the larger subsidy to offset the cost of a plan at any metal-level. For example, subsidized enrollees may be able to purchase a gold plan with richer benefits at a cost below or comparable to a silver plan, or purchase a bronze plan at minimal or no cost.

9. Central to its reform provisions, the ACA includes an "individual mandate" requiring that individuals and families have qualifying health insurance coverage[3] or pay a penalty on their personal income tax returns. *See* 26 U.S.C. § 5000A. The Tax Cuts and Jobs Act (TCJA), enacted by Congress in December 2017, eliminated the imposition of a penalty beginning in plan year 2019 for the failure to purchase qualifying coverage.

10. In February 2018, the Board and the Department of Financial Regulation (DFR) commissioned a study to estimate the impact on the Vermont market of the elimination of the individual mandate penalty. The study, conducted by Lewis & Ellis (L&E), the Board's contract actuary, estimated that enrollment in the state's individual and small group market would decrease by approximately 3.5% to 6.0% as fewer younger, healthier individuals purchased insurance, causing an estimated increase in premiums from 1.6% to 2.4%. *See* Individual Mandate Study (Feb. 16, 2018) *available at* http://ratereview.vermont.gov/sites/dfr/files/2018/Individual%20Mandate-%20impact%20in%20Vermont.pdf.

11. The Vermont Legislature reacted to the elimination of the penalty associated with the federal individual mandate by enacting Act 182 (2018), which 1) creates a state mandate that individuals maintain minimum essential coverage, 2) forms a working group to develop recommendations concerning administration and enforcement of the mandate, with the enforcement mechanism to be enacted by the Legislature in 2019, and 3) tasks DVHA, in consultation with the Office of the Health Care Advocate (HCA) and other stakeholders, with engaging in outreach efforts to educate Vermonters about the importance of, responsibility to maintain, and availability and options for health insurance coverage. Act 182 (2018), *available at* https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT182/ACT182%20As%20Enacted.pdf.

12. To stabilize the individual and small group markets and protect against risk selection, the ACA includes a permanent risk adjustment program that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees. In February 2018, the United States District Court for the District of New Mexico held that the methodology used to calculate risk transfer payments was "arbitrary and capricious." *See New Mexico Health Connections v. U.S. Dep't of Health & Human Services*, No. 16-cv-878 (D.N.M. Feb. 28, 2018). On July 7, 2018, the Trump Administration indicated that it was suspending the risk adjustment program and withholding risk adjustment payments as a result of the decision. The Centers for Medicare & Medicaid Services (CMS) has since adopted a methodology consistent with the court's ruling, and announced that the program will continue. *See* CMS Press Release, *CMS Adopts the*

[3] 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.

Methodology for the Permanent Risk Adjustment Program under the Patient Protection and Affordable Care Act for the 2017 Benefit Year (July 24, 2018) *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-24-2.html.

13. To help fund federal and state marketplaces, Section 9010 of the ACA includes a Health Insurance Providers Fee, that is based on a covered entity's share of net health insurance premium in the prior year. *See* 26 C.F.R. Part 57. Congress imposed a moratorium on collection of the fee for plan year 2017. The fee was resumed for 2018, but was again been suspended for the 2019 plan year. *See* Internal Revenue Service, Affordable Care Act Provision 9010 - Health Insurance Providers Fee (June 15, 2018), *available at* https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010 (IRS guidance explains fee calculation and moratorium).

14. Besides amending the Internal Revenue Code to eliminate the penalty associated with the individual mandate, the TCJA made substantial changes to the tax rates and bases for individuals and businesses, *see* Pub. Law 115-97 (Dec. 22, 2017). Under the new law, BCBSVT will no longer pay federal corporate income tax and will receive refunds in the form of credits over the course of four years, beginning in late 2019, of the accrued corporate alternative minimum tax (AMT) it previously remitted to the Internal Revenue Service (IRS). Company CEO Don George has pledged that "the full impact of these [tax] changes will be dedicated to mitigating [ratepayers'] future premium increases." *See* Press Release, *Blue Cross and Blue Shield of Vermont Members to Benefit from Federal Tax Cuts* (Mar. 1, 2018), *available at* http://www.bcbsvt.com/wps/wcm/connect/16b8c8a5-4bc0-48a5-bc4f-7a3bd5725f26/2018-bcbs-members-benefit-from-fed-tax-cuts-03.01.18.pdf?MOD=AJPERES.

15. On October 12, 2017, President Trump issued an Executive Order that called for the Secretary of Labor to consider making access to health care coverage through Association Health Plans (AHPs) less restrictive for small businesses. E.O. 13813; *Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States* (Oct. 12, 2017).

16. The Department of Labor (DOL) released a final rule on June 19, 2018 that expands the availability of AHPs by adopting a more flexible "commonality of interest" test for employers. *See* DOL website, *About Association Health Plans*, (includes links to Executive Order, final regulation, FAQs) *available at* https://www.dol.gov/general/topic/association-health-plans. The final rule allows fully insured plans to begin operating on September 1, 2018. 83 Fed. Reg. 28961 (June 21, 2018), *to be codified at* 29 C.F.R. § 2510.3-5 *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-06-21/pdf/2018-12992.pdf.

17. On July 2, 2018, DFR announced that it was in the process of drafting an emergency regulation that would provide additional regulatory oversight to protect Vermont consumers beyond what is required under the DOL final rule. According to DFR Commissioner Michael Pieciak, the emergency regulation was needed to "ensure Vermonters are protected and well-served by these health plans." Pieciak stated that in the past, similar plans in other states "were poorly run, and many were fraudulent." *See* http://www.dfr.vermont.gov/press-release/dfr-implement-emergency-rules-response-us-dol-greatly-expanding-association-health. On July 26,

2018, a coalition of twelve state attorney generals, led by New York and Massachusetts, filed a legal challenge to the DOL final rule. *See* https://ag.ny.gov/sites/default/files/complaint_as-filed.pdf.

18. On August 1, 2018, DFR filed the emergency regulation with the Vermont Secretary of State pursuant to the Vermont Administrative Procedures Act. *See* 3 V.S.A. § 844 (provides that an agency may issue an emergency rule when it "believes that there exists an imminent peril to public health, safety, or welfare"). According to DFR, the reintroduction of AHPs into the insurance market beginning September 1, 2018 poses a threat to Vermonters "unless a regulatory framework protecting Vermont consumers and stabilizing Vermont's insurance markets is implemented" prior to that date. The emergency regulation, effective August 1, 2018, imposes a series of requirements that AHPs must meet regarding licensure, solvency, reserves, and rating. Also on August 1, 2018, DFR filed a proposed AHP regulation with requirements that mirror the emergency regulation. *See* http://www.dfr.vermont.gov/proposed-rules-and-regulations (links to emergency and proposed rules).

19. In the forms filed with the Secretary of State's office, DFR provided a summary of the economic impact of its proposed rule governing AHPs, stating that the regulation will "requir[e] fully-insured AHPs to offer comprehensive health insurance coverage rather than limited benefit plans that appeal to the youngest and healthiest lives," and will therefore mitigate the migration of healthy members from VHC. DFR stated that "[a]t the present time, it is impossible to quantify the impact that fully-insured AHPs will have on premiums in VHC." *See* Proposed Rule Filing – Fully-Insured Multiple Employer Welfare Arrangements and Association Health Plans (Aug. 1, 2018) (emphasis added); *available at* http://www.dfr.vermont.gov/sites/default/files/dfr-association-health-plan-proposed-rule-i-2018-01-documents-submitted-to-lcar.pdf; *see also* Emergency Rule no. E-06 (adopted Aug. 1, 2018); *available at* https://secure.vermont.gov/SOS/rules/results.php.

Procedural History

20. On May 11, 2018, BCBSVT filed its 2019 Individual and Small Group Market Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed rates for coverage commencing January 1, 2019 for QHPs and for reflective silver plans that will be offered by the insurer off the exchange. The filing proposed an average annual rate increase of 7.5% with increases ranging from 3.5% to 18.87%.[4] Taking into account the availability of increased premium assistance for eligible Vermonters, as described in ¶ 8, above, the proposed average annual rate increase would be 5.3%, with increases ranging from 3.5% to 6.8%. Exhibit 1 at 2, 4, 5, 12.[5]

[4] Because it accounts for a minimal number of lives, we have excluded the proposed 1.25%, increase for the catastrophic plan from the lower end of the range throughout this document.

[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/node/702, and are described by their titles, rather than as numbered exhibits.

21. On May 18, 2018, the Office of the Health Care Advocate, 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. *See* 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule (Rule) 2.000 §§ 2.105; 2.202; 2.307.

22. From May 11, 2018 through July 26, 2018, the Board requested that BCBSVT respond to a series of interrogatories, including two sets of questions suggested by the HCA and forwarded to BCBSVT on the HCA's behalf. BCBSVT provided responses to each set of interrogatories. Exhibits 2-12.

23. On July 10, 2018, 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. Exhibit 14.

24. On July 11, 2018, the HCA filed an Expert Witness Report of Chief Health Care Advocate Michael Fisher (Fisher Report), who the HCA had previously disclosed as one of its two expert witnesses.[6] The Fisher Report stated Fisher's view, as a former legislator, of the legislative intent of Act 48 of 2011, supplemented by excerpts from archived legislative records.

25. L&E reviewed the filing and on July 10, 2018, issued an actuarial memorandum and recommendations to the Board. L&E recommended that the Board 1) adjust BCBSVT's pool morbidity factor downward by 1.3% to normalize the impact of induced utilization; 2) accept BCBSVT's revised calculation of the impact of selection to more accurately reflect the effect of the reflective and silver-loaded plans; 3) modify the company's projected risk adjustment to reflect the most recently available information; and 4) require BCBSVT to revise the mapping of projected membership. Cumulatively, the four modifications would reduce the rate by 0.3%; L&E also recommended that the Board consider in its decision any updated information it may receive regarding unit cost increases. Exhibit 13 at 16-17.

26. On July 18, 2018, BCBSVT amended its rate filing. The company first incorporated L&E's four recommended modifications, which it does not contest, and which reduced the rate by 0.3%, from 7.5% to 7.2%. The company next added 0.1% to the rate to account for two recently enacted changes in Vermont law—the first regarding copayments for chiropractic care and the second concerning cost-sharing for certain breast imaging services. In addition, the amended filing included the company's request for a 2.3% rate increase to account for a projected migration of small group members to newly-allowed AHPs. Exhibit 17 at 1-9.

27. Last, in addition to the proposed rate changes, the amendment included an allegation that due to pricing strategies by MVP, BCBSVT is at a "profound" rate disadvantage for bronze-level plans, which "BCBSVT senior management believes . . . creates an unfair market environment." *Id*. at 10. Although the carrier attached no rate impact to its allegation, it "urge[d] the GMCB to investigate and correct this market structural defect." *Id*. at 11

[6] The HCA disclosed that its Hotline supervising attorney Marjorie Stinchcombe would also provide expert testimony. Ms. Stinchcombe did not offer an expert report, nor did she appear to testify at hearing.

28. On July 19, 2018, BCBSVT filed a motion *in limine* to exclude the Fisher Report and related testimony. *See* Motion *in Limine* to Exclude the Report and Testimony of Michael Fisher (July 19, 2018) at 3-4.

29. The Board held an administrative hearing on the rate filing on July 24, 2018 at the Vermont State House. General Counsel Judith Henkin served as hearing officer by designation of Chair Kevin Mullin. Attorney Jacqueline Hughes represented BCBSVT and presented testimony of BCBSVT Chief Financial Officer (CFO) Ruth Greene, Actuarial Director Paul Schultz, Vice President of Client Relations and External Affairs Andrew Garland, and Medical Director Dr. Josh Plavin. Attorney Jay Angoff of Mehri & Skalet in Washington D.C. represented the HCA, assisted by local counsel Kaili Kuiper and Eric Schultheis. Commissioner Michael Pieciak testified for the Department of Financial Regulation. Sebastian Arduengo, staff attorney for the Board, led the direct testimony of David Dillon of L&E, the Board's consulting actuary.

30. The parties stipulated to 16 exhibits that were admitted into evidence at the start of hearing, and at the HCA's request, the hearing officer agreed that the Board could take administrative notice of a series of documents and reports. Hearing Transcript (TR) at 16-17. Over the HCA's objection, the July 18, 2018 amendment to the filing was also admitted into evidence. *Id*. at 34-35.

31. Prior to taking testimony from the witnesses, the hearing officer addressed BCBSVT's motion *in limine* to exclude the Fisher Report and Fisher's related testimony. After oral argument by both parties, the hearing officer ruled on the record that the Fisher Report and testimony was not admissible because 1) Vermont precedent holds that a single legislator's view of legislative intent is inconclusive as to the legislative body's intent, and 2) V.R.E. 702 requires that the expert opinion assist the trier of fact, and the Fisher Report did not address any factual matter in dispute or explain the evidence; rather, the plain statutory language requires that the Board consider affordability in its review. TR at 9-14.

32. Following the ruling, Attorney Angoff requested that Fisher be allowed to provide his opinion about the legislative intent "not as an expert witness but simply describing what he saw as a fact witness." The hearing officer denied the request, again explaining that there is precedent in Vermont that one legislator's opinion is not representative of the underlying legislative intent of an enacted law. TR at 14.

33. At the close of the day's evidence, the hearing officer accepted public comment and recessed the proceedings pending receipt of additional information from BCBSVT and L&E's analysis of the carrier's July 18 amended filing. On August 1, 2018 at the start of its regularly scheduled Board meeting, the hearing officer took administrative notice of the 2014 Vermont Household Health Insurance Survey, extended the date the Board would issue its decision to no later than August 15, 2018,[7] and closed the hearing.

34. A public comment period concerning the proposed rate increase began on May 11, 2018 and closed on July 25, 2018. The Board received more than 160 written comments. The

[7] Section 4062(a)(2) of Title 8 allows the Board to extend the time period for review of a rate filing up to thirty additional days.

Board also accepted public comment from 25 Vermonters who chose to speak in person either at the close of the hearing or at a separately-scheduled public comment session.[8] The commenters overwhelmingly requested that the Board deny any rate increases, stated that health insurance and health care in general is unaffordable for Vermonters—many offered personal accounts of their own or their families' difficulties in accessing or paying for care—and many commenters urged the Board to implement a single payer system.

35. On July 25, 2018, BCBSVT filed its responses to questions posed by Board members during the hearing.

36. On July 31, 2018, L&E submitted an addendum to its July 10, 2018 actuarial memorandum addressing the issues raised in BCBSVT's amended filing. L&E opined that BCBSVT's assumptions concerning an additional 0.1% in rate for changes in Vermont law, and a 2.3% increase for the impact of migration to newly-formed AHPs, were reasonable. L&E based its latter opinion on its review of data provided by BCBSVT that showed that its small group membership had lower claims than its individual membership, had 20% lower administrative costs, and that its projection of an 8,000 member migration represents approximately 25% of BCBSVT's AHP market in 2013. Addressing BCBSVT's allegation that there was a "market structural defect" to the carrier's disadvantage, L&E concluded that the rate disparity resulted primarily from the disparity in health status between the carriers' covered populations.

37. BCBSVT and the HCA each filed a post-hearing memorandum of law on August 3, 2018. On August 8, 2018, BCBSVT filed a Reply Memorandum of Law and Supplemental Proposed Findings of Fact.

Findings of Fact

38. BCBSVT is a non-profit hospital and medical service corporation and the largest provider of major medical health insurance to the merged individual and small group market in the State. BCBSVT has been offering coverage to the merged market through VHC since 2014.

39. On May 11, 2018, BCBSVT requested an average annual rate increase of 7.5% with increases ranging from 3.5% to 18.9%. Because many Vermonters will qualify for additional premium tax credits to offset the rise in premiums for plans offered through VHC, the increases felt by Vermonters would average 5.3%, and would range from 3.5% to 6.8%. Exhibit 1 at 4, 5, 12.

40. The rates in the filing will be used for BCBSVT's individual and small group market plan offerings for coverage beginning January 1, 2019 and ending December 31, 2019. Exhibit 1 at 4.

[8] Because each of the two carriers filing rates for the individual and small group market file on the same date, the public comment periods run simultaneously, and the majority refer to rate increases in general. However, of the overall 173 written comments received, 41 addressed Blue Cross Blue Shield of Vermont's rate filing, 11 specifically addressed MVP's rate filing, and the remainder did not specify a carrier.

41. The filing reflects a decline in BCBSVT's individual and small group membership from approximately 70,035 lives in March 2017[9] to 53,644 members as of March 2018. Exhibit 1 at 20; TR at 37.

42. BCBSVT utilized a 4.1% allowed medical trend assumption that includes a 1.4% utilization trend and 2.7% unit cost trend, and an allowed pharmacy trend of 13.3%. Exhibit 1 at 26-33.

43. Administrative costs in this filing are 6.9% of premium, and increase the rate by 0.6%. Exhibit 1 at 13, 85; TR at 55. Personnel costs (wages and benefits), which account for 83.5% of administrative expenses, are assumed to increase by 3.0%. Exhibit 1 at 38-40; TR at 41. The administrative expenses include a decrease of -0.9% for non-recurring expenses, and a 3.4% increase as a result of a declining membership over which to spread fixed costs. Exhibit 1 at 38-40. As submitted, the filing is expected to produce a federal minimum loss ratio of 91.8%. *Id.* at 42.

44. To account for the elimination of the individual mandate penalty, BCBSVT increased the index rate by 2.0%. The underlying calculation assumed that all members in the individual market without claims or with only preventative claims who do not receive premium subsidies (1,073 members) will forgo coverage in 2019, leaving nearly the same expected total claims with a smaller, less healthy membership pool. Exhibit 1 at 20-21. At hearing, BCBSVT's actuary Paul Schultz acknowledged that he could have used a different, more precise methodology to determine the rate impact. For example, when questioned why he had not accounted for "risk averse" individuals that would likely remain insured even if they never or rarely use health care services, Schultz agreed that his methodology was imprecise but reasonable, and pointed out that his results were consistent with the results in the Individual Mandate Study. Exhibit 1 at 20-23; TR at 112-113; 119-123; 182-85.

45. When members discontinue paying their premiums, the company is obligated to cover services during a 30-day grace period, whether or not the premiums are recovered. BCBSVT included a 0.1% increase in rate for these uncollected premiums, represented in the filing as bad debt. The 0.1% is equal to the company's four-year average and the actual 2017 amount of uncollected premium. Exhibit 1 at 41; TR at 31.

46. BCBSVT projected that its rates will be reduced by 2.0% due to the suspension of the Health Insurance Providers Fee for 2019, but that elimination of the individual mandate penalty offsets any rate reduction. Exhibit 1 at 13.

47. BCBSVT included a 1.5% contribution to reserves (CTR) in the filing, set by BCBSVT management, based on its commitment to "pass[] 100 percent of federal income tax savings to consumers." Exhibit 1 at 13-14. BCBSVT advised the Board that the elimination of its corporate income tax liability enables it to reduce the CTR from its prior long-term level of 2.0% to 1.5%, which will allow it to maintain an adequate level of surplus to protect consumers and a

[9] The March 2017 membership count was derived from BCBSVT's SERFF filing for its 2018 Vermont Health Connect book of business.

risk-based capital (RBC) ratio that meets regulatory requirements. *Id.* at 41,180-83; TR at 78, 103.

48. BCBSVT targets an RBC level of between 500 and 700% that was approved by DFR approximately ten years ago. TR at 79. As outlined in DFR's solvency opinion, the company's RBC ratio has trended downward since 2014, is approaching the bottom of the approved range, and is at its lowest point since the Board was established. Exhibit 14. DFR attributes the decline in RBC to rate reductions ordered by the Board in prior QHP filings and to the regulatory uncertainty and changes to the ACA at the federal level. DFR concludes that the Board should only depart from the filed rate "with great caution," and warns that any downward adjustments to the filing's rate components that are not actuarially supported will reduce surplus over time and negatively impact the company's solvency. *Id.* at 5.

49. At hearing, Commissioner Pieciak testified about some of the concerns outlined in the written solvency opinion, including an observation that BCBSVT's growth in earned premium since 2013 has significantly outpaced the growth of its surplus. Pieciak explained that this growth disparity leaves the company vulnerable to further changes and uncertainty in federal health care policy, which have already negatively impacted the carrier and contributed to the decline in its RBC level. TR at 233-38.

50. Although BCBSVT expects annual AMT refunds over a four-year period beginning in late 2019 or early 2020 of $16.6 million, $7.9 million, $3.6 million, and $2.8 million, it did not account for the first refund of $16.6 million in the filing. Exhibit 1 at 181; Exhibit 4 at 210; TR 79-81. According to CFO Greene, when the funds are received, they will "come into surplus, and to the extent that our surplus position is within our target range it will serve to mitigate future increases to members." TR 81-82. According to the company's estimates, the AMT credits equal approximately 65, 32, 16 and 14 RBC percentage points, respectively, or approximately four percentage points for each million dollars. Exhibit 4 at 210; TR at 104, 244-45.

51. DFR has agreed to issue BCBSVT a "permitted practice" which allows the company to report its AMT refund on its financial statement when it is received, rather than reflect the expected refund in its current financial statement. TR at 237-38.

52. CFO Greene contends that there is uncertainty whether the federal government will refund the AMT provided for in the TCJA, testifying that "we know that the federal government has changed its payment policy." TR at 195. To support her claim of uncertainty, Greene cited the recent withholding of risk adjustment payments to insurers and the federal defunding of CSRs. TR at 81.

53. In 2018, BCBSVT entered into a one-year shared savings/shared risk agreement with Accountable Care Organization (ACO) OneCare Vermont (OneCare), with options to renew for three additional one-year periods. Exhibit 1 at 15; Exhibit 9 at 246. Working with OneCare, BCBSVT projects savings for its entire risk pool relating to two goals for 2019: reducing inpatient admissions by 4.0%, and reducing emergency room visits by 5.0%. If the targets are achieved, they are projected to reduce medical claims by 1.1%, reducing the medical utilization trend from 2018 to 2019 to 0.9%. *Id.* at 30, 69. BCBSVT did not include an expectation of

savings due to ACO operations within its 2019 rates, but will reflect any actual savings generated by its risk contracts in its experience in future rate filings. Exhibit 1 at 15.

54. BCBSVT pays OneCare $3.25 per-member per-month (PMPM) for attributed members to directly support ACO providers, which is included as a claims expense in the risk sharing calculation, adding $0.61 PMPM to rates. As of March 2018, 37.4% of BCBSVT's single risk pool was attributed to OneCare. Exhibit 1 at 25; Exhibit 3 at 199.

55. BCBSVT expects that some of its self-funded block of business will participate in the ACO in the future, and has been working with the ACO to "push the model so that it is scalable and can be available as an attractive alternative." TR at 176.

56. In response to a question to the carrier concerning quality of care, BCBSVT provided examples of BCBSVT's care management programs, including utilization management, chronic condition disease management, and case management. BCBSVT's Medical Director testified that the company is working with OneCare to avoid duplication of its efforts, although BCBSVT still performs "a lot of utilization management [that] ideally could be done in a different way," and that overhead costs could eventually be transferred to OneCare. TR at 182.

57. BCBSVT plans to improve its technology capabilities in 2019. The company intends to make available real-time admission, discharge and transfer information; currently, the company might experience delays up to sixty days before its claims system would receive notification. TR at 97. In addition, the company will implement a new web-based tool to engage consumers that can "manage fairly complex and customized incentive campaigns." TR at 170. The company has not projected any savings in 2019 from the tool's implementation, but intends to focus on getting it working and raising member and provider awareness about its availability. *Id.*

58. In response to a question sent to BCBSVT on behalf of the HCA, the company cited a statistic from the National Academy of Medicine that approximately 25% of the annual cost of health care per year is waste. Exhibit 9 at 250. Since 2014, BCBSVT has implemented programs to eliminate fraud, waste and abuse (FWA), and recoveries, as a percentage of claims, have increased from 0.09% in 2014 to 1.10% in 2017. Exhibit 1 at 28. BCBSVT projects that the recovery level will remain at approximately 1.0% for 2019, considers this a "pretty good result," and advised the Board that the problem often stems from incorrect coding by providers. TR at 185-87.

59. When asked how the company could further reduce waste, Medical Director Plavin testified that it plans to manage "runaway" lab costs, acknowledged that there is a solution available to do so, but that it would require an investment in technology and take time to implement. Dr. Plavin added that he was hopeful that OneCare and the All-Payer Model will help mitigate health care costs. TR at 173-74.

60. Witnesses Greene and Garland each testified at hearing that the company does not agree that rate reductions ordered by the Board will make it more efficient, and that the marketplace will provide incentives for achieving efficiencies. *See* TR at 73 (Greene testifies that

the company is efficient and has "no need to be further incentivized" by the Board); *id*. at 84-87 (Garland testifies that market competition provides the incentive to be efficient).

61. BCBSVT negotiates and directly contracts with 201 hospitals for pricing and believes that its negotiations are fruitful. If the company were to use the "nuclear option" and failed to reach contractual agreements with providers, it contends that members may not be able to access needed care, the company might not meet regulatory requirements, and that providing notification to members and paying out-of-network claims would be costly. In addition to its contract negotiation team, BCBSVT has employees tasked with reviewing payment polices to help manage how provider claims are paid. TR at 88-89.

62. BCBSVT did not include any rate impact for member migration to AHPs in its May 11, 2018 rate filing based on its view that AHPs would likely enter the Vermont market in 2020, rather than in 2019. On June 21, 2018, BCBSVT reminded the Board that it "chose **not** to reflect the likely detrimental impact of AHPs on the single risk pool" in its filing, even though the recent promulgation of DOL's final regulation "makes a 2019 entry a more distinct possibility" Exhibit 6 at 219, ¶ 6 (emphasis in original).

63. On July 18, 2018, BCBSVT submitted its amended filing requesting a 9.6% average annual rate increase. In the amended filing, BCBSVT accepted L&E's recommended rate modifications, implementing changes in pool morbidity (-1.3%), impact of selection (+0.4%), risk adjustment (+0.1%), and the mapping of non-CSR members (+0.1%). Exhibit 17 at 2-4. BCBSVT confirmed at hearing that it has agreed to these modifications. TR at 59-61.

64. The amended filing requests a 0.1% increase for the impact of two laws passed after the rate filing deadline. Act 7 (2018 Sp. Sess.) was signed into law on June 25, 2018 and places limits on cost-sharing for chiropractic visits starting in 2019. Act 141 (2018), signed into law on May 21, 2018, provides that certain patients may receive breast imaging services such as ultrasound, with no cost-sharing. Exhibit 17 at 4-5.

65. The amended filing also requests an additional 2.3% rate increase for the impact of AHPs on BCBSVT's small group market. According to the carrier, the request was prompted by two precipitating events: First, DFR publicly announced its intention to file an emergency rule on AHPs, and second, the carrier had been approached by several associations expressing their interest in offering AHPs to their members. The company projects that 8,000 of its current QHP members will migrate to AHPs. Exhibit 17 at 6-7; TR at 146-47.

66. In response to questions at hearing, BCBSVT's actuary testified that the company's sales department was working with several associations to develop AHP membership projections, and that the associations had contacted BCBSVT about their interest in AHPs "well before the federal regulations" were released. TR 38-39, 144. As to the timing of the amended filing's submission, Schultz testified that "it took some time" to review and assess the DOL final rule, and DFR's announcement that it would issue an emergency regulation triggered the submission. TR at 142-44.

67. DFR's emergency and proposed AHP regulations will provide "robust regulatory regime around Association Health Plans." TR at 36. When asked if BCBSVT would benefit from acquiring an AHP book of business, Commissioner Pieciak opined that he would prefer that a domestic insurer, regulated by DFR, offer AHPs to Vermonters, rather than leaving Vermonters vulnerable to out-of-state carriers whose AHPs would not be "offering as high quality or robust benefits" as Vermont will require. TR at 236, 251. Pieciak confirmed that it is unknown how substantial the AHP market will be, or how long it will last. TR at 252.

Standard of Review

The Board reviews rate filings to ensure the proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency and is not unjust, unfair inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3). Rate filings must be actuarially sound, and therefore cannot be excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b). On review of a filing, the Board must consider changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

Under the plain statutory language, the Board's review of a rate filing is not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the Legislature granted the Board review standards that 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.

In arriving at its decision, the Board must also consider DFR'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 public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The burden is on the insurer proposing a rate change to justify the requested rate. Rule 2.000 § 2.104(c).

Decision

I. The Board Adopts L&E's Recommended Modifications to the Initial Filing, Which are Not Contested by BCBSVT and Which Lower the Average Annual Rate Increase, as Initially Filed, by Approximately 0.3%.

First, the Board accepts our actuaries' recommendations to modify the May 11, 2018 rate filing, as set forth in L&E's actuarial memorandum and incorporated into BCBSVT's amended filing. These modifications to the calculation of pool morbidity, impact of selection, risk adjustment transfer payment, and the mapping of non-CSR members are unopposed by the carrier and result in a rate reduction of approximately 0.3%. Finding of Fact (Finding) ¶ 63.

II. The Board Modifies the Filing by Reducing BCBSVT's Projected Rate Increase Attributable to Elimination of the Individual Mandate Penalty.

We next turn to BCBSVT's assumption that removal of the individual mandate penalty will have the effect of increasing premiums by 2.0%, as healthier individuals drop coverage in the absence of a financial penalty incentivizing them to stay in the market. Finding ¶ 44. BCBSVT contends its assumption that all of its members in the individual market who do not receive subsidies and have no claims or only preventative claims will forgo coverage in 2019 is reasonable, and that results of the analysis closely matches results in the February 2018 Individual Mandate Study, *see id*., which projected an overall increase in premiums in the individual and small group market of between 1.6% and 2.4%. Finding ¶ 10.

While we agree that both the study and company's more simplistic analysis provide a useful baseline for modeling how the removal of the individual mandate penalty may impact premiums and enrollment, each projection was prepared with the best information available at the time. Subsequent to when the study was released, and after careful consideration with the goal of counteracting any measurable reduction in enrollment, the Vermont Legislature passed Act 182 (2018) which creates a state mandate, forms a working group to develop recommendations for its enforcement to be acted upon by the Legislature in 2019, and charges DVHA, in consultation with stakeholders, to engage in outreach efforts to educate Vermonters about their responsibility to maintain coverage and the availability and options to do so. Finding ¶ 11. Neither the study nor the carrier's analysis takes into account factors such as risk aversion, health status, or knowledge of pending legal and regulatory changes that may affect an individual's decision to drop coverage. *See* Finding ¶ 44. In light of these considerations and our obligation to provide Vermonters with the lowest insurance rates feasible, we require that BCBSVT reduce the assumed 2.0% rate impact to 1.6%, the low end of the range identified in the study, thereby reducing its requested rate increase by 0.4%.

We further conclude that BCBSVT's 0.1% rate adjustment to account for an increase in bad debt is unsupported. Consistent with our view that elimination of the federal penalty has a less significant impact in Vermont than it may have in other states—Vermont's uninsured rate prior to enactment of the ACA was low, and some of the ACA's consumer protections already in place—we are not persuaded that in 2019 there will be an increase of BCBSVT members, in this admittedly less-healthy book of business, that will forgo paying their premiums. We therefore require BCBSVT to modify its rate downward by an additional 0.1%.

III. The Board Allows BCBSVT's Request for an Approximate 0.1% for Recently Enacted Changes to Vermont Law.

In its amended filing, the carrier requested a small increase in rate to account for changes to Vermont law that occurred after it submitted its original filing. Finding ¶ 64. We conclude that despite the lateness of the amendment, these changes are minimal, reflect Vermont health care policy choices as determined by the Legislature that expand access to quality care, and by law bind the insurer to provide the subject services. We therefore allow the rate 0.1% rate adjustment.

IV. The Board Disallows BCBSVT's Proposed 2.3% Rate Increase Based on Projected Migration from its Small Group Market to Association Health Plans.

Next, we consider whether the insurer has met its burden to show that its proposed 2019 rate should be increased based on its projections related to changes to the insurance market made at the federal level. Specifically, BCBSVT contends that migration to newly-formed AHPs will significantly erode its individual and small group membership. For the reasons explained below, we decline to allow the requested increase.

The reentry of AHPs into the insurance market has been on the horizon since well before BCBSVT developed its rates; The Trump Administration announced the pending change in October 2017. Finding ¶ 15. BCBSVT chose not to include any potential rate impact within its initial May 11, 2018 filing, although it had already begun discussions with a number of associations interested in offering AHPs in the Vermont market. Findings ¶¶ 62, 66. Again, in its June 21, 2018 response to an interrogatory posed by the Board, BCBSVT confirmed that it "chose **not** to reflect an impact" for AHPs within its filing, even though the DOL had recently issued its final rule concerning their availability. Finding ¶ 62. Four weeks later, and five days prior to the hearing, BCBSVT amended its filing to include what it projects to be a significant rate impact as members move from its small group population to AHPs. According to BCBSVT, it did not file the amendment sooner because it needed time to assess the DOL rule's impact, and was prompted by DFR's July 2, 2018 announcement that it would issue an emergency rule. Finding ¶ 66.

BCBSVT's explanation as to why it made its late request for an additional rate increase casts doubt on its necessity. The company was made aware that AHPs would become part of the insurance marketplace as far back as October 2017 when it was announced via Executive Order, and at some point "well before" the mid-June release by DOL of its final rule, BCBSVT had already begun to meet with Vermont associations to discuss potential offerings and earn their business. Even when the DOL final rule was issued—which makes it crystal clear that fully-insured AHPs can enter the market beginning September 1, 2018—the carrier reminded the Board that it had specifically chosen not to request an increase in rate based on their potential impact on the individual and small group market.

The carrier also contends that it was impelled to amend its filing based on DFR's July 2, 2018 announcement that it was planning to release an emergency regulation. Finding ¶ 66. It is unclear why the pending DFR regulation would have been key to the carrier's decision to request an additional rate increase; to the contrary, the DFR announcement, and the resulting emergency regulation and near-identical proposed regulation, clearly convey DFR's intent to limit the types of plans that might be otherwise available pursuant to the DOL final rule, and to impose comprehensive regulatory limits on AHPs licensed in Vermont to protect consumers from obtaining substandard coverage or benefits. *See* Findings ¶ ¶ 17, 18. DFR's prompt reaction to the DOL rule, and its adopted emergency regulation and proposed regulation that establish comprehensive regulatory parameters to make AHPs comparable to other plan offerings, should help mitigate migration from the small group market.

We further find, and the record supports our finding, that the carrier's projection of a significant migration to AHPs is speculative and uncertain, as is the effect on VHC rates. Commissioner Pieciak testified at hearing that the impact of AHPs on the insurance market is unknown, as is how long the AHP market will last. Finding ¶ 67. In its summary of the economic impact of the emergency and proposed regulations upon the rules' filing with the Secretary of State, DFR acknowledged that some migration of small groups may occur, but the impact of the new AHP market on migration would be mitigated by "requiring fully-insured AHPs to offer comprehensive health insurance coverage rather than limited benefit plans that appeal to the youngest and healthiest lives." Finding ¶ 19. Most telling is DFR's explanation of the economic impact of its proposed rule, which mirrors the justification language for the adopted emergency rule filing: "At the present time, it is "*impossible to quantify the impact that fully-insured AHPs will have on premiums in VHC*." *Id*. (emphasis provided). We also note that the DOL final rule is currently being challenged by a sizeable number of states' attorneys general in federal court. Finding ¶ 17.

In discussing this issue, we must point out the inconsistency in BCBSVT's rationale for a rate increase based on the AHP migration, versus its position on receipt of AMT credits. At hearing, the company repeatedly stated that the AMT credits it will receive in 2019 are uncertain and should not be considered in this filing, notwithstanding that they are provided for in the Internal Revenue Code in accordance with the TCJA and the amount to be refunded for 2018 is known ($16.6 million), as is approximately when it will be received (late 2019 or early 2020). Findings ¶¶ 14, 50, 52. In contrast, BCBSVT contends that AHPs will with certainty impact the market as it has projected, resulting in added premium costs for those remaining in the individual and small group market. We disagree with the certainty of both propositions. As to the latter, as we have already explained, we find that the company's projection of the AHP impact is speculative and fails to recognize that AHPs offered in Vermont must meet state regulatory requirements comparable to other plan offerings in the State. Moreover, BCBSVT has informed the Board that it intends to make AHPs available to its members, and will therefore be setting their price and developing their design to meet all state-imposed requirements.

Even accepting that the migration of BCBSVT's small groups to AHPs is as significant as the carrier has warned, we do not foresee a resulting threat to the company's solvency. As its actuary testified at hearing, BCBSVT expects that its AHP membership will be drawn from small groups currently enrolled in BCBSVT plans. If so, the company's overall membership will remain stable and will continue contributing to company reserves. This change in membership differs considerably from BCBSVT's recent membership loss to its competitor, which it failed to anticipate, and which is reflected in this year's filing. *See* Docket no. GMCB-008-17rr, SERFF Filing Actuarial Memo at 9 (projects retention of approximately 70,000 members in plan year 2018). We also note that the company could cushion any impact on solvency when it receives the AMT refund, which based on its own estimation, will equal approximately 65 percentage points of RBC. *See* Finding ¶ 50.

Based on the discussion above, the Board disallows the proposed 2.3% increase for AHP migration.

V. The Board Reduces the Overall Rate by 1.0% to Provide Greater Affordability for Vermonters.

We last consider our statutory charge to provide Vermonters with rates that are affordable, promote quality care and access to health care, and protect insurer solvency. The first three of these review standards are not defined within the law, but are fluid and open-ended, "reflect[ing] the practical difficulty of establishing 'more detailed, narrow or explicit standards' … given advancements (and setbacks) in technology, medicine, employment, and economic well-being." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16 (citation omitted). Given the potential conflict between our review standards, we cannot view one in isolation, without regard for the others. An affordable rate may not promote quality care or protect insurer solvency, and in turn limit access to care, while an unaffordable rate may limit access to quality care, and will ultimately erode insurer solvency, thereby limiting access to care. As we have stated in past decisions, we must strike the appropriate balance between affordability and solvency, a goal that has become increasingly difficult as consumers and insurers adjust to health care policy changes at the federal level—elimination of the individual mandate penalty and the reentry into the market of AHPs are recent examples—that have impacted the individual and small group market.

We first acknowledge that BCBSVT's rate filing, detailed responses to interrogatories from the Board and the HCA and testimony at hearing demonstrate the company's ongoing efforts to provide its members with access to quality health care services. Notably, in 2018, BCBSVT contracted with OneCare to help move the State closer to the goals of the All-Payer Model Agreement, and has targeted a goal of reductions in hospital readmissions and emergency room visits. Findings ¶¶ 53, 54. The company is implementing new technology to more quickly and efficiently track patient admissions and discharges, and will launch a web-based tool to engage consumers and provide targeted incentives for them to participate in wellness programs and activities. Finding ¶ 57. While we find these initiatives and programs commendable, and are encouraged by the company's pledge to dedicate its significant tax savings for the benefit of its members, *see* Findings ¶¶ 14, 50, health care costs remain unaffordable for too many Vermonters, impeding their access to quality care.

During the public comment period, the Board received numerous written comments from Vermonters, and more than two dozen attended our hearings to address the Board in person. Finding ¶ 34. Many of their comments were compelling and personal, and nearly all underscored a common theme – health care remains unaffordable for many Vermont individuals, families and businesses. We share that perspective, and believe that rising health care costs are unsustainable, notwithstanding our State's comparatively high marks for its health care system. *See, e.g.*, The Commonwealth Fund, *2018 Scorecard on State Health System Performance*, (2018 "scorecard" ranks Vermont's system fourth overall, and third for access and affordability) *available at* https://interactives.commonwealthfund.org/2018/state-scorecard/files/Radley_State_Scorecard_2018.pdf. As long as too many Vermonters are spending too much of their incomes on health care costs, there is no cause to become complacent, and we require our insurers, including BCBSVT, to help move the needle and keep health care costs as low as is feasible.

To that end, we are not persuaded that BCBSVT is without any reasonable levers to constrain costs and premium growth while maintaining its financial solvency, notwithstanding its testimony and written submissions that largely ascribe any fault for the rising cost of premiums to external causes. As Vermont's largest domestic provider of health insurance, the company must use its significant bargaining power to negotiate lower prices with hospitals both in and outside of the State. We expect BCBSVT to actively and critically review its policies and procedures and institute best practices that reduce administrative burdens and inefficiencies, provide fair and equitable provider reimbursement, ensure appropriate utilization of services, and improve health outcomes. The company must continue its collaboration with OneCare to ensure that there is no duplication of services, and that needed patient care is delivered timely and efficiently in the most appropriate setting. *See* Finding ¶ 56. BCBSVT must pursue operational and systemic improvements to become more efficient and reduce wasteful spending. Consistent with its testimony that incorrect coding is a source of excess costs, *see* Finding ¶ 58, BCBSVT must expand its efforts to closely scrutinize provider coding and help ensure that miscoding, and its resulting cost to the health care system, can be avoided in the future. Eliminating even a fraction of what the company cites as the 25% of health care spending that is attributed to waste— beyond what the company recovers through its FWA program— can reduce consumer premiums and make them more competitive in the marketplace. *Id.* And notwithstanding recent increases in BCBSVT's recoverables through its FWA programs, national estimates indicate seven percent of health care spending is lost to fraud and abuse alone, well above the percentage now recovered by BCBSVT. *See generally* N. Sahni *et al.*, *How the U.S. Can Reduce Waste in Health Care by $1 Trillion*, Harv. Bus. Rev. (Oct. 13, 2015) (discusses reforms that can be implemented to reduce waste in health care spending); J. Martinez *et al*., *Improving the Health Care System: Seven State Strategies*, Nat'l Conference of State Legislatures (July 2016) (discusses reducing waste and inefficiencies). Moreover, while we acknowledge that administrative expenses in this filing are below MLR requirements as a percentage of premium, administrative spending should be routinely examined by the carrier for opportunities for savings. For example, we question why BCBSVT, for the fifth consecutive year, has assumed a 3.0% increase in wages and benefits for its employees,[10] in light of its concerns with its decreased RBC level, and its submission of rate proposals that outpace other measures of economic growth. Although the savings from altering the wage assumption may produce little in savings on its own, we require that the carrier trims spending across its operations, so that meaningful aggregate savings can be attained.

In requiring BCBSVT to produce savings to make its rates more affordable for Vermonters, the Board is not unmindful of BCBSVT's need for adequate reserves to safeguard its members and remain financially sound in case of unexpected adverse events. We recognize that its RBC ratio is currently on the low end of its target range. We have considered federal changes that have, or may in the future, negatively impact the company's solvency. We have also considered federal changes that will positively impact solvency—the elimination of the company's corporate income tax obligation, and the pending receipt of the AMT refunds. As we review the filing with these considerations in mind, we find that on balance, the carrier has the far greater ability to effect changes that will produce lower rates and tightened spending, while the Vermont consumer has less influence, and fewer options.

[10] This information can be found on the Board's website in BCBSVT's Vermont Health Connect rate filings for 2016, 2017, and 2018 rates, within the company's actuarial memoranda.

Accordingly, to fulfill our statutory charge within the bounds of current law,[11] we require that the company reduce its rate by an additional 1.0%.

Order

For the reasons discussed above, we modify and then approve BCBSVT's 2019 individual and small group market rate filing. Based on the proposed 9.6% average annual rate increase reflected in the July 18, 2018 amended filing, we order that BCBSVT: (1) reduce the rate by 0.4% to account for elimination of the individual mandate penalty, and by an additional 0.1% for bad debt; (2) reduce the rate by 2.3% attributed to the migration of small groups to the AHP market; and (3) reduce the overall average annual rate increase by 1.0% to make rates more affordable for Vermonters.

The amended filing includes a 0.1% increase for changes to Vermont law (chiropractic and imaging services), and incorporates recommended modifications to pool morbidity, impact of selection, risk adjustment transfer payment, and mapping of non-CSR members, reducing the rate by 0.3%. The Board allows both of these changes.

As modified, we approve an average annual rate increase of approximately 5.8%. Because many Vermonters will receive larger federal subsidies to cover the increased costs, as explained herein, ***the average annual rate increase that will be borne by Vermonters is approximately 3.2%.***

SO ORDERED.

Dated: August 14, 2018 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Tom Pelham*)
)
s/ Maureen Usifer)

Filed: August 14, 2018

* *Member Pelham filed a separate concurrence to this decision.*

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

[11] The majority to this decision does not share the concurring member's view that appropriating additional funds to DVHA, under existing federal or state law, will allow for an increase in the amount of, or eligibility for, subsidies for individuals in the merged market.

Pelham, concurring.

I join the majority in approving the company's individual and small group market rate filing as modified above. I write separately, however, to discuss my deep concern with the evidence presented as to the affordability of the proposed rates.

In testimony, Actuary Schultz of Blue Cross and Blue Shield of Vermont (BCBSVT) discussed affordability. He noted:

> So affordability really can't be assessed in the absence of looking at policy and Vermont has made a number of policy decisions over the last several years that do impact affordability. Notably Vermont decided that at the onset of the program that members making less than 300 percent of federal poverty level [FPL] the premiums would not be affordable for these members; therefore, they implemented the Vermont premium assistance and additional cost share reductions for members below 300 percent of FPL. Notably they did not implement similar programs for members making more than 300 percent of FPL.

TR at 66. He further noted:

> There is one other policy consideration I want to address and that's the cost shift. Because Medicare and Medicaid do not fully fund what they pay providers, in other words, provider costs are not fully funded by what Medicare and Medicaid pays them, those costs need to be shifted to private commercial payers.

TR at 68. The Board estimated the Medicaid cost shift for hospitals alone in 2017 at approximately $224 million. *See* Green Mountain Care Board, Cost Shift for Budget 2018 and Actual 2017 (2018), *available at* http://gmcboard.vermont.gov/sites/gmcb/files/2018_Act53_Cost_Shift_Trend_PROFILE_Table_7.pdf.

Absent state and federal subsidies, the premium rates proposed by BCBSVT would be unaffordable to many consumers in the Individual market. For example, I calculated that absent subsidies, the 2018 premium for a couple at 250% of poverty ($41,150) would consume 28.5% of their annual income for a Bronze Standard plan, one of the least expensive offered.[12] *See* TR at 198-199. For a family of 4 at 250% of poverty, or $62,250, the 2018 annual premium for a Silver plan would consume 26.2% of income. *See* TR at 199. Overall, the average 2018 premium to income ratio across all income categories up to 500% FPL and across all plan types (single, couple, adult with child, and family) is 27.2% for Bronze and 31.3% for Silver. For gold plans the comparable ratio is 36.6% and platinum plans 41.95%. *See* TR at 199-200. Clearly, such premiums absent subsidies would place many Vermonters in desperate financial and/or health care jeopardy.

[12] My calculations are based on published 2018 rates in the company's filing as well as the Vermont Health Connect subsidy estimator. *See* Exhibit 1 at 91; Vermont Health Connect, 2018 Subsidy Estimator, *available at* http://info.healthconnect.vermont.gov/Subsidy_Estimator.

But even with federal and state subsidies available through Vermont Health Connect, premium costs are hefty. For example, at 400% of poverty the Single Bronze plan consumes 11.4% of income and the Silver plan for a couple consumes 19.1% of income. Further, these ratios do not include the added costs of co-insurance such as copays and deductibles. Now that Vermont remains committed to the Individual Mandate, it's important that the negative effects of the cost shift and rising commercial insurance rates be mitigated so as to not force Vermonters into unacceptable financial corners.

To the goal of affordability, the Vermont Premium Assistance Program (VPA) is a state program to help qualified Vermonters, up to 300 percent of poverty, pay insurance premiums. *See* 33 V.S.A. § 1812(a). It is funded both by state general funds and federal global commitment funds. For fiscal year 2018 just ending, the program cost $6.6 million, comprised of $3.08 million in state general funds and the balance with federal global commitment funds. For fiscal 2019 the legislature has appropriated $7.1 million for this program. Further, after reconciling financial issues with the operations of Vermont Health Connect, the state was able to add $78.09 million in general funds to the Human Services Caseload Reserve, thus increase its balance to $110.09 million. Of this amount the legislature designated $14.06 million for "A sub-account for Medicaid-related pressures related to caseload, utilization, changes in federal participation in existing human services programs, and settlement cost associated with managing the Global Commitment waiver." Act 11 (2018 Special Session) § D.104(a)(3). Expenditures from this Reserve can be authorized separately by the General Assembly or by the Emergency Board, which is comprised of the Governor and the Chairs of the House and Senate Appropriations Committees, and the Chairs of the Senate Finance Committee and the House Ways and Means Committee. *See* 32 V.S.A. § 131.

Given the recent elimination of funding for the federal Cost Sharing Reduction and the elimination of the penalty for the Individual Mandate, the Emergency Board might consider finding a path, consistent with state and federal law, for at least an interim funding increase to cushion the impact of these recent federal changes on consumers and allow time for these changes to be considered and absorbed by Vermont's health care funders and providers. An allocation of just $4 million of the $14.06 million "sub-account", budgeted over two state fiscal years, represents nearly a doubling of the premium assistance to consumers in the Individual Market, and possibly the expansion of the program to 400 percent and 500 percent of the federal poverty level.

Dated: August 14, 2018 at Montpelier, Vermont

s/ Tom Pelham
Member, 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: Agatha.Kessler@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 within ten days of the date of this decision and order.