STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont	)	GMCB-18-14-rr
Vermont Health Connect Rate Filing	)	
	)	
SERFF No. BCVT-129572217	)	

DECISION & ORDER

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) contains provisions aimed at making health insurance rates more transparent for consumers, including the establishment of health benefit "exchanges." In Act 48 of 2011, the Vermont Legislature created this state's exchange – Vermont Health Connect (VHC) – a marketplace where individuals, families and small businesses can comparison shop online[1] for qualified health insurance coverage.

Among its other responsibilities, the Green Mountain Care Board is charged with the review of major medical health insurance rates for Vermont consumers. In 2013, the Board reviewed the first health insurance rates offered on the exchange when two carriers – Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Plan, Inc. (MVP) – filed proposed 2014 rates. Again for 2015, each carrier has filed proposed exchange rates for the Board's review.

In this filing, BCBSVT proposes a 9.8% average annual rate increase for health plans offered on the exchange beginning in 2015. Based on our review of the record and the testimony and evidence provided at hearing, we modify the rates as explained below, and then approve the filing.

Background

1. Starting January 2014, each Vermont resident must obtain qualifying health insurance coverage. In Vermont, individuals, families, and small employers (fifty or fewer employees) are required to purchase their plans through the exchange. The rates are based on a single risk pool which includes the individual and small group markets.

[1] In addition to online enrollment, Vermonters may use a specially trained "assistor" who can help provide in-person help. *See* http://info.healthconnect.vermont.gov/find ("Find In-Person Help").

2. Plans are offered to consumers in five categories, including four "metal" levels – bronze, silver, gold and platinum. The metal levels are based on the cost to the insurer relative to that of the policyholder. For example, a bronze plan will have the least expensive premium, but the insurer will pay a smaller portion of the cost of the consumer's health care. A platinum plan will require the consumer to pay a higher premium, but a larger percentage of the cost of care will be paid by the insurer. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.[2]

3. Health insurance plans offered on the exchange must be affordable. Individuals enrolling for coverage who do not have employer-sponsored insurance may be eligible for federal premium assistance depending on their household income. *See* 26 U.S.C. §36B (Refundable credit for coverage under a qualified health plan). Vermont has chosen to further reduce the cost of health insurance by capping the percentage of household income that eligible individuals and families pay for health insurance premiums and by offering subsidies for lower deductibles and co-payments.

4. All plans offered on the exchange must include specific services known as "essential health benefits" (EHBs): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

5. In Vermont, health insurance rate review has historically fallen under the authority of the Department of Financial Regulation (Department). In Act 48, the Vermont Legislature created a role for the newly-formed Green Mountain Care Board, and from 2012 until January 2014, the Board shared the responsibility for rate review with the Department. Under the two-tiered process, the Department received the filing and conducted an actuarial analysis before making a recommendation to the Board that it approve, modify, or disapprove the rate. The 2014 exchange rates were reviewed under this bifurcated process.

6. The Legislature expanded the Board's rate review authority when it enacted Act 79 of 2013, and beginning January 1, 2014, the Board became primary reviewer of major medical

[2] Catastrophic coverage is characterized by low premiums and high deductibles, and individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

health insurance rates, with the Department retaining the limited role of advising the Board on the issue of insurer solvency. No. 79, § 5c, *eff*. Jan. 1, 2014. In conjunction with its expanded role, the Board entered into a contract with Lewis & Ellis (L&E), an actuarial firm that assists the Board's decision-making process by providing actuarial analysis of health insurance rate filings.

7. Last year, this Board for the first time reviewed BCBSVT exchange rates for the coverage period from January 1, 2014 to December 31, 2014. In our Decision and Order of July 8, 2013, we modified BCBSVT's filing, resulting in an approximate 4.3% reduction in its average annual exchange rate.[3] *See BCBSVT 2014 Exchange Products Rate Filing*, Docket no. GMCB-16-13-rr (July 8, 2014), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/016_13rr_decision_rev.pdf

Procedural History

8. On June 2, 2014, BCBSVT filed its 2015 Vermont Exchange Products Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlined the development of proposed exchange rates for coverage commencing January 1, 2015. *See* Exhibit 1;[4] *available at* http://ratereview.vermont.gov/sites/dfr/files/018_14rr_7_21_14.pdf.

9. On June 4, 2014, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered its Notice of Appearance. *See* http://ratereview.vermont.gov/sites/dfr/files/018_14rr_HCA_NOA.pdf.

10. L&E conducted an actuarial review of the filing for the Board, including a series of follow-up questions and requests for additional information from BCBSVT. Taking responses from BCBSVT into consideration, L&E issued an actuarial memorandum summarizing its analysis and recommendations for modification. The memorandum was posted to the Board's rate review website on August 1, 2014. *See* Exhibit 8; *also available at* http://ratereview.vermont.gov/sites/dfr/files/018_14rr_Final_Actuarial_Memo.pdf.

11. L&E recommends four modifications to the filing prior to approval of the rates. First, L&E recommends that the carrier use standard U.S. Department of Health and Human Services

[3] Because cost sharing and benefits will vary among plans, the 4.3% decrease to 2014 proposed rates also varies depending on plan.

[4] The exhibits referred to in this decision were either stipulated to by the parties or admitted into evidence upon motion at hearing.

(HHS) induced utilization factors[5] in its rate development; second, that BCBSVT adjust the pricing actuarial value (AV) for family tiering; third, that it reduce the insurer fee to 2.5% of premium, and last, that it use HHS's proposed reduced attachment point parameter ($45,000) for transitional reinsurance recovery. L&E calculated that the modifications would reduce the rate increase from 9.8% to 7.2% and opined that after modification, the filing would not produce rates that are excessive, inadequate or unfairly discriminatory. *Id.*

12. On July 28, 2014, the Department issued an opinion and analysis of the impact of BCBSVT's rate filing on the company's solvency. The Department opined that a 2.0% contribution to surplus would be "more appropriate," but that a 1.0% contribution, as requested in the filing, "should be considered the absolute minimum." Exhibit 9.

13. On August 4, 2014, after reviewing the L&E actuarial memorandum, the Department supplemented its opinion and analysis. The Department expressed its concern that if the Board were to adopt L&E's recommendation to reduce the transitional reinsurance attachment point to $45,000 and the change was not made by HHS, BCBSVT would need to make up for a shortfall in its reserves in future filings and would suffer a "weakened solvency position." *Id.*

14. The Board held a public administrative hearing on August 12, 2014 in Room 11 of the Vermont Statehouse. Judith Henkin served as hearing officer by designation of Board chair Al Gobeille. Jacqueline Hughes, Esq. of Storrow Buckley Hughes, LLP represented BCBSVT. Ruth Greene, BCBSVT Chief Financial Officer (CFO), and BCBSVT Actuarial Director Paul Schultz testified for the carrier. Lila Richardson, Esq. and Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Consulting. The Department's general counsel, David Cassetty, testified regarding the Department's solvency analysis and opinion. In addition, David Dillon, L&E's supervising actuary for the BCBSVT filing, testified about L&E's actuarial review and recommendations to the Board.

15. The Board accepted public comments on the proposed rates for both BCBSVT and MVP from June 3, 2014 through August 18, 2014. During that period, the Board received 275 comments, 234 of which are based on a template provided to consumers and submitted to the Board by the Vermont Public Interest Research Group (VPIRG). Although some of the VPIRG

[5] Induced utilization is the tendency of individuals to make greater use of services as their cost sharing decreases and less use as their cost sharing increases. HHS has developed induced utilization factors intended to help equalize the impact of health status on health insurance plans.

comments include personal observations and details, all reference both Vermont carriers in the exchange and state that the rate increases are not affordable. In addition, the Board received 29 comments that specifically address BCBSVT's proposed rate increase, three that address exchange rate changes in general, and 11 that address only MVP's proposed rate increase. Virtually all of the comments characterize the impact of the higher rates as unaffordable and encourage the Board to control the cost of health insurance premiums. *See* Public Comments, *available at* http://ratereview.vermont.gov/Exchange_Public_Comment.

Findings of Fact

Nature of the Filing

16. BCBSVT is a non-profit hospital and medical service corporation that provides major medical, Medicare supplement and prescription drug coverage to Vermonters. As the larger of the two issuers offering plans on the exchange, the company has 35,037 policyholders and almost 58,000 covered lives in its Vermont Health Connect plans.

17. BCBSVT offers consumers in the exchange both standard and non-standard (Blue Rewards) plans. The standard plans are not unique to the carrier and provide benefits approved by the Board, offer members access to a nationwide network of providers, and include coverage for all EHBs. The two health and wellness-based non-standard plans are carrier-specific but still must comply with all requirements for participation in the exchange.

18. Enrollment for the 2015 exchange plans begins in November 2014, with coverage beginning on January 1, 2015.

Summary of the Data, Analysis, and Testimony Presented at Hearing

19. To develop the exchange rates, BCBSVT utilized claims incurred by members enrolled in BCBSVT small group and individual products and The Vermont Health Plan (TVHP)[6] small group products for the period January 1, 2013 through December 31, 2013, and paid through March 31, 2014 (the "experience period"). Exhibit 1 at 19-20.

20. BCBSVT projected the experience period claims forward to the rating period using an 8.4% pharmacy trend and 4.4% medical trend, for a combined trend of 5.1%.[7]

[6] TVHP is a fully owned subsidiary of BCBSVT.
[7] In most basic terms, trend refers to the change in the cost of health care and consists of utilization (frequency of use of the product or service) and unit cost.

21. BCBSVT developed the 4.4% medical trend using claims incurred between January 1, 2010 and December 31, 2013 and completed through March 31, 2014, with data sourced from BCBSVT's data warehouse. The carrier chose a flat utilization trend assumption of 0.0%, and cost trend assumption of 4.4%. Exhibit 1 at 29-33.

22. Rather than using induced-utilization factors developed by HHS to adjust for "benefit richness," BCBSVT used its own group claims and membership over a 56 month period to model the correlation between utilization and the cost sharing design of a plan. Exhibit 2 at 9-10; Exhibit 4 at 8

23. BCBSVT developed its pharmacy trend using incurred claims from October 1, 2011 to September 31, 2013 with payments through March 31, 2014, intentionally excluding the fourth quarter of 2013 from the analysis due to a significant increase in utilization prior to the implementation of the exchange, which BCBSVT considered a one-time phenomenon. BCBSVT analyzed the components of trend (cost and utilization) separately for brand named drugs, generics and specialty drugs to arrive at the 8.4% pharmacy trend. Exhibit 1 at 26-28.

24. Approximately 91.5% of BCBSVT's proposed rate consists of projected claims costs. In addition, the rate includes an administrative expense load of approximately 6.13%. BCBSVT did not project administrative costs forward from the 2013 experience period due to membership growth, which allows fixed costs to be spread over a larger base, and did not include one-time administrative costs relating to the exchange in its projection. Transcript (TR) at 62-63 (testimony of Paul Schultz). The proposed 2015 administrative costs are 2.2% lower than for 2014. Exhibit 8 at 6.

25. BCBSVT included in its rate calculation a 1.0% contribution to reserve[8] which it states is "the minimum required to avoid depleting Risk Based Capital (RBC)." Exhibit 1 at 39; TR at 63 (Schultz testifies that "[a] one percent contribution . . . supplemented with the investment income allows us to maintain the surplus position that we need to maintain with our target range.")

26. BCBSVT has been financially strong over the last five years, has seen a growth in membership, has improved member service and quality scores, and has maintained its risk based capital (RBC) within in the middle of its target levels. TR at 52-53 (testimony of Ruth Greene).

[8] Although the Department refers to this component solely as the "contribution to surplus," here we will, where appropriate, use the terminology as used by the carrier.

Despite its current financial health, the company is concerned with "the uncertainties around what's going to happen with the subsidies and the claims experience on the exchange." *Id*. at 52.

27. In addition to claims and administrative costs, the rate includes approximately 4.5% in state and federal taxes and fees. The rate is offset, however, by a reduction for the federal transitional reinsurance program, established under the ACA and intended to stabilize premiums during its first three years by reimbursing insurers for certain high cost claims. BCBSVT calculated this offset using parameters set by HHS regulation that include a $70,000 attachment point.

28. On review of the filing, L&E recommended four modifications. First, L&E recommends that the company use standard HHS induced utilization factors – rather than the company's group claims and membership data – to insure that health status is not taken into consideration in adjusting for benefit richness. Exhibit 8 at 8, 9. If implemented, the modification would reduce the rate by approximately 0.2%. *Id*.

29. Second, L&E recommends that BCBSVT adjust the pricing AV (actuarial value) for family tiering after developing the index rate. The adjustment has no impact on rates, and BCBSVT does not oppose the change. Exhibit 8 at 9; TR at 77. Accordingly, we will not discuss this issue further in our decision, but order that the modification be implemented.

30. Next, L&E recommends that the carrier reduce the proposed insurer fee – an industry assessment that is premium based and applies only to fully insured businesses – from 2.83% to 2.5% of premium, resulting in a 0.4% decrease in the rate. L&E advised the Board that BCBSVT "rounded up" its fee estimate in 2014 without adequate support for the increase to account for businesses that might be "motivated by the Affordable Care Act to move towards self insurance." BCBSVT then used the rounded 2014 estimate as the basis for its 2015 calculation. Exhibit 8 at 7; TR at 80 (Schultz testimony).

31. Since L&E reviewed the filing, BCBSVT received a preliminary bill from the IRS from which it can quantify support for a more accurate estimate of the insurer fee. Using the IRS bill as the basis for projecting the fee forward, BCBSVT has lowered its estimate of the fee from 2.83% of premium to 2.74%. BCBSVT Exhibit A; TR at 82-84.

32. Last, L&E recommends that BCBSVT recalculate its estimate of recovery under the federal transitional reinsurance program. Exhibit 8 at 5-6, 9. For 2015, HHS set a $70,000 attachment point by Final Rule, and BCBSVT used the approved attachment point in its rate

development. *See*, Exhibit 12 (79 Fed. Reg. No. 47, 13745). More recently, HHS announced that it will propose lowering the attachment point to $45,000. *Id.* (79 Fed. Reg. No. 101, 30259) ("We intend to propose changes to the reinsurance parameters for 2015. . . [and] intend to propose to lower the 2015 attachment point from $70,000 to $45,000.")

33. L&E actuary David Dillon testified that among the states with which he works or is aware, approximately 60% of the filings submitted use the approved $70,000 attachment point, and 40% the proposed $45,000. TR at 131.

34. Donna Novak, the HCA's expert witness, agrees that BCBSVT should use the lower, proposed attachment point in its rate development, noting that insurers in other states have used both the $45,000 and $70,000 attachment points. Exhibit 10 (NovaRest Actuarial Report) at 6-9; TR at 157. Novak contends that the fact that HHS's proposal to reduce the attachment point was written into the Federal Rule is significant:

> CMS publically came out and said that they intended to make that proposal. I have been very--working very closely with CMS first as a client, but then as reviewing rates for the work we did with the Academy of Actuaries . . . I find they are very reluctant to put anything in writing. Very, very reluctant. If they put something in writing it shows to me a strong intention to follow through on it.

TR at 155.

35. Novak explained that HHS similarly adjusted the attachment point downward from $60,000 to $45,000 for 2014, did so well after exchange rates were approved and implemented, and it is foreseeable that it would do so again for 2015. Moreover, Novak contends that BCBSVT benefited financially from the change because it developed its 2014 rate using the $60,000 attachment point. Exhibit 10 at 8; *see* Exhibit 12 (79 Fed. Reg. No. 47, 13745).

36. In conclusion, Novak stated: "In determining appropriate rates, decision makers should give any benefit of the doubt to consumers and to taxpayers who, together, bear the cost of Vermont health insurance coverage." Exhibit 10 at 9.

37. BCBSVT disputes each of L&E's and the HCA's rationales for use of the proposed, lower attachment point. BCBSVT actuary Paul Schultz testified that the attachment point would be unlikely reduced for 2015 without a corresponding change in coinsurance, that conditions that prompted HHS to reduce the 2014 attachment point were unique to that one year, and that contrary to the HCA's assertion, the company received no windfall from using a higher attachment point in 2014 because the percentage of individuals as compared to small groups who

purchased exchange plans differed from BCBSVT's projections. Terming use of the lower, proposed attachment point "imprudent," Schultz stated his belief that nationally, insurers with a significant presence in their respective markets are generally using the $70,000 attachment point. Schultz advised the Board that if it were to order BCBSVT to use the lower attachment point and it was not ultimately reduced by HHS, the impact to the carrier would be approximately $6 million. TR at 84-99.

38. When asked the consequence if the attachment point is lowered to $45,000 and BCBSVT leaves its attachment point unchanged, Schultz responded that the company "would proactively work with the Green Mountain Care Board to determine the best way to get those excess funds back in the hands of the policyholders." TR at 99. Because any conclusive change by HHS would likely occur "well into the benefit year," Schultz believes it possible that the company could offer a rebate to 2015 plan enrollees, or account for the excess funds in the 2016 filing. *Id*. at 104.

Standard of Review

1. Vermont law provides that the Board shall review health insurance rate filings to ensure that rates are affordable, that they are not "excessive, inadequate or unfairly discriminatory," that they promote quality care and access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. §§ 4512(b); 4062(a)(2),(3); GMCB Rule 2.000, *Rate Review*, §§ 2.301(b), 2.401. In addition, the Board takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6).

2. As part of its review, the Board will consider the Department's analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2), (3). The Board shall also consider any public comments received on a rate filing. Rule 2.000, §2.201.

3. The burden falls on the insurer proposing a rate change to justify the requested rate. *Id*. § 2.104(c).

Conclusions of Law

I. Consistent with the Board's Order in BCBSVT's 2014 Exchange Filing, the Carrier Must Apply the Standard HHS Induced Utilization Factors to Protect Against the Possibility of Morbidity-Based Selection.

Under provisions of the ACA and Vermont law, insurers may not deny coverage based on pre-existing conditions and are limited in their ability to charge different premiums based on a person's age or health status (morbidity). To avoid unintended consequences on the insurance marketplace resulting from induced utilization – the tendency of members with low cost sharing to utilize health services more often than those with high cost sharing – HHS has developed a set of factors that quantify the expected increases and decreases in utilization as a plan's actuarial value changes. These factors are intended to minimize the effect of health status on health insurance plan premiums.

L&E recommends that the carrier use the HHS induced utilization factors, rather than those developed by the carrier based on its own group data. As explained in L&E's actuarial memorandum, BCBSVT's group members have a choice of three plans on average, and less healthy members typically choose plans with lower cost sharing and higher premiums, while healthy members choose higher cost sharing and lower premiums. Exhibit 8 at 8. Use of the HHS developed factors is appropriate and better ensures that health status is not reflected in the induced utilization factors, and that exchange plans comply with the ACA. *See, e.g.,* TR at 159 (HCA actuary "agree[s] that the HHS induced utilization factors are probably the best induced utilization that we have that separates out the increased demand because of lower cost versus selection.")

Last year, albeit under slightly different circumstances because the exchange plans were set to commence, for the first time, at the start of 2014, we made the same observation and required that BCBSVT use the HHS factors rather than its own, a modification with which BCBSVT agreed. *In re: BCBSVT 2014 Exchange Products Rate Filing*, Docket no. GMCB 16-13-rr. *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/016_13rr_decision_rev.pdf. Here, BCBSVT has failed to present any convincing evidence that the induced utilization factors used in its 2015 filing eliminate the impact of health status. Accordingly, we accept L&E's analysis and recommendation. L&E estimates that the change will decrease the overall average rate by 0.2%. Exhibit 8 at 8.

II. At Hearing, BCBSVT Provided Credible, Quantifiable Support for its Revised Insurer Fee Calculation of 2.74% of Premium.

The ACA created an annual fee that is imposed on an insurer's health insurance premiums based on market share. The fee does not apply to entities that self-insure, government-

run insurance programs, or to certain non-profit insurers. For 2014, the aggregate fee to be collected from all insurers is $8 billion; for 2015, it rises to $11.3 billion.

L&E recommends that BCSVT reduce the tax from 2.83% to 2.5% of premium because the company inappropriately "rounded up" the fee in 2014 to account for businesses that may choose to self-insure, and the 2014 fee estimate was used as the basis for 2015. Exhibit 8 at 7. At hearing, however, BCBSVT advised the Board that it had received a preliminary IRS bill for 2014 from which it was able to more accurately estimate the fee for 2015, and provided the Board a revised calculation.[9] BCBSVT Exhibit A.

We agree with BCBSVT that the preliminary IRS bill provides the best foundation for estimating what the company will need to collect to pay the fee in 2015. BCBSVT's actuary has calculated the 2015 fee at 2.74% of premium, *id*., and the filing should be modified accordingly.

III. Use of the $45,000 Proposed Transitional Reinsurance Attachment Point, Rather than the $70,000 Parameter Currently Approved by HHS, is Reasonable and Appropriate and Enhances Affordability for the Vermont Consumer.

L&E's most impactful recommendation – if implemented, would reduce the proposed rate increase by 2.0% – concerns the parameters for the transitional reinsurance program, a federal program intended to stabilize premiums in the individual market during the first three years of the ACA. All individual, group, and self-funded major medical issuers contribute funds to the reinsurance program, and the funds are reallocated to issuers that cover certain high cost claims.[10]

On March 11, 2014, HHS issued a Final Rule setting the 2015 program payment parameters – a $70,000 attachment point, a $250,000 reinsurance cap, and a 50% coinsurance rate. Exhibit 12 (79 Fed. Reg. No. 47, 13745). BCBSVT developed its rates using these parameters. On May 27, 2014, however, HHS announced:

> We intend to propose changes to the reinsurance parameters for 2015 . . . [s]pecifically, in the proposed 2016 Payment Notice, we intend to propose to lower the 2015 attachment point from $70,000 to $45,000. We may also propose to modify the target 2015 coinsurance rate

[9] As of the date of hearing, neither the Board nor its actuaries had viewed the preliminary bill or the company's revised calculation.

[10] The program is more fully explained in non-technical language in a Henry J. Kaiser Family Foundation Publication, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, available online at http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

> based on estimates of roll-over of funding from 2014 and estimates of collections and payments for 2015. These proposals will be subject to notice and comment rulemaking.

Id.; (79 Fed Reg. No. 101 30259).

According to BCBSVT, it would be "imprudent" to lower the attachment point based on the HHS statement of intention, as opposed to the Final Rule. BCBSVT actuary Paul Schultz testified that if the company used the lower attachment point and the change did not materialize in federal rule, it would cost the company $6 million which it would need to recoup in future rates. He further explained that if HHS reduced the attachment point it would likely also adjust the coinsurance, that in his view most insurers with significant market share were using the $70,000 parameter, and that if BCBSVT's assessment proved incorrect – it retains the $70,000 attachment point but HHS lowers it to $45,000 – the company would work with the Board to ensure that any excess funds would be returned to policyholders, whether in 2015 or 2016.

Although we recognize that there is no certainty in the HHS statement, both the HCA and L&E have presented convincing arguments in support of adopting the proposed $45,000 attachment point. First, there is precedent for HHS to lower the attachment point, having reduced the "final" $60,000 threshold for 2014 to $45,000. *See* Exhibit 12 (79 Fed. Reg. No. 47, 13745) (proposal to decrease 2014 attachment point to $45,000 finalized, no change made to other 2014 reinsurance parameters).

Second, there is support in other states and in Vermont for using the proposed attachment point; L&E's witness and the HCA's expert testified that other insurers – according to L&E, approximately 40% of the filings in the states in which it conducts reviews – have adopted the $45,000 attachment point, either voluntarily, or by order. *See, e.g., In the Matter of the Proposed Increase Application of Anthem Blue Cross and Blue Shield*, State of Connecticut Insurance Department, Docket no. LH14-155 (July 22, 2014), *available at* http://www.catalog.state.ct.us/cid/portalApps/images/reports/10103870.pdf. Indeed, Vermont's only other insurer participating in the exchange used the lower, proposed parameter in its 2015 exchange rate development. *See MVPHP 2015 Exchange Rate Filing*, Docket no. GMCB 017-14-rr, *available at* http://ratereview.vermont.gov/sites/dfr/files/017_14rr_7_21_14.pdf (SERFF filing).

We also find credible Donna Novak's testimony concerning HHS's disinclination to announce its intentions publically and in writing unless it was likely to follow through with its

proposal. TR at 155 ("If they put something in writing it shows to me a strong intention to follow through on it.")

Finally, we agree with Ms. Novak's statement, similar to the comments of Vermonters who voiced their concerns over the increasing cost of health care premiums, that "decision makers should give any benefit of the doubt to consumers and to taxpayers who, together, bear the cost of Vermont health insurance coverage." Exhibit 10 at 9. While we cannot guarantee that our assessment is correct and the regulation will surely be altered, we too believe the better alternative in this instance is to err on the side of the consumer and allow BCBSVT to recoup any shortfall in the future, if so required.

Based on L&E's calculation, this modification will reduce the rate by 2.0%

Conclusion

As we complete our second year reviewing Vermont Health Connect insurance rates, we remain mindful of the challenges that health insurers face when pricing plans for participation in the health benefit exchange. For 2015, our observations include that there is scant data and member experience on which to base rate assumptions, that there are underlying cost drivers that are in large part beyond the insurers' control,[11] and that our insurers must remain financially viable if they are to continue as participants in this nascent endeavor. And while we rely on actuaries to help us predict risk and analyze the impact of varied benefit designs, reimbursement arrangements, health plan pricing and current and future governmental regulations and policy, we are keenly aware that the science is not exact, and that finding that a proposed insurance rate is actuarially reasonable does not fulfill our broader obligation.

The Legislature has charged this Board with the task of ensuring that all Vermonters gain access to affordable, quality health care. Our decision today is intended to move us closer to that goal, as we continue to look for ways to exert downward pressure on health care costs system wide. As a result of today's decisions, BCBSVT's average annual 2015 Vermont Health Connect rate increase is reduced from 9.8% to 7.7%.

[11] The American Academy of Actuaries recently analyzed the factors underlying 2015 health insurance rate increases. Key to its findings are that many of the uncertainties concerning risk pool composition and enrollee health status present in 2014 remain in 2015, and that increases in health care costs and declining federal reimbursement through the transitional reinsurance program are major drivers of higher health insurance premiums. American Academy of Actuaries Issue Brief (June 2014) *available at* http://actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf .

Order

Based on the reasons discussed above, the Board modifies BCBSVT's 2015 Vermont Health Connect Rate Filing, and then approves the filing. Specifically, we order that BCBSVT (1) apply the HHS induced-utilization factors, rather than its own; (2) adjust the pricing AV by changes in the family tiering factor; (3) reduce the federal insurer fee to 2.74% of premium; and (4) use $45,000 as the attachment point to estimate federal transitional reinsurance recoveries.

As modified, the average annual rate increase is reduced from the proposed 9.8% to 7.7%.

So ordered.

Dated: September 2, 2014 at Montpelier, Vermont

s/ Alfred Gobeille)
)
s/ Karen Hein) GREEN MOUNTAIN
) CARE BOARD
s/ Cornelius Hogan) OF VERMONT
)
s/ Allan Ramsay)
)
s/ Betty Rambur)

Filed: September 2, 2014

Attest: s/ Janet Richard
Green Mountain Care Board, Administrative Services Coordinator

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (E-mail address: Janet.Richard@state.vt.us).
Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed with the Clerk of the Board within ten days of the date of this decision and order.