STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2020 Individual and Small Group Rate Filing	)	GMCB-006-19rr
	)	SERFF No. BCVT-131936226

DECISION AND ORDER

Introduction

On May 10, 2019, Blue Cross and Blue Shield of Vermont (BCBSVT or "the company") proposed an average increase of 15.6% to the premiums it will charge individuals, families, and small employers for major medical health insurance coverage beginning January 1, 2020, with plan-level increases ranging from 9.1% to 18.5%. Following a review by Lewis & Ellis (L&E), the Green Mountain Care Board's (GMCB or "the Board") contract actuaries, BCBSVT reduced its requested increase from 15.6% to between 14.3% and 14.5%. Based on a review of the record, including the testimony and evidence presented at a hearing held on July 23, 2019, and guided by our statutory directive and commitment to approve the most affordable rates possible without threatening the company's financial stability, we modify the rate downward and then approve the filing. As modified, the filing will result in an average premium increase of approximately 12.4% across all BCBSVT's individual and small group plans.

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, the state's health benefit exchange (VHC or "the Exchange"). VHC allows individuals, families, and small employers (up to 100 employees) to compare qualified health plans (QHPs) with rates based on a single risk pool, or "merged market." *See* 33 V.S.A. §§ 1803, 1811.

2. Health insurance plans are offered in Vermont's merged individual and small group market in bronze, silver, gold, and platinum metal levels; catastrophic coverage is also available to 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.

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). 42 U.S.C. § 18071. The federal government used to offset the cost of CSRs by making payments directly to insurers. In October 2017, however, the federal government announced that it would stop making CSR payments to insurers, notwithstanding the insurers' continued obligation to offer CSRs to enrollees. 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).[3] To date, the federal government has not resumed making CSR payments to insurers.

5. 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," outside the Exchange. These plans must be similar to silver plans offered on VHC ("silver-loaded plans"), but unlike the VHC plans, they do not include any funding to offset the loss of the CSR payments and are therefore less expensive. *See* 33 V.S.A. § 1813.

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 their deductibles and copayments. 33 V.S.A. § 1812(b).

7. As of January 2019, approximately two out of every three Vermonters in the individual market received APTCs. Many of these Vermonters also received additional state or federal assistance such as CSRs to reduce their premiums and out-of-pocket costs. Dep't of Vermont Health Access (DVHA), Health Coverage Map (June 7, 2019).[4]

8. Central to its reform provisions, the ACA includes an "individual mandate" requiring that individuals and families have qualifying health insurance coverage[5] or pay a penalty on their personal income tax returns. *See* 26 U.S.C. § 5000A. The Tax Cuts and Jobs Act (TCJA), enacted

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[2] Taxpayers can choose to have the estimated credit computed and paid to the insurance company to lower their 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

[3] https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

[4] https://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2019Mar%20v2.pdf

[5] 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.

by Congress in December 2017, eliminated the imposition of a penalty beginning in plan year 2019 for failure to purchase qualifying coverage.

9. To help counteract the elimination of the penalty associated with the federal individual mandate, the Vermont Legislature in its 2018 session enacted Act 182. The Act requires Vermonters to maintain minimum essential health coverage beginning in 2020; established a working group to make recommendations and issue a report regarding enforcement of the mandate, with the enforcement mechanism to be enacted by the 2019 Legislature; and required that DVHA and other stakeholders engage in outreach and education to encourage Vermonters to retain insurance for the 2019 and 2020 plan years. Act 182 (2018).[6] The working group formed under Act 182 ultimately agreed that "there should be a continued focus and additional emphasis on outreach about health care coverage as a key mechanism to maintain and increase coverage and that improved monitoring and timeliness of data on the uninsured is a good idea" but the group did not reach consensus on whether to recommend a financial penalty. *See* Individual Mandate Working Group Report (Nov. 1, 2018).[7] In its 2019 session, the Vermont Legislature enacted Act 63. This Act requires taxpayers to report whether they have had minimum essential health insurance coverage during the tax year on their tax return and puts a process in place for targeted outreach to those without minimum essential coverage. *See* Act 63 (2019), Sec. 1.[8]

10. Despite the concern about the negative impact the elimination of the federal penalty for the individual mandate could have on enrollment through VHC, the absence of a penalty did not seem to impact enrollment for the 2019 plan year. In February 2019, DVHA reported that while there were significant changes in federal and state policy in 2018, "enrollment in Vermont's individual health plans remained stable from 2018 to 2019. The number of new members, subsidized members, and unsubsidized members all exceeded the prior [2018 plan] year." Vermont's 2019 Individual Enrollment in Five Graphs (Feb. 2019), 2.[9]

11. To help stabilize premiums across the market, the ACA includes a risk adjustment program. Under this program, insurers with an enrolled population with lower than average actuarial risk provide payments to insurers whose population has higher than average actuarial risk. The risk adjustment program is intended to reduce incentives for insurers to avoid high risk enrollees by structuring plan offering to make them most attractive to a healthy, low-risk population, while unattractive to a less healthy population more in need of health care services.

12. By final rule in 2019, the U.S. Department of Health and Human Services (HHS) made several changes related to the risk adjustment program that are intended to ensure the integrity of the results of risk adjustment, and others intended to alleviate issuer burden associated with complying with risk adjustment data validation requirements. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454, 17457 (Apr. 25, 2019). The changes to the HHS risk adjustment program relate to the determination of the final coefficients for the 2020 benefit year, and the data sources used to calculate those coefficients. *Id.* at 17459

[6] https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT182/ACT182%20As%20Enacted.pdf
[7] https://legislature.vermont.gov/assets/Legislative-Reports/Individual-Mandate-Working-Group-Report.pdf
[8] https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT063/ACT063%20As%20Enacted.pdf
[9] https://info.healthconnect.vermont.gov/sites/hcexchange/files/2019%20Individual%20Enrollment%20Recap.pdf

13. To help fund federal and state marketplaces, the ACA also includes a Health Insurance Providers Fee based on a covered entity's share of net 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 again for 2018 and was again suspended for the 2019 calendar year. *See* Internal Revenue Service, Affordable Care Act Provision 9010 - Health Insurance Providers Fee (June 15, 2018).[10] Absent a new moratorium, which is unlikely, the fee will resume in 2020.

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 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.

15. The U.S. Department of Labor (DOL) adopted a final rule in June 2018 that expanded the ability of small employers and sole proprietors to band together to purchase large group coverage under an Association Health Plan (AHP). Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912, 28912-28964 (June 21, 2018).[11] The next month, twelve state Attorneys General brought an action in the U.S. District Court for the District of Columbia to vacate and set aside DOL's final rule. Complaint for Declaratory and Injunctive Relief, Case 1:18-cv-01747.[12]

16. On March 28, 2019, the U.S. District Court for the District of Columbia invalidated major portions of DOL's final rule. *New York v. United States Dep't of Labor*, 363 F.Supp.3d 109, 141 (D.D.C. 2019). DOL appealed the district court's ruling on April 26, 2019 but did not request a stay. On June 13, 2019, the Vermont Department of Financial Regulation (DFR) issued guidance addressing the status of AHPs in Vermont in light of the federal court's decision. The guidance clarifies that AHPs formed under DOL's final rule will not be permitted to operate in Vermont beyond 2019 and members of these AHPs will need to seek alternative coverage for 2020. DFR Insurance Bulletin No. 205, *Vermont Association Health Plans* (June 13, 2019).[13]

Procedural History

17. On May 10, 2019, BCBSVT filed its 2020 Individual and Small Group Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The filing outlined the development of premiums for the 2020 QHPs the company will offer on the Exchange as well as the 2020 silver reflective plans it will offer outside of the Exchange. The filing proposed an average annual rate increase (also referred to as the "overall average rate increase") of 15.6%, or $89.39 on a per-member per-month (PMPM) basis, with plan-level increases ranging from 9.1% to 18.5%. BCBSVT Ex. 14 at 2; BCBSVT Ex. 1 at 100.

[10] https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010
[11] https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans
[12] https://ag.ny.gov/sites/default/files/complaint_as-filed.pdf
[13] https://dfr.vermont.gov/reg-bul-ord/vermont-association-health-plans

18. On May 17, 2019, the Office of the Healthcare Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care services and health insurance, entered a Notice of Appearance as an interested party to the proceeding. *See* 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule (Rule) 2.000, §§ 2.105, 2.202, 2.307.

19. From May 14 through July 24, 2019, the Board and L&E asked BCBSVT to respond to six sets of questions, including ones suggested to the Board by the HCA. BCBSVT responded to each set of questions. BCBSVT Ex. 2-11.

20. L&E reviewed the filing on behalf of the Board and issued an actuarial memorandum on July 9, 2019. L&E recommended seven modifications to the filing. L&E estimated that these modifications would reduce the overall rate increase from 15.6% to approximately 11.4%, before accounting for any changes in the unit cost trend that may be required in light of more up-to-date information. BCBSVT Ex. 14 at 24-25.

21. On July 10, 2019, DFR, BCBSVT's principal solvency regulator, issued an opinion and analysis regarding the impact of the filing on the company's solvency. BCBSVT Ex. 15.

22. The Board held a hearing on the filing on July 23, 2019, at the Vermont State House. Michael Barber, the Board's General Counsel, served as hearing officer by designation of Board Chair Kevin Mullin. BCBSVT was represented by attorneys Michael Donofrio and Bridget Asay from Stris & Maher LLP. The HCA was represented by attorney Jay Angoff from Mehri & Skalet PLLC, as well as HCA staff attorneys Kaili Kuiper and Eric Schultheis. Testifying on behalf of BCBSVT at the hearing were the company's Chief Financial Officer (CFO), Ruth Greene; Actuarial Director, Paul Schultz; and Vice President of Client Relations and External Affairs, Andrew Garland. Commissioner Michael Pieciak testified for DFR. Amerin Aborjaily, Associate General Counsel for the Board, led the direct testimony of David Dillon, Senior Vice President and Principal at L&E. Chief Health Care Advocate Michael Fisher testified for the HCA.

23. The parties stipulated to a total of 43 exhibits, which were admitted into evidence at the beginning of the hearing. Hearing Transcript (Tr.), 6-7. The exhibits were divided into two binders; Binder #1 contained BCBSVT Exhibits 1 – 20 while Binder #2 contained HCA Exhibits 1 – 23. Following the hearing, BCBSVT submitted a revised version of BCBSVT Exhibit 19 without objection from the HCA.

24. At the hearing, BCBSVT agreed with some of L&E's recommendations, disagreed with others, and proposed additional adjustments that had not been included in the initial filing. In all, the changes the company proposed making reduced the overall rate request from 15.6% to between 14.3% and 14.5%. BCBSVT Ex. 19; Testimony of Paul Schultz, Tr. at 46.

25. A special public comment period began on May 13, 2019 and closed on July 25, 2019. The Board received approximately 600 written comments, an unprecedented number. The Board also accepted public comment from Vermonters who chose to speak in person at a public comment session held from 4:30 p.m. to 6:30 p.m. on July 23, 2019. Commenters overwhelmingly requested that the Board deny any rate increases, stated that health insurance and health care in general is

unaffordable—many offered personal accounts of their own or their families' difficulties in accessing or paying for care—and numerous commenters urged the Board to implement a single payer system.

26. On July 24, 2019, the Board asked BCBSVT to provide written responses to a series of questions that Board Members had posed at the hearing. That same day, July 24, 2019, L&E asked BCBSVT to respond to a set of questions regarding certain calculations or adjustments BCBSVT's actuary had described at the hearing. BCBSVT responded to L&E's questions on July 26, 2019 and to the Board's questions on July 30, 2019. BCBSVT Response (Resp.) to L&E Inquiry #5; BCBSVT Resp. to GMCB Request for Supplemental Information.

27. On July 30, 2019, L&E issued an addendum to its July 9, 2019 actuarial memorandum in which it revised its recommendations in light of the new information it had received. L&E now recommends an overall rate increase of between approximately 12.3% and 12.5%. BCBSVT and the HCA each submitted a post-hearing memorandum on July 30, 2019.

Findings of Fact

28. BCBSVT is a non-profit hospital and medical service corporation and is the largest provider of major medical health insurance coverage to Vermont's merged individual and small group market. However, the company has seen declining enrollment in the products it sells in this market in recent years. Its membership fell from 70,035 in 2017 to 53,664 in 2018, a loss of 23.4%, and to 43,939, in 2019, an additional loss of 18.1%. BCBSVT Ex. 14 at 1.

29. BCBSVT's filing outlines the development of premiums for the 2020 QHPs the company will offer on the Exchange as well as the 2020 silver reflective plans it will offer outside of the Exchange. The filing's proposed overall average rate increase of 15.6% over 2019 premiums is attributable to several factors, including trend, updated membership assumptions, and changes to state and federal programs. BCBSVT Ex. 14 at 3.

30. Unit cost trends reflect changes in the amount that providers are paid for providing services, while utilization and intensity trends reflect changes in the utilization of services and the mix of those services. Testimony of Paul Schultz, Tr. at 29. BCBSVT projected a medical unit cost trend of 2.6% (2.3% for 2018 to 2019 and 2.9% for 2019 to 2020) and a medical utilization and intensity trend of 3.2% (4.1% before accounting for cost containment efforts). BCBSVT Ex. 14 at 5, 11.

31. Fifty-one percent of BCBSVT's medical costs are related to hospitals regulated under the Board's hospital budget review process. Testimony of Paul Schultz, Tr. at 30; *see also* BCBSVT Ex. 14 at 5. The company's filing assumed the Board would approve hospital budgets for October 1, 2019 and October 1, 2020[14] that include commercial increases identical to those approved by the Board in its most recent round of hospital budget reviews (including mid-year modifications). Testimony of Paul Schultz, Tr. at 30-31; BCBSVT Ex. 1 at 35. L&E reviewed

[14] Hospitals' fiscal years run from October 1 through September 30, whereas the rates developed by BCBSVT are for a calendar year.

these assumed increases and determined that they are generally consistent with the actual budget increases approved by the Board. BCBSVT Exhibit 14 at 5.

32. Vermont hospitals submitted their FY 2020 budgets in July 2019, after BCBSVT submitted its 2020 Individual and Small Group Rate Filing. Hospitals will present their budgets to the Board from mid- to late-August 2019. GMCB FY 2020 Hospital Budget Hearing Schedule.[15] The Board will establish each hospital's budget by September 15, 2019. 18 V.S.A. § 9456.

33. The proposed FY 2020 budgets that hospitals submitted reflect higher unit cost increases than the Board approved last year. If the Board approves the budgets as filed, it will increase BCBSVT's unit costs such that 2020 premiums will rise by approximately 0.5%. However, the Board generally approves budget increases that are less than those requested by the hospitals. Based on the pattern of historical reductions, L&E believes that the FY 2020 hospital budget increases would result in a 0.3% increase to premiums, rather than 0.5%. L&E Post-Report Addendum (July 30, 2019) at 1.

34. Vermont insurance carriers are experiencing higher medical facility cost trends compared to the revenue trends experienced by Vermont hospitals. One contributing factor is that there has been an increase in members seeking medical treatment outside the Board's jurisdiction. In 2016, 54% of BCBSVT's medical claims were impacted by the Board's hospital budget review process. In 2018, that proportion decreased to 51%. BCBSVT Ex. 14 at 10.

35. To project changes in utilization and intensity, BCBSVT analyzed utilization in the following benefit categories: inpatient, outpatient, professional, and medical pharmacy (Rx). The company projects a 5% annual increase in professional services, a 15% annual increase in medical pharmacy services, a 0% annual increase in inpatient services, and a 2.5% annual increase in outpatient services. The weighted average of these utilization trend assumptions is 4.1%. BCBSVT Ex. 14 at 7-8; *see also* Testimony of Paul Schultz, Tr. at 32-33.

36. The company used several statistical methods to project inpatient utilization trend for 2020. Some produced positive trends, but most produced negative trends. Several of the statistical methods that produced negative trends were slightly better at predicting actual 2018 results. *See* BCBSVT Ex. 1 at 38-39.

37. BCBSVT's actuary testified that care has been moving to more appropriate settings, resulting in less care being delivered in inpatient settings and more care being delivered in professional settings. Testimony of Paul Schultz, Tr. at 80.

38. The company's 2.5% outpatient utilization trend consists of 4.0% for outpatient surgical procedures and 2.0% for all other outpatient procedures. Testimony of Paul Schultz, Tr. at 34; BCBSVT Ex. 1 at 39.

39. Cost containment strategies led the company to reduce its estimated 2018 to 2020 utilization trend projection from 4.1% to 3.2% per year. Combining the company's proposed unit

[15] https://gmcboard.vermont.gov/sites/gmcb/files/Hospital%20Budget%20Calendar-revised%20comment%20periods.pdf

cost trend of 2.6% with its proposed utilization trend of 3.2% results in an overall allowed medical trend of 5.9% per year. L&E believes actual allowed medical trend will fall in the range from 3.5% to 6.5% per year. BCBSVT Ex. 14 at 11.

40. While BCBSVT normalized the data that it used to analyze medical utilization to account for changing age and induced utilization since 2015, L&E found that these adjustments alone did not appear to address significant changes in BCBSVT's underlying membership since 2015. Since 2017, BCBSVT has lost 37% of its membership. Generally, the members that left BCBSVT were healthier than the members that stayed. While BCBSVT excluded some 2018 small groups who migrated to another block of business, actual risk adjustment results indicate that the members who stayed continuously enrolled with BCBSVT were sicker in 2018 than in 2016. Therefore, L&E concluded that a portion of the observed utilization increases reflected in the dataset could be the result of anti-selection. BCBSVT Ex. 14 at 8-9.

41. Two analyses were performed to assess whether anti-selection was present. For the first analysis, L&E asked BCBSVT to compare the increased utilization it had observed to the increase in risk scores over the same period. Based on the data provided, the company's risk scores have increased faster than utilization—these data suggest that utilization trend, net of morbidity changes, may have been negative over that period. L&E concluded that while the increase in risk scores is partly due to coding efforts, the risk score increases could result from durational anti-selection. Given that coding improvements lead to increases in contribution to reserve (CTR), L&E noted that BCBSVT's recent CTR results relative to expectations suggests the company may not have achieved coding improvements substantially better than its competition. *See* BCBSVT Ex. 14 at 9; Testimony of David Dillon, Tr. at 261.

42. In the second analysis, L&E sought to decompose observed trend into distinct morbidity and utilization components by using market-wide data (i.e. a combination of utilization data from BCBSVT and MVP). The goal of L&E's analysis was to observe market-wide utilization trends in order to mitigate the impact of enrollment shifts. While BCBSVT's membership has changed materially since 2015, the aggregate QHP population has been relatively stable during this period. By utilizing more stable and hence more predictable market-wide data, L&E was able to mitigate the impact of enrollment shifts. BCBSVT Ex. 14 at 9; *see also* Testimony of David Dillon, Tr. at 260.

43. L&E calculated a 24-month estimate of market-wide utilization (4.2%) that was substantially similar to the two-year estimate BCBSVT observed using only its data (4.1%). However, L&E's 36-month estimate of market-wide utilization (2.0%) was materially lower than BCBSVT's observed three-year estimate (3.1%). Since its market-wide study produced long-term utilizations trends that were lower than BCBSVT's observed long-term trend, L&E concluded that anti-selection by members transitioning between carriers may have distorted the data underlying BCBSVT's trend development. BCBSVT Ex. 14 at 10.

44. BCBSVT asserts that L&E should not have relied on its 36-month study of market-wide data as evidence of anti-selection because BCBSVT gained members from 2015 to 2016. The company therefore concludes that there could not have been any anti-selection in the additional 12

months covered by L&E's 36-month study as compared to its 24-month study. Testimony of Paul Schultz, Tr. at 57; BCBSVT Post-Hearing Memo at 7-8.

45. The time period covered by L&E's 24-month market-wide study is January 2017 through December 2018. The time period covered by L&E's 36-month market-wide study is January 2016 through December 2018. L&E Post-Report Clarifications (July 15, 2019) at 1.

46. The time period covered by BCBSVT's two-year average is 2016 to 2017 and 2017 to 2018 and the time period covered by BCBSVT's three-year average is 2015 to 2016, 2016 to 2017, and 2017 to 2018. BCBSVT Ex. 14 at 6. Using these same time periods, L&E's two-year average market-wide utilization estimate is 2.7%, and its three-year average market-wide utilization estimate is 1.3%. L&E Post-Report Clarifications (July 15, 2019) at 2.

47. L&E recommended reducing the company's utilization trend assumption to 2.5% per year, including the impact of cost containment. It based its recommendation on the fact that the company's outpatient utilization trend has oscillated in recent years and has leveled off in 2018 and on the fact that this assumption is consistent with market-wide data. L&E believes its assumption of 2.5% strikes a better balance between whether the risk score increases BCBSVT calculated are due to coding efforts or morbidity increases. BCBSVT Ex. 14 at 11.

48. L&E's recommended change to the medical utilization trend would reduce the overall allowed medical trend from 5.9% to 5.2% per year (prior to any changes in unit cost assumptions related to hospital budgets) and have a rate impact of -1.1% BCBSVT Ex. 14 at 11, 24.

49. A new ambulatory surgery center recently opened in Colchester, Vermont. *See* Testimony of Paul Schultz, Tr. at 83. At the hearing, BCBSVT's actuary stated that the company had no means of estimating utilization at the newly-opened center and, while the company believed there will be savings for members choosing that site for their care, he anticipated it would be "fairly limited" in 2020. Testimony of Paul Schultz, Tr. at 83.

50. In last year's filing, the Board required BCBSVT to reduce its overall rate increase by 1.0% for affordability and directed the company to produce these savings where it could. *In re: Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing*, GMCB-009-18rr, Decision and Order, 17-19 (Aug. 14, 2018). In this filing, the company added this 1.0% back into its trend development for 2018 to 2019. BCBSVT Ex. 1 at 15.

51. In 2018, BCBSVT had a shared-risk agreement with OneCare Vermont (OneCare), a statewide accountable care organization (ACO). This agreement reduces the risk faced by BCBSVT on claims for "attributed" members because it transfers some of this risk to health care providers. BCBSVT estimates that its settlement receipts for the 2018 plan year will be equal to 0.2% of claims, which reduces its projected liability for 2020. BCBSVT Ex. 14 at 18.

52. BCBSVT expects that its collaboration with OneCare, along with enhanced data capabilities, will reduce medical claims by 0.4% for OneCare-attributed members in 2020. BCBSVT Ex. 1 at 31. BCBSVT also anticipates that the number of participating providers in the ACO program will increase in 2020 and, therefore, the number of attributed members will increase

as well. Because of the expected inclusion of more members in the program and the reduction in medical claims, the company reduced overall projected claims by 0.2%. BCBSVT Ex. 1 at 32.

53. The company expects that a large group pool will go into the ACO program in 2020 and is also working to bring self-funded clients into the program. Testimony of Andrew Garland, Tr. at 247.

54. BCBSVT has implemented programs to combat fraud, waste, and abuse. The returns from these programs increased from 2015 through 2017 but fell in 2018. The program recovered 0.81% of total allowed claims in 2015, 1.05% in 2016, 1.09% in 2017, and 0.96% in 2018. The company expects the percentage of claims recovered through its fraud, waste, and abuse programs will remain at approximately 1% through 2020. BCBSVT Ex. 1 at 27.

55. The company will initiate a new shared savings arrangement with a lab benefits manager in 2020 and expects this new relationship to save $1.4 million. The company will also initiate a Convenient Care program in 2020, which will offer qualified patients the opportunity to have their infusion therapies done in the comfort of their homes by trained nurses. Collectively, these two new programs are expected to reduce medical claims by 0.5%. BCBSVT Ex. 1 at 43.

56. In 2018, the computer system the company used to process claims was unable to properly enforce the requirement that Medicare-eligible members enroll in Medicare, which would place primary claims responsibility on Medicare. BCBSVT now has that capability, which reduces the amount the company expects to pay for professional claims for these members. This development has the impact of reducing the rate by 0.7%.

57. BCBSVT is requesting an overall allowed pharmacy trend of 13.0% per year. Within this overall trend, BCBSVT developed annual trends for brand, generic, and specialty drugs. BCBSVT projects a 20% trend for specialty drugs, which account for 47% of BCBSVT's overall pharmacy spending. BCBSVT Ex. 14 at 12. BCBSVT estimates that spending on specialty pharmaceuticals, both through the retail pharmacy and the medical benefit (discussed above), is increasing rates by 7.8%. BCBSVT Ex. 1 at 61.

58. L&E reviewed BCBSVT's development of the overall pharmacy trend. It also compared the company's overall drug cost assumptions against aggregate historical data to ensure the decomposition of pharmacy costs did not create an inaccurate picture of the overall trend. L&E concluded that the company's assumptions were reasonable and that its overall pharmacy trend of 13.0% is reasonable in relation to historical data. BCBSVT Ex. 14 at 13.

59. BCBSVT projects that the 2020 population morbidity will be higher than the experience period morbidity. There are a number of factors impacting this adjustment. The only one that L&E and BCBSVT disagree on concerns the impact of the removal of the individual mandate penalty. *See* BCBSVT Ex. 14 at 13-14; BCBSVT Ex. 19.

60. The company proposes increasing premiums by 0.5% to account for the absence of an individual mandate penalty in 2020. It assumes that all its unsubsidized members in the individual market that had no claims or only had preventive claims in 2018 (0.8% of members) will not

purchase a policy in 2020. BCBSVT saw a portion of this group (0.3% of members) leave the company in 2019. This led the company to assume the remainder would leave in 2020. BCBSVT Ex. 14, 16; Testimony of Paul Schultz, Tr. at 73-74; BCBSVT Ex. 1 at 25-26. BCBSVT does not know whether these members that left BCBSVT in 2019 dropped coverage due to the lack of a penalty or went to another carrier. Testimony of Paul Schultz, Tr. at 84-85.

61. The company acknowledged that "not a lot" of the members it thought would leave in 2019 due to the absence of a penalty actually did leave (a 0.3% impact rather than a 2.0% impact). Testimony of Paul Schultz, Tr. at 74. However, it attributed this to the Legislature's enactment of a mandate in the 2018 legislative session and its instruction to develop a penalty in the 2019 session. *See* Testimony of Paul Schultz, Tr. at 37; *see also* BCBSVT Post-Hearing Memo at 10.

62. Despite the elimination of the individual mandate penalty in 2019, overall membership in Vermont's individual and small group market grew slightly from 2018 to 2019, from 79,652 to 80,060. BCBSVT Resp. to L&E Objection #5 at 1-2.

63. L&E concluded that it is not appropriate for BCBSVT to assume a 0.5% increase due to the elimination of the penalty. L&E expects that most members who would leave the market due to the elimination of the penalty will have done so in 2019. BCBSVT Ex. 14 at 16.

64. Based on discussions with AHPs operating in Vermont in 2019, both of whom were customers of BCBSVT, the company assumed that 2,000 additional small group members would join AHPs in 2020. BCBSVT Ex. 1 at 25. It also assumed the members that would migrate to AHPs would be disproportionately healthy, resulting in a deterioration of the health status of the QHP risk pool. The company assumed this would have the effect of increasing premiums by 1.4%, counteracted in part by a risk adjustment component. The net impact to rates assumed by the company in the initial filing, considering both the morbidity increase and the risk adjustment, was approximately a 1.0% increase. BCBSVT Ex. 14 at 14.

65. As of March 2019, BCBSVT had approximately 43,939 members in the individual and small group market. BCBSVT Ex. 1 at 25. BCBSVT had approximately 6,000 members in AHPs in 2019. Testimony of Paul Schultz, Tr. at 85. The bulk of these 6,000 members had previously been insured by BCBVT in its small group plans in 2018, although some employers came from MVP or Cigna plans or had not previously offered insurance. Testimony of Paul Schultz, Tr. at 85-86.

66. It is extremely unlikely that there will an AHP market in Vermont in 2020. DFR has determined that, in light of a federal court decision vacating key portions of DOL's final rule on AHPs, any AHPs formed under this rule, including the two operating in Vermont in 2019, will not be permitted to operate in Vermont in 2020. Relatedly, the Board recently disapproved BCBSVT's 2020 AHP rate filing. *In re: Blue Cross and Blue Shield of Vermont 2020 Association Health Plan Rate Filing*, GMCB-004-19rr, Decision and Order (June 24, 2019).

67. L&E asked BCBSVT to illustrate the overall rate impact of the Board's decision regarding AHPs. The company responded that, of the small groups that left the QHP market and enrolled in an AHP in 2019, it assumes only the sicker groups will return to the QHP market and

the healthier groups will self-insure. As a result, it projects that the Board's decision will have an impact of less than -0.2% on the rates it proposed in the filing. BCBSVT Ex. 14 at 14.

68. After reviewing BCBSVT's assumptions, L&E concluded that given the lower QHP rates offered by MVP, some of the groups that purchased an AHP for 2019 would return to the QHP market in 2020 and purchase a plan from MVP, which would increase BCBSVT's relative risk score and produce additional revenue to BCBSVT through the risk transfer payment. L&E therefore recommended that the filing be modified such that the overall impact of AHP groups be a 0.7% increase, net of any risk adjustment impact, which would require reducing BCBSVT's overall rate request in this filing by 0.3%. *See* BCBSVT Ex. 14 at 14. BCBSVT agrees with this recommendation. BCBSVT Ex. 19; Testimony of Paul Schultz, Tr. at 47.

69. During its review of the filing, L&E discovered that BCBSVT's projections did not account for newborns that would be born during 2020. After L&E brought this omission to BCBSVT's attention, the company estimated that accounting for newborns would increase rates by 0.6%. In its memorandum, L&E advised the Board that it did not consider this increase to be actuarially justified because it did not account for any premiums the company would see in connection with these newborns. BCBSVT Ex. 14 at 17; L&E Post-Report Addendum at 2.

70. At the hearing, BCBSVT's actuary claimed that the offsetting premiums newborns would generate would reduce the 0.6% increase to 0.4%. Testimony of Paul Schultz, Tr. at 62-63. The offset is relatively small because, due to Vermont's family premium tiering structure, only the first child generates additional premium. Furthermore, BCBSVT does not charge additional premium for newborns in the first two months of life. Testimony of Paul Schultz, Tr. at 63. In response to this testimony, L&E's actuary said it would be reasonable for the Board to review BCBSVT's calculations. Testimony of David Dillon, Tr. at 266. Following the hearing, L&E reviewed the company's calculations and concluded that a 0.4% increase was reasonable, appropriate, and actuarially justified. L&E Post-Report Addendum at 2.

71. BCBSVT projects that its 2020 PMPM administrative costs will increase by about 15% over the prior filing, from $40.26 to $46.54 PMPM. These projections are based on the carrier's 2018 costs adjusted for expected changes, including a trend of 2.5% per year. The trend is based on a 3% increase to personnel costs (which comprise 83.4% of the company's total administrative costs). BCBSVT Ex. 14 at 21; BCBSVT Ex. 1 at 51. While BCBSVT may lose members in 2020 in this market due to its higher premiums, it has not assumed an increase in PMPM administrative costs for this block of business due to loss of additional members. BCBSVT Ex. 14 at 21-22.

72. L&E reviewed BCBSVT's calculation of 2020 PMPM administrative costs and used information from National Association of Insurance Commissioners Annual Statements to compare BCBSVT's administrative costs with those of other BCBS plans. L&E found BCBSVT's administrative expense assumptions to be reasonable. BCBSVT Ex. 14 at 22.

73. L&E reviewed data from BCBSVT and MVP and calculated the impact of changes to the risk transfer program's risk adjustment model. Based on these calculations and on more recent data from CMS, L&E made several recommendations in its actuarial memorandum. It recommended that BCBSVT's projected risk adjustment transfer reflect the most recent data available (i.e., the final numbers published by CMS) and L&E's modeled impact from

implementing the 2020 risk adjustment coefficients (resulting in a PMPM of $38.16), as well as the invalidation of the federal AHP rules. BCBSVT Ex. 14 at 25. The company agrees with these recommendations. Testimony of Paul Schultz, Tr. at 50.

74. At the hearing, BCBSVT proposed making an adjustment to the risk transfer projections to account for the relative risk of groups that left the company in 2019 and were assumed to have moved to MVP. This adjustment would increase rates slightly. Testimony of Paul Schultz, Tr. at 50-51; *see also* BCBSVT Response to L&E Inquiry #5 at 2. Following the hearing, L&E reviewed BCBSVT's calculations and agreed that the adjustment is reasonable. Accounting for this adjustment, L&E's recommendations regarding risk adjustment would reduce the overall rate request by approximately 1.3%. L&E Post-Report Addendum at 2.

75. Beginning with the 2018 benefit year, HHS will implement a nationwide reinsurance program for high-cost enrollees. Under this program, carriers that have members in the individual and small group markets with claims exceeding $1 million will be reimbursed 60% of the costs exceeding $1 million. The cost of the program will be collected from each carrier such that the program will be budget neutral overall. BCBSVT Ex. 14 at 19.

76. BCBSVT's filing proposes a 0.5% premium increase related to federal reinsurance costs. CMS recently clarified that the actual 2018 charge is 0.21% for merged market plans. L&E recommends that the company's assumption be reduced to 0.25%, which will reflect the impact of trend on the unchanging $1 million threshold. BCBSVT Ex. 14 at 19. The company agrees with this recommendation. BCBSVT Ex. 19; Testimony of Paul Schultz, Tr. at 47.

77. In its memorandum, L&E recommended that the selection and AV factors be moved from an index rate adjustment to a pricing AV adjustment. The recommendation does not impact rates. BCBSVT Ex. 14 at 25. The company agrees with this recommendation. BCBSVT Ex. 19.

78. BCBSVT projects that taxes and fees in 2020 will increase as a percentage of premium, due primarily to the Federal Health Insurer Fee being reinstated for 2020. BCBSVT projects this fee will be 2.2% of premium in 2020. In total, changes in taxes and fees increase premiums by 2.6%. L&E concluded that this component of the company's proposed rate increase is reasonable and appropriate. BCBSVT Ex. 14 at 22.

79. Risk Based Capital (RBC) is a method of measuring the amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size and risk profile. From 2011 until earlier this year, BCBSVT targeted an RBC ratio in the range of 500% to 700%. However, this past winter, BCBSVT asked DFR to increase its range to between 590% and 745%. The request was based on an analysis performed by Axene Health Partners, LLP (Axene) on behalf of the company. BCBSVT Ex. 17 at 1-2.

80. In the report Axene prepared for BCBSVT, it noted that the company has opportunities to improve its care management effectiveness and is not on the leading edge of structuring arrangements that shift risk to providers. BCBSVT Ex. 17 at 38.

81. DFR retained Oliver Wyman Actuarial Consulting (Oliver Wyman) to evaluate BCBSVT's proposal. Oliver Wyman found the proposed range to be reasonable for the company. BCBSVT Ex. 17 at 6-7. On February 7, 2019, DFR approved the proposed range and ordered the company to promptly develop a plan to move within the range if its RBC ratio ever falls outside the range. BCBSVT Ex. 17 at 3.

82. As outlined in DFR's solvency opinion to the Board, the company's net premiums earned has grown 10% since 2014, while surplus has decreased 20.4% and membership has remained relatively flat. This means the company's risk exposure has increased considerably while its corresponding surplus safety net has decreased. The company's RBC ratio has trended downward since 2014, when it was 666%, to 495% at the end of 2018. BCBSVT Ex. 15 at 4, 8.

83. In its solvency opinion, DFR cites downward adjustments by the Board to the company's previous filings as having contributed to the decline in the company's RBC ratio. DFR warned that any downward adjustments to BCBSVT's filed rate components that are not actuarially supported will likely erode the company's surplus and negatively impact its solvency over time, thus jeopardizing access to health insurance in Vermont. BCBSVT Ex. 17 at 4.

84. BCBSVT's financial statements over the past five years reflect real reductions to the company's surplus, primarily due to $24.2 million in expenditures related to electronic data processing equipment and software and $21.2 million in net underwriting losses. Letter from Commissioner Michael Pieciak (July 30, 2019).

85. In 2018, BCBSVT reported a statutory net loss of $6.7 million, driven in part by an overall net underwriting loss of $15.5 million, $10.1 million of which came from the company's individual and small group lines of business. BCBSVT Ex. 15 at 7; HCA Ex. 21 at 68; HCA Ex. 22 at 2. This loss, combined with a $4.6 million decline in the value of the company's investment portfolio, a $33.2 million decrease in non-admitted assets due in part to a permitted practice from DFR, and a $5.4 million decline in the company's pension plan assets, reduced BCBSVT's total adjusted capital by $23.9 million, to $110.2 million by year's end. BCBSVT Ex. 15 at 7; HCA Ex. 21 at 6, 68; Testimony of Ruth Greene, Tr. at 167, 170; BCBSVT Ex. 10 at 7. With that $110 million, BCBSVT could pay claims for a little less than three months. Testimony of Paul Schultz, Tr. at 131.

86. Accounting for 2018 risk transfer receipts would reduce the overall net underwriting loss from $15.5 million to approximately $7 million and would increase the company's RBC ratio by 36 percentage points, to 531%. *See* Testimony of Ruth Greene, Tr. at 99, 134.

87. BCBSVT's actual CTR for its individual and small group lines of business has been negative in 2015, 2016, 2017, and 2018; from 2014 through 2018, the company has had an actual CTR of -1.6%. BCBSVT Ex. 20; *see also* Testimony of Paul Schultz, Tr. at 23

88. BCBSVT expects to receive tens of millions of dollars in the next few years in AMT credit refunds. BCBSVT expects to receive $17.9 million later this year, $8.7 million in 2020, $4.0 million in 2021, and $3.4 million in 2022. BCBSVT Ex. 10 at 2. The company plans to use the

refunds it receives in 2019 and 2020 to move within its new target RBC ratio range by the end of 2020. BCBSVT Ex. 1 at 128.

89. After accounting for 2019 and 2020 refunds and for 2019 and 2020 operating and investment results, BCBSVT projects it will have an RBC ratio of 615% by the end of 2019 and 656% by end of 2020. Testimony of Ruth Greene, Tr. at 134; BCBSVT Ex. 1 at 128. An RBC ratio of 656% is only slightly below the midpoint of the company's new range and is above the midpoint of the company's prior range. BCBSVT Ex. 15 at 8.

90. On March 18, 2018, BCBSVT filed suit in the Court of Federal Claims to recover at least $7.2 million in CSR payments for the fourth quarter of 2017 and the entirety of 2018. The case is currently awaiting a decision. While BCBSVT's case has been pending, several similar cases have been resolved in favor of insurers. The federal government has appealed some of those rulings. BCBSVT Ex. 10 at 3. The company's plan to move into its new target RBC range does not rely on any recoveries that may result from this lawsuit. *See* BCBSVT Ex. 1 at 128.

91. At the direction of BCBSVT management, a 1.5% CTR was included in the filing. BCBSVT Ex. 1 at 126-129; BCBSVT Ex. 14 at 22. BCBSVT requested a 1.5% CTR in its 2019 filing. BCBSVT Ex. 14 at 22.

92. BCBSVT has assumed a 1.5% CTR as part of its plan to move into its new target RBC ratio range by the end of 2020. Testimony of Ruth Greene, Tr. at 134. If BCBSVT were not putting the AMT credits it will receive in 2019 and 2020 towards surplus, it would have needed to file a CTR of 7% to get to the same surplus position. Testimony of Paul Schultz, Tr. at 113.

93. To analyze BCBSVT's CTR request, L&E reviewed 2019 individual and small group filings from across the country. Of the 777 filings included in the data, over 82% had assumed CTRs higher than 1.5%. L&E also reviewed the company's RBC ratio relative to other BCBS plans and found that the company's current target RBC range of 590% to 745% is in the bottom half of actual RBCs for BCBS plans nationwide. An RBC ratio of 495% ranked 59th out of 63, meaning only four BCBS plans had lower RBC ratios than BCBSVT. L&E concluded that the company's proposed CTR of 1.5% is reasonable. BCBSVT Ex. 14 at 23-24.

94. When members stop paying their premiums, the company is obligated to cover the cost of services during a 30-day grace period, whether or not the premiums are recovered. BCBSVT included a risk margin for bad debt of 0.1% to pay the claims of members for whom premiums are never collected. The average amount of non-paid premiums due to the grace period provision over the last several years was 0.1%. L&E concluded the margin is reasonable. BCBSVT Ex. 14 at 24.

95. BCBSVT acknowledges that, to some degree, the solvency issues it is facing are a result of its loss of market share. Testimony of Paul Schultz, Tr. at 98. If the company continues to lose membership, there will be upward pressure on its administrative costs as fixed costs are required to be spread over fewer people. *See* Testimony of Paul Schultz, Tr. at 98.

96. The risk transfer program does not fully cover the increased costs associated with covering riskier members. *See* Testimony of Paul Schultz, Tr. at 95 (stating that "the risk

adjustment program in Vermont is not a one-to-one on claims" and that some actuaries "believe that it's 70 cents on the dollar"). If BCBSVT continues to lose healthier members and risk adjustment does not make up for the loss of this "good risk," it will impact the company's financial results and, ultimately, its solvency. Testimony of Paul Schultz, Tr. at 98.

Standard of Review

The Board reviews rate filings to determine whether 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). In addition, proposed rates cannot be excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b). The Board is required to 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. 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), (a)(3), and any public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201.

The Board's review is plainly 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.

The burden falls on the insurer proposing a rate change to justify the requested rate. Rule 2.000 § 2.104(c).

Decision

In this section, we describe our rationale for making modifications to the filing that we believe will reduce the overall average rate increase from 15.6% to approximately 12.4%. However, before do so, we would like to provide some important context and commentary.

We have remarked in prior decisions on the tensions inherent in the statutory standards governing our review. *See, e.g., In re: Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing*, GMCB-009-18rr, Decision and Order, 15 (Aug. 14, 2018). These tensions were heightened this year, making our task more difficult than in the past. We were also discouraged that a substantial portion of the sizeable rate increase proposed in this filing is being driven by factors that are difficult to address except at the national level, such as specialty drug prices and the return of a federal tax on health insurers, while some of the increase, specifically for AHPs, is also due in part to BCBSVT's own business decisions.

While we always consider actuarial standards in our review of a rate filing, concerns about rate adequacy took on increased significance this year. In its solvency opinion, DFR advised the Board that any cuts to the requested rate that are not actuarially justified will negatively impact the company's solvency over time and therefore threaten to jeopardize Vermonters' access to health insurance. Findings, ¶ 83. While DFR has provided similar opinions in the past, it conveyed its recommendations this year with an increased sense of urgency given continuing declines in the

company's RBC ratio. At the same time, the increase BCBSVT has requested in this filing is large—indeed, it is the largest in our collective memory—and we heard no less urgent pleas from the public to reduce or reject the rate increase. More than 600 people submitted comments on the Exchange filings this year, an unprecedented number. *See* Procedural History, ¶ 25. We heard about the obstacles that rising premiums and cost sharing requirements are having on people's ability to access care and we understand the anger and frustration people feel as the costs they pay for health care continue to rise faster than wages, inflation and other relevant economic indicators. Affordability and access therefore weigh heavily in our minds as we reach our decision on this filing, knowing that we must somehow reconcile the statutory mandate to determine whether a rate is affordable while also protecting quality and access to care and insurer solvency. In reducing the requested rate increase from 15.6% to 12.4% while also adhering to the recommendations of our actuaries and the solvency opinion of DFR, we have attempted to strike the best balance we can between these competing rate review standards.

The size of the increase BCBSVT has requested in this filing underscores the importance of the work the State is engaged in with the All-Payer Accountable Care Organization Model. We will continue to use the levers we have to achieve the model's goals of reducing cost growth while improving the quality of care people receive and the overall health of the population. We expect BCBSVT to do the same, for example by using its substantial bargaining power to reduce unnecessary utilization and negotiate lower prices with providers; improving its efforts to combat fraud, waste, and abuse; and implementing and expanding programs, such as the ACO program, that encourage and incentivize more appropriate utilization of services and a focus on prevention and wellness. While we are encouraged that BCBSVT is implementing new cost saving measures in 2020, such as entering into an agreement with a lab benefits manager, *see* Findings, ¶ 55, BCBSVT can and must do more. For example, the company's own consultant, Axene noted that the company has opportunities to improve its care management effectiveness and is not on the leading edge of structuring arrangements that shift risk to providers. Findings, ¶ 80. The company also recovered less in 2018 through its fraud, waste and abuse programs than it had in previous years. Findings, ¶ 54. We expect BCBSVT to look for additional opportunities to improve in these areas, for example, by following through on its planned expansion of the ACO program to other lines of business. *See* Findings, ¶ 53.

I.

First, we adopt L&E's recommendations to modify the filing by (1) reducing the AHP morbidity load on claims and making any associated changes to risk adjustment and plan change factors, such that the projected premiums are reduced by approximately 0.3%; (2) reducing BCBSVT's assumption for the federal high-cost member program from 0.5% to 0.25%; (3) moving the selection and AV factors from an index rate adjustment to a Pricing AV adjustment; and (4) using a PMPM of $38.16 as a starting point for the projected risk transfer before adjustments for the high-cost member program or changes relative to the 2018 market due to AHPs and shift to self-insurance. BCBSVT has agreed with each of these recommendations. Findings, ¶¶ 68-69, 74, 76-77.

We adopt L&E's recommendation regarding AHPs because it is reasonable to expect that small businesses that purchased an AHP in 2019 will choose in 2020 to buy a lower cost plan with

MVP or self-insure. *See* Findings, ¶¶ 67-68. However, it is important to note that 2020 premiums are increasing in part due to BCBSVT's own business decisions. BCBSVT is the only carrier that offered AHPs in 2019, despite the legal uncertainty surrounding these products. *See* Background, ¶ 15. We rejected BCBSVT's request to increase premiums to account for the movement of healthier small groups to AHP plans in 2019. *In re: Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing*, GMCB-009-18rr, Decision and Order, 16 (Aug. 14, 2018). However, premiums will increase 0.7% in 2020 due to BCBSVT's decision to offer these products and draw relatively healthy people out of the combined risk pool.

II.

Second, we allow BCBSVT to increase premiums by 0.4% to account for the newborns it expects will be born in 2020—a 0.6% increase to account for demographic changes and an offset of 0.2% for the additional premiums the company expects to receive.[16] L&E concluded that this adjustment is reasonable, appropriate, and actuarially justified. *See* Findings, ¶¶ 69-70.

III.

Third, we adopt L&E's recommendation to remove the 0.5% load that BCBSVT added for the elimination of the individual mandate penalty. We agree with L&E that this increase is not appropriate because most members who would leave the market due to the elimination of the penalty will have already done so in 2019. We expect this modification will reduce the overall average rate increase by approximately 0.5%. *See* Findings, ¶ 63.

BCBSVT disagrees with L&E that most members who would leave the market due to the elimination of the penalty will have already done so in 2019. It notes that while the Vermont Legislature indicated in Act 182 (2018) that it would adopt a financial penalty for 2020, it is now clear that there will be no penalty. Findings, ¶ 61. In other words, BCBSVT believes the threat of a penalty in 2020 caused people who would have left to continue coverage in 2019. However, this conflicts with the position the company took last year, when it asserted Act 182 would have no impact on members' decisions about 2019 coverage because members could forego coverage (or "self-insure") just for 2019. *In re: Blue Cross Blue Shield 2019 Individual and Small Group Rate Filing*, BCBSVT Response to Interrogatory #4, Q.6 (June 15, 2018).

Even if the continued absence of a penalty will impact BCBSVT's membership in 2020, BCBSVT's assumed 0.5% membership decline is not reasonable. As BCBSVT acknowledged, out of the entire group it expected to leave the market due to the lack of a penalty from 2018 to 2019, relatively few left BCBSVT (about 0.3% of its members). Findings, ¶¶ 60-61. Even if this 0.3% left the market due to the absence of a penalty, which we think is a questionable assumption since

[16] While we allow BCBSVT to make this adjustment, we note our displeasure with BCBSVT's delay in requesting it. *See* Findings, ¶ 76-77. Paul Schultz testified that while L&E initially raised the issue of offsetting premiums, it never calculated the value of the premiums or asked BCBSVT to do so. Tr. at 62. However, this is BCBSVT's filing and BCBSVT has the burden to both propose the rate increase it is asking the Board to approve and to justify that rate increase. The Board has 90 days to review a filing and L&E has a mere 60 days to provide its opinion to the Board. 18 V.S.A. § 4062(a)(2)(A), (d)(1). Amendments or adjustments to a filing made at the hearing, which occurs after L&E has issued its recommendations, are difficult to accommodate in this process and must be discouraged.

market-wide membership actually went up slightly from 2018 to 2019, Findings, ¶ 62, BCBSVT is assuming an even larger drop in 2020, this second year of a "no penalty" landscape.

IV.

Fourth, we adopt L&E's recommendation to reduce the medical utilization trend, net of cost containment measures, from 3.2% per year to 2.5% per year. This will reduce the overall rate increase by approximately 1.1%. Findings, ¶ 48.

L&E's recommendation is consistent with and supported by market-wide data. *See* Findings, ¶¶ 42-47. There have been significant shifts in enrollment in Vermont's individual and small group market in recent years and these shifts complicated the utilization projections this year. *See* Findings, ¶ 40. While BCBSVT normalized its data for changing age and induced utilization since 2015, these adjustments alone were insufficient to address the changes in the carrier's underlying membership. *Id*. While BCBSVT's membership has changed materially since 2015, the aggregate QHP population has been relatively stable during this period. By analyzing more stable and hence more predictable market-wide data, L&E was able to mitigate the impact of enrollment shifts. Findings, ¶ 42. It appropriately used this additional data to inform its recommendation to the Board. *See* Findings, ¶ 47.

BCBSVT claims that L&E should not have relied on its 36-month study of market-wide data as evidence of anti-selection. Because BCBSVT gained members from 2015 to 2016, the company claims there could not have been any anti-selection in the additional 12 months covered by this study as compared to L&E's 24-month study. Findings, ¶ 44. We are not persuaded by this argument. L&E's 36-month study of market-wide data included the period January 2016 through December 2018; it did not include 2015. Findings, ¶ 45. Using the same time periods as BCBSVT's data, the two-year, market-wide average increase is 2.7% per year, significantly lower than BCBSVT's observed increase of 4.1%, while the three-year increase is 1.3%, significantly lower than BCBSVT's observed increase of 3.1%. Findings, ¶ 46. Regardless of how the results are compared, the disparity between the market-wide estimate and the company's estimate remains.

We also note that while BCBSVT projected a 2.5% outpatient utilization trend, as L&E observed, its outpatient utilization trend has oscillated in recent years and leveled off in late 2018. Findings, ¶ 47. Moreover, of the various statistical methods BCBSVT used to project inpatient utilization, several methods that best predicted actual 2018 results produced negative trends, Findings, ¶ 36, which is consistent with the company's assumption that care is moving to more appropriate clinical settings. *See* Findings, ¶ 37.

The recent opening of the Green Mountain Surgery Center, an ambulatory surgery center in Colchester, Vermont, also supports our decision to adopt L&E's recommendation. BCBSVT has observed that claims related to outpatient surgeries are increasing faster than other outpatient claims. *See* Findings, ¶ 38. The ambulatory surgery center will offer a lower cost setting for some of these services. *See* Findings, ¶ 49. While we do not have the data needed to predict the impact on the overall medical costs of the specific population covered by this filing, it is reasonable to

assume that there will be an impact.[17] While we are not requiring BCBSVT to make a specific adjustment for the surgery center, it is a factor supporting our decision to adopt L&E's recommendation.

To avoid any misunderstanding of our decision, we want to be clear that we are not selecting the low end of a range;[18] we are adopting our actuary's best estimate of trend. The range that L&E calculated for the overall allowed medical trend was 3.5% to 6.5% per year. Findings, ¶ 39. Before accounting for an increase in unit cost trend (discussed later), L&E's recommended modification of the utilization trend would result in an overall allowed medical trend of 5.2%, which is below BCSVT's assumption, but above the midpoint of L&E's range.

We note that, in the name of affordability, the Board required BCBSVT to reduce its overall rate increase by 1.0.% in the previous filing and directed the company to produce these savings where it could. The company added this 1.0% back in when developing its trend assumptions. Findings, ¶ 50. However, the company has separately assumed material reductions in trend due to things like its ACO program, a new contract with a lab benefits manager, and a computer system that allows the company to ensure that Medicare pays where appropriate. *See* Findings, ¶¶ 55-56. In addition, BCBSVT has indicated that it is growing its ACO programs. Findings, ¶¶ 52-53. As a result, the Board is satisfied that the company is increasing its efforts to contain costs.

Lastly, we note that the Board has sought to ensure that its hospital budget review and insurance rate review processes are not conducted in silos, but rather are integrated and transparent. As a result, L&E reviewed the unit cost assumptions in the filing to ensure the trend reflects the approved hospital budgets for FY 2019. Findings, ¶ 31. As noted earlier, 51% of the company's medical costs are impacted by the hospital budget process. *Id.* In addition, there has been an increase in members seeking medical treatment at facilities that are outside the Board's jurisdiction. Findings, ¶ 34. In combination, these factors contribute to the company's trends being higher than those approved in the hospital budget process.

V.

Fifth, we allow BCBSVT to raise premiums by no more than 0.3% to account for new information on FY 2020 hospital budgets. *See* Findings, ¶ 33. These budgets, which we received at the beginning of July 2019, are preliminary and untested. Furthermore, the Board has actively sought to control the growth in hospital spending by consistently ordering reductions to hospitals' initial budget submissions, both in terms of net patient revenues and commercial rate increases. *See id*. Without a better sense of what the Board will do with these budgets, our prior decisions are the best information we have. L&E concluded that, based on the pattern of historical reductions, the budget increases will result in a 0.3% increase to premiums. We therefore allow BCBSVT to adopt this assumption and allow the company to raise premiums by no more than 0.3% in connection with this issue.

VI.

[17] Indeed, MVP reduced its outpatient trend by 0.2% and its overall rate request by 0.1% to account for the impact of the ambulatory surgery center.
[18] *See* BCBSVT Post-Hearing Memo at 10 (citing Testimony of Michael Pieciak, Tr. at 320).

Given the significance it took on this year, we feel that we must address the issue of solvency in more depth than we have in past decisions.

BCBSVT reported an overall net underwriting loss for 2018 of $15.5 million. Findings, ¶ 85. Accounting for actual 2018 risk transfer payments reduces this underwriting loss to approximately $7 million. Findings, ¶ 86. The company's RBC ratio has declined each year since 2014, when it was 666%. At the end of 2018, the company's RBC ratio was 495%, slightly below its target range of 500% to 700%. Findings, ¶¶ 79, 82. However, accounting for actual 2018 risk adjustment results would increase BCBSVT's RBC ratio by 36 percentage points to 531%, which was within its target range at that time. Findings, ¶ 86.

At BCBSVT's request, DFR allowed the company to increase its target RBC ratio range. Findings, ¶ 81. If the company ever fell below or increased above its new range, DFR required BCBSVT to promptly develop a plan to move into the range within a reasonable timeframe. Findings, ¶ 81. The company's RBC ratio is below its new range. BCBSVT has developed a plan to move into its new range by the end of 2020, primarily by using tens of millions of dollars it will be receiving in 2019 and 2020 in AMT refunds. Findings, ¶ 88. Using these refunds to increase its surplus, BCBSVT projects that its RBC ratio will be 615% by the end of 2019 and 656% by end of 2020. Findings, ¶ 89. An RBC ratio of 656% is only slightly below the midpoint of the company's new range and is above the midpoint of the company's prior range. *Id.*

We recite these facts not to cast doubt on solvency concerns voiced by BCBSVT and DFR. We are concerned about the company's financial performance. However, we are also concerned about the trajectory the company appears to be on. As a result of its higher premiums relative to its competitor, BCBSVT has experienced pronounced membership losses in recent years. Findings, ¶ 28. The members BCBSVT is losing appear to be younger and healthier than the members that remain. *See* Findings, ¶ 40. Furthermore, risk transfer payments do not fully cover the loss of this "good risk." Findings, ¶ 96. With declines in membership, administrative costs need to be spread over fewer and fewer members, putting additional upward pressure on premiums. *See* Findings, ¶ 95.

Faced with this dynamic, we see risk in BCBSVT's request for an increase in its target RBC ratio range. While the company is relying primarily on AMT refunds and not premium increases to move into its new range, had BCBSVT chosen not to request a new range, some portion of the refunds could have been used to make premiums more competitive and thereby counteract the membership trends the company has been seeing. The company's suggestions that the Board has cut too far in its past rate cases ignores the impacts of members' price sensitivity and willingness to leave BCBSVT for lower rates.

Order

For the reasons discussed above, we modify and then approve BCBSVT's 2020 Individual and Small Group Rate Filing. Specifically, we require that BCBSVT (1) reduce the AHP morbidity load on claims and make any associated changes to risk adjustment and plan change factors, such that the projected premiums are reduced by approximately 0.3%; (2) reduce its assumption for the

federal high-cost member program from 0.5% to 0.25%; (3) move the selection and AV factors from an index rate adjustment to a Pricing AV adjustment; (4) use a PMPM of $38.16 as a starting point for the projected risk transfer before adjustments for the high-cost member program or changes relative to the 2018 market due to AHPs and shift to self-insurance; (5) remove the 0.5% load for the elimination of the individual mandate penalty; and (6) reduce the medical utilization trend from 3.2% per year to 2.5% per year. Finally, we allow BCBSVT to increase premiums by 0.3% to account for new information on FY 2020 hospital budgets and by 0.4% to account for the impact of newborns.

As modified, we approve an average annual rate increase of approximately 12.4%, with plan-level increases ranging from 6.0% to 15.5%. We note that many Vermonters will receive larger federal subsidies to cover the increased costs in 2020, as explained herein, and we encourage Vermonters to use Vermont Health Connect's Plan Comparison Tool (available at https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action beginning this Fall) when determining what their best plan options are.

SO ORDERED.

Dated: August 8, 2019 at Montpelier, Vermont

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

Pelham, dissenting.

While in solidarity with the Board's majority decision regarding BCBSVT's rate request, I write this dissenting opinion in order to highlight some of the competing interests before the Board inhibiting the Board's ability to fully accommodate all statutory goals. These goals include that a rate be affordable, promote quality care, promote access to health care, protect insurer solvency, and not be unjust, unfair, inequitable, misleading, or contrary to the laws of the State. By opposing BCBSVT's requested increase, I'm better able to exercise the freedom of the minority to profile economic and institutional realities fundamental to the establishment of premium rates that hamper affordability and access. However, if my vote were necessary to support the majority opinion, I would have done so as access to even a high-priced plan is better than no access at all.

BCBSVT currently insures 19,431 Vermonters with "Individual" plans and another 24,508 Vermonters through "Small Group" plans (the Plans). BCBSVT Ex. 1 at 7. In recent years BCBSVT requested premium rate increases of 8.2%, 12.7% and 9.6% for the Plans in 2017, 2018, and 2019 respectively. The Board approved much lower increases of 7.3%, 9.2%, and 5.8%

respectively.[19] For 2020, BCBSVT filed a request with the Board to increase the Plans' premiums by 15.6% or $47.1 million. BCBSVT Ex. 1 at 7. Clearly, this trend of rate increases is not aligned with the economic lives of most Vermonters and is therefore not sustainable.

For context, it's important to know that BCBSVT's Individual and Small Group plans comprised about 68% of BCBSVT's entire premium-based health insurance business from 2015 to 2018. In 2018, premiums from the Plans comprised $341 million of BCBSVT's total premium portfolio of $508.6 million. HCA Ex. 22 at 7. Further, in 2018, after paying claims, investing in preventive health measures and covering administrative costs, BCBSVT had a cumulative net income loss of $10.17 million on the Plans business while the company's overall net income was negative at $6.67 million. HCA Ex. 22 at 3; HCA Ex. 21 at 68. From 2015 to 2018, BCBSVT's cumulative net income was a mere $3.4 million. HCA Ex. 21 at 68. Over this same period and through 2019, as BCBSVT increased premiums, BCBSVT lost Individual and Small Group customers, dropping from 67,050 members in 2015 to 43,939 in 2019. BCBSVT Ex. 14 at 1. In contrast, MVP's market share increased from 6,417 members in 2015 to 30,887 in 2019. *See In re: MVP Health Plan, Inc. 2020 Individual and Small Group Market Rate Filing*, GMCB-005-19rr, L&E Actuarial Memorandum (July 9, 2019) at 1. Clearly, a multi-year string of steep rate increases has not only cost BCBSVT customers, this trend has eroded BCBSVT's bottom line with steep net income losses that threaten BCBSVT's overall business model.

BCBSVT also has non-premium-based customers, called the "self-insured." These customers, mostly employers like the State of Vermont for example, hire BCBSVT to manage their self-insurance plan for which BCBSVT is paid a fee while the employer remains directly responsible for covering health providers' claims. In 2018, such claims amounted to $601.2 million. HCA Ex. 21 at 52. Thus, on a combined basis in 2018 for example, BCBSVT had direct and indirect leverage over more than $1 billion of health insurance claims.

I worry that BCBSVT is in a downward spiral relative to its premium-based health insurance business as the cycle of rising premiums results in fewer customers and negative cash flows and low capital reserves. BCBSVT is a Vermont-based business important to the state and regional economies. In his "solvency" opinion to the Board, Commissioner Pieciak of the Vermont Department of Financial Regulation (DFR) expressed an "increased sense of urgency" in support of BCBSVT's requested rate increases and noted that "BCBSVT insures more Vermonters than any other health insurance company" and "there is significant risk that BCBSVT's surplus will erode . . . unless applicable rates are adequate and set at a level that maintains adequate surplus." BCBSVT Ex. 15 at 1-2.

Yet, recent history makes clear that the Board alone cannot put BCBSVT on a sustainable fiscal track nor accommodate DFR's solvency concerns simply through large annual rate increases. Other than higher premiums, co-pays and deductibles, to what might BCBSVT, and DFR, look to assure Vermonters have affordable access to healthcare and BCBSVT remains on solid financial ground? It's clear that the current cycle of higher premiums and fewer customers is not working. Here are some observations.

[19] https://ratereview.vermont.gov/bcbsvt-rate-review-decision-made

- **The Medicaid Cost Shift**: The cost shift occurs when hospitals and other health care providers charge higher prices for services paid by commercial insurance payers to make up for lower reimbursements from government programs like Medicaid that don't cover the cost of provided health care services. The Board's current estimate of the 2019 Medicaid cost shift is $216.2 million, up from $207.5 million over 2018. *See* GMCB Annual Report for 2018 at 12.[20] Evidence of the cost shift also exists in the state budget where Medicaid appropriations for health care services increased by just nine-tenths of one percent for 2020 over 2019. *See* Joint Fiscal Office, FY 2020 Big Bill Conference Web Report, Sec. B.307.[21] Further, in response to Board questions, BCBSVT stated "The resulting calculation leads to a rate decrease of 16.8 percent from filed rates if the cost shift at Vermont hospitals were to be completely eliminated by 2020." BCBSVT Ex. 11 at 5. In order to mitigate the deteriorating effects of the cost shift on premiums, and thus enhance affordability, BCBSVT might press state financial policy makers to better fund Medicaid commitments with public dollars, rather than cost shifting these commitments onto the premiums of commercial rate payers.

  Further, the cost shift threatens the success of Vermont's effort to migrate from the more costly system of "fee for service" to a system of fixed Value Based Payments as anticipated in Vermont's All-Payer ACO Model (APM) Agreement with the federal Center for Medicare and Medicaid Innovation. The cost shift is a substantial wild card that increases risk for both commercial insurers and health care providers when negotiating "per member per month" fixed prices. With the APM, all payers need to contribute their fair share to the pooling of funds that support fixed Value Based Payments.

- **Operating Margin Distribution:** In written responses to Board questions, BCBSVT stated, "as the GMCB has become more aggressive in the hospital budget review process, Vermont hospitals have consistently indicated that they are unwilling to remain in BCBSVT's network unless BCBSVT fully funds GMCB-approved increases to commercial rates." BCBSVT Ex. 11 at 3.

  While the financial relationships between BCBSVT and hospital providers are not transparent, with direct or indirect influence over $1 billion in annual claims expenses as occurred in 2018, BCBSVT might better utilize its negotiation leverage, especially with the UVM Medical Center. As noted above, over the four-year period 2015 to 2018, BCBSVT gained only $3.4 million in net income. Over the same period, according to the Board's records, UVM Medical Center had average annual receipts from commercial claim payments of $693.8 million, totaling $2.77 billion. *See* The University of Vermont Medical Center Fiscal Year 2018 Analysis (Mar. 25, 2019) at 3.[22] Certainly, a substantial share of these payments came from Vermont's largest health insurer, BCBSVT. Yet, during this period, while BCBSVT had net income of $3.4 million, UVM Medical Center gained $264.4 million in operating margin; a striking difference in financial outcomes between

[20] https://gmcboard.vermont.gov/sites/gmcb/files/GMCB%202018%20Annual%20Report%201%2015%202019.pdf
[21] https://ljfo.vermont.gov/custom_reports/webreports/webreports/web/FY2020%20Big%20Bill%20Web%20Report%20Conference.html
[22] https://gmcboard.vermont.gov/sites/gmcb/files/A18%20H21%20Staff%20Analysis%20UVMMC.pdf.

Vermont's largest health insurer and Vermont's largest health care provider. *See* Fiscal Year 2018 Vermont Hospital Budgets: Year-End Actuals Reporting (Mar. 21, 2019), 34.[23]

If BCBSVT cannot better leverage its price negotiations with providers doing well in Vermont's health care landscape, then BCBSVT might seek to make the process more transparent with the goal of price transparency and affordability the desired outcome.

- **The Benchmark Plan**: The Individual and Small Group health insurance policies are a product of the federal Affordable Care Act (ACA). The ACA requires each state to have a "benchmark" plan that provides 10 areas of "essential healthcare benefits" for consumers and which is foundational to the development of the Bronze, Silver, Gold and Platinum plans sold on Vermont's ACA exchange, Vermont Health Connect. Benchmark plans differ significantly among states. In Vermont, each fall the Dept. of Vermont Health Access (DHVA) convenes a group of "stakeholders" to develop recommendations for changes to Vermont's ACA health plans. The ACA requires health insurance issuers in the individual and small group markets to spend at least 80% of their premium income on medical care and health care quality improvement, leaving the remaining 20% for administration, marketing, and profit or contribution to reserve. This ratio is known as the Medical Loss Ratio (MLR). BCBSVT's Individual and Small Group MLR is consistently over 90% with the resulting pressure on premiums. BCBSVT Ex. 11 at 1-3. To lower premiums and/or improve BCBSVT's solvency, BCBSVT might work with DHVA to revisit the benefits allowed under Vermont's "benchmark" plan.

- **The Subsidy Cliff:** Many Vermonters purchasing health insurance via Vermont Health Connect find a premium's "list price" is not the real price. These plans are aligned with a system of state and federal subsidies that lower premium costs to less than 5% of federal poverty level (FPL) for households at or below 400% FPL. Regrettably, there are no subsidies associated with Individual plans above 400% FPL or for most employers/employees purchasing insurance in the Small Group market. These Vermonters must pay the "list" price, which often consumes a double-digit percentage of household income, not including the burdens of co-pays and deductibles.

  The Subsidy Cliff is steep and harsh. For example, this year a couple with income just below 400% FPL at $65,800 can purchase a low-cost Bronze Plan for $150 per month. But, for a couple just over the 400% FPL, say at $66,000, the premium price rises to $852 per month.[24] This price differential certainly inhibits many Vermonters from participating in BCBSVT's Individual and Small Employer insurance plans.

  With my concurring vote last year on Individual and Small Group premium rates, I explicitly raised this important affordability issue and proposed a plan to mitigate it. In furtherance of that plan, in February, DHVA was asked and agreed to calculate the cost of incremental expansions of a subsidy program to 450% FPL and 500% FPL, allowing a cap at 9.86% of income, the "affordability" level established under the ACA for 2019. This

[23] https://gmcboard.vermont.gov/sites/gmcb/files/FY18%20Actuals%20Report-%20March%2021%20update.pdf.
[24] https://legislature.vermont.gov/Documents/2020/WorkGroups/Senate%20Finance/Bills/H.524/Written%20Testimony/H.524~Mitch%20Fleischer~Testimony%20from%20Business%20Resource%20Service~4-23-2019.pdf

basic information is necessary to support the design of an expanded program consistent with available funding. Though agreeable last February, DHVA has made no substantive progress on this request. Given BCBSVT is often a "stakeholder" in most processes associated with ACA plans, BCBSVT might raise this matter with DHVA in the context of mitigating the "cost shift" discussed above.

The above highlights just some of the established forces outside the control of the Board's rate review process but which directly affect the affordability of and access to health care services by Vermonters. The cost shift is the domain of state fiscal leaders, operating margins are the non-transparent domain of BCBSVT and providers, and the benchmark plan and subsidy cliff are primarily the domains of DHVA. In the face of these pressures, all of which BCBSVT is well aware are embedded in the actuarial analysis presented to the Board, BCBSVT can continue down the path of seeking the Board's approval for higher and higher premiums, copays and deductibles to address solvency and bottom-line weaknesses; but it's clear this approach is a dead end. Vermonters are voting with their feet and leaving the BCBSVT fold. Further, BCBSVT's rates are inconsistent with the APM target of 3.5 per cent per member per month, a target which I support. BCBSVT is a valued Vermont organization and might use its substantial position among Vermont's health care system to correct the existing and emerging imbalances in the system that currently result in health care premiums and ancillary costs outside the reach of more and more Vermonters.

Dated: August 8, 2019 at Montpelier, Vermont

s/ Tom Pelham
Member, Green Mountain Care Board

Filed: August 8, 2019

Attest: s/ Jean Stetter, Administrative Services Director
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: Christina.McLaughlin@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.