

STATE OF VERMONT  
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont	)	GMCB-008-15-rr
2016 Vermont Health Connect Rate Filing	)	
	)	
SERFF No. BCVT-130082559	)	
_____	)	

**DECISION & ORDER**  
**Introduction**

The Patient Protection and Affordable Care Act of 2010 (ACA) requires that health insurance exchanges—marketplaces where individuals, families and small businesses can shop for qualified health insurance coverage—be established in each state by January 2014. In Act 48 of 2011, Vermont’s seminal health care reform law, the Vermont legislature created this state’s exchange, Vermont Health Connect (VHC).

The Green Mountain Care Board, also created by Act 48, is the independent board tasked with ensuring that changes in the health system improve the quality and accessibility of health care while stabilizing its costs. Among its regulatory tasks,<sup>1</sup> the Board reviews major medical health insurance rates. The Board first reviewed rates offered on VHC in 2013 when Blue Cross and Blue Shield of Vermont (BCBSVT) and MVP Health Plan, Inc. (MVP) each filed proposed 2014 rates; accordingly, this is the third year that the Board has reviewed health insurance rates offered through the exchange.

In this filing, BCBSVT proposes an 8.6%<sup>2</sup> average annual rate increase for health plans offered on VHC with coverage beginning January 1, 2016. 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 in January 2014, the ACA requires that individuals and families have qualifying health insurance coverage or pay a penalty on their personal income tax returns.

---

<sup>1</sup> The Legislature assigned the Board three main responsibilities: regulation, innovation, and evaluation. In its regulatory role, the Board regulates health insurance rates, hospital budgets and major health care expenditures.

<sup>2</sup> As explained in the decision, BCBSVT originally filed for an 8.4% increase, and amended its filing to reflect an 8.6% increase on June 26, 2015. *See* Finding of Fact (Finding) ¶ 9.

Qualifying coverage includes coverage from an employer, health insurance purchased through the exchange, or government-sponsored coverage that meets federally mandated minimum levels of coverage.

2. Vermont Health Connect offers qualified health plans (QHPs) to individuals, families and small employers, with rates based on a single risk pool that includes the individual and small group markets. *See* 33 V.S.A. §§ 1803 (“Vermont Health Benefit Exchange”); 1811 (“Health benefit plans for individuals and small employers”). For plan years 2014 and 2015, a small employer was defined as employing up to 50 employees. Beginning in 2016, Section 1304(b) of the ACA expands the small employer definition to include employers with 51-100 employees.<sup>3</sup> *See also* 33 V.S.A. §1811 (a)(3)(B) (defines small employer to include up to 100 employees as of January 1, 2016).

3. Plans are offered to consumers in four “metal levels”: bronze, silver, gold and platinum. In addition to the metal level plans, catastrophic coverage is available primarily to persons under thirty years of age.<sup>4</sup>

4. In order to make health insurance plans offered on the exchange more 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”). In addition, Vermont caps the percentage of household income that eligible individuals and families pay for health insurance premiums and offers subsidies for lower deductibles<sup>5</sup> and copayments.<sup>6</sup>

5. The ACA requires that all exchange plans include ten categories of services, called “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

---

<sup>3</sup> Small employers with 51-100 employees may also choose to self-insure, particularly if their populations are young and healthy. *See* American Academy of Actuaries Issue Brief, *Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees* (March 2015) at 5-6, available at [http://www.actuary.org/files/Small\\_group\\_def\\_ib\\_030215.pdf](http://www.actuary.org/files/Small_group_def_ib_030215.pdf)

<sup>4</sup> Catastrophic coverage is characterized by low premiums and high deductibles. Individuals enrolled in catastrophic plans do not qualify for income-based subsidies.

<sup>5</sup> A deductible is the amount a patient pays for covered services before his or her health plan begins to pay.

<sup>6</sup> A copayment is a fixed amount a patient pays for a covered health care service, usually at the time the service is delivered.

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.

6. The ACA includes three risk spreading mechanisms intended to stabilize costs and provide incentives for insurers to participate in the exchanges. The transitional reinsurance program is funded through fees levied on health insurance plans and ends with the 2016 plan year. Under this temporary program, the federal government reimburses an insurer for a percentage of an individual's high cost claim that falls within specified parameters.

7. The risk corridors program, also ending in 2016, protects against pricing uncertainty by requiring insurers to calculate allowable costs and targets for each QHP based on a specific formula. If a plan earns a profit under the formula, the insurer must share it with the federal government; conversely, if a plan shows a loss, the federal government shares some of the loss.

8. The risk adjustment program applies to ACA-compliant plans in both the individual and small group markets. Under this program, plans with an enrolled population with lower than average actuarial risk will make payments to those plans that have an enrolled population with higher than average actuarial risks. The program is intended to protect against adverse selection among QHPs.

#### Procedural History

9. On May 15, 2015, BCBSVT filed its 2016 Vermont Health Connect Rate Filing with the Board through the System for Electronic Rate and Form Filing (SERFF). The SERFF filing outlines the development of proposed exchange rates for coverage commencing January 1, 2016. *See Exhibit 1;*<sup>7</sup> *available at* [http://ratereview.vermont.gov/sites/dfr/files/GMCB\\_008\\_15rr\\_SERFF\\_7\\_8\\_15.pdf](http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_SERFF_7_8_15.pdf). The initial SERFF filing showed a proposed rate increase of 8.4%; on June 26, 2015, BCBSVT amended the filing to request an 8.6% average rate increase to account for legislative changes to Vermont's Blueprint for Health.<sup>8</sup>

10. On May 27, 2015, the Office of Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of consumers of Vermont health care, entered a Notice of

---

<sup>7</sup> The exhibits referred to in this decision were either stipulated to by the parties or admitted into evidence upon motion at hearing.

<sup>8</sup> Pursuant to Vermont law, insurers are required to participate in the Blueprint for Health, Vermont's initiative to improve population health and control costs by promoting prevention and care coordination. 18 V.S.A. § 706 ("Health insurer participation"); § 703 ("Health prevention; chronic care management").

Appearance as an interested party to the proceeding. *See*

[http://ratereview.vermont.gov/sites/dfr/files/GMCB\\_008\\_15rr\\_HCA\\_NOA.pdf](http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_HCA_NOA.pdf).

11. On July 6, 2015, the Department of Financial Regulation (Department) issued an opinion and analysis of the impact of BCBSVT's rate filing on the company's solvency. The Department advised the Board that "downward adjustments to rate components should not be made unless GMCB's consulting actuary explicitly opines that the filed rates, without any modification, are excessive." Exhibit 15 at 3, *available at*

[http://ratereview.vermont.gov/sites/dfr/files/GMCB\\_008\\_15rr\\_Solvency\\_Analysis.pdf](http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_Solvency_Analysis.pdf).

12. Lewis & Ellis (L&E), the Board's contract actuary, conducted a review of the filing and issued an actuarial memorandum summarizing its analysis and recommendations. The memorandum was posted to the Board's website on July 15, 2015. *See* Exhibit 14; *available at*

[http://ratereview.vermont.gov/sites/dfr/files/GMCB\\_008\\_15rr\\_Actuarial\\_Memo.pdf](http://ratereview.vermont.gov/sites/dfr/files/GMCB_008_15rr_Actuarial_Memo.pdf).

13. The Board held a public administrative hearing on July 29, 2015. Judith Henkin served as hearing officer by designation of Board Chair Al Gobeille. Jacqueline Hughes, Esq. represented BCBSVT. BCBSVT's Chief Financial Officer (CFO) Ruth Greene and Actuarial Director Paul Schultz testified on the company's behalf. Lila Richardson, Esq. and Kaili Kuiper, Esq. appeared for the HCA and presented testimony of independent actuary Donna Novak, principal of NovaRest Actuarial Consulting. Ryan Chieffo, Assistant General Counsel for the Department, testified regarding the Department's solvency analysis. Mike Donofrio, General Counsel, represented the Board and conducted the examination of Jackie Lee, Vice President and consulting actuary for L&E, who testified about the firm's actuarial review of the filing and recommendations for modification.

14. The Board accepted public comments on the proposed rates from May 15, 2015 through July 29, 2015<sup>9</sup> and received 484 comments concerning both BCBSVT's and MVP's filings. 450 of the comments are based on a template provided to consumers by the Vermont Public Interest Research Group (VPIRG); many include personal statements along with the submissions. In addition to the 450 VPIRG comments, 19 of the remaining written comments specifically address BCBSVT's proposed rate increase, and seven comments were verbally submitted to the Board during the BCBSVT rate hearing. The comments overwhelmingly discuss

---

<sup>9</sup> Although the deadline for accepting comment expired on July 29, 2015, additional comments were received and reviewed by the Board subsequent to that date.

the issue of affordability for Vermonters and oppose any increase in premium rates. *See* Public Comments, *available at*

[http://ratereview.vermont.gov/sites/dfr/files/VPIRG\\_Rate\\_Comments\\_2015.pdf](http://ratereview.vermont.gov/sites/dfr/files/VPIRG_Rate_Comments_2015.pdf);

[http://ratereview.vermont.gov/sites/dfr/files/Public\\_Comment\\_2016\\_Exchange\\_Final.pdf](http://ratereview.vermont.gov/sites/dfr/files/Public_Comment_2016_Exchange_Final.pdf).

### **Findings of Fact**

#### **Nature of the Filing**

15. 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, BCBSVT has 40,864 policyholders and 67,050 covered lives in its Vermont Health Connect plans. Of the covered lives, 31,147 are individual policyholders and 35,903 are covered through small group plans.

16. BCBSVT offers consumers in the exchange both standard and non-standard 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, Blue Rewards and Blue Rewards CDHP, are carrier-specific but still must comply with all requirements for participation in the exchange.

17. Enrollment for the 2016 exchange plans begins in November 2015 for coverage beginning on January 1, 2016.

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

18. BCBSVT developed its 2016 VHC rates based on claims incurred by its individual, small group and QHP membership, and by members enrolled in small group products offered by The Vermont Health Plan (TVHP)<sup>10</sup> for an experience period from January 1, 2014 through December 31, 2014, and paid through February 28, 2015. Exhibit 1 (Actuarial Memorandum) at 6-7.

19. BCBSVT adjusted its rate projection to account for the expansion of small groups to include employers with 51-100 employees. BCBSVT assumed that slightly less than half of such groups will realize lower premiums and enter the exchange; of the remaining, it assumed that none would purchase exchange plans. *Id.* at 17-18. At hearing, BCBSVT's actuary explained the rationale for the latter assumption, citing the "well developed marketplace in Vermont for self-

---

<sup>10</sup> TVHP is a fully owned subsidiary of BCBSVT.

funded groups of smaller size,” the possibility that brokers will steer the groups to the captive insurance market, and the likelihood that many of these small groups will postpone their decisions by choosing an earlier plan renewal date, allowing them to retain their current plans until late in 2016. Transcript (TR) at 82-83.

20. BCBSVT projected the experience period claims forward to the rating period using an allowed medical trend<sup>11</sup> factor of 7.4% and pharmacy trend of 6.5%. The medical trend comprised a 2.0% utilization factor and a 5.3% unit cost trend. Exhibit 1 (Actuarial Memorandum) at 14-22. Following discussions with L&E, BCBSVT agreed to reduce its unit cost trend to 5.1%, reducing the overall medical trend to 7.2%. According to L&E, the most likely actual trend centers around its best estimate and ranges from 7.1% to 7.3%. Exhibit 14 at 4; *id.* at n 5.

21. BCBSVT’s proposed rates include an administrative load of \$28.40 PMPM, equaling 6.4% of total premium. Salary and benefits comprise 74.9% of the administrative load. Exhibit 1 (Actuarial Memorandum) at 28-29.

22. The proposed rates also include a 2.0% contribution to reserves (CTR).<sup>12</sup> BCBSVT contends that a 2.0% CTR is needed in case of regulatory action that impacts surplus, membership growth that creates a need for additional Risk Based Capital (RBC),<sup>13</sup> or an unexpected adverse event such as a flu epidemic. *Id.* at 30-31.

23. On review of the filing, L&E recommends four modifications. First, it recommends that the carrier reduce the total allowed medical trend from 7.4% to 7.2%, the midpoint of L&E’s “best estimate” range of 7.1% to 7.3. *See* Finding ¶ 20. Second, L&E recommends that BCBSVT reduce its administrative costs by 0.1% to reflect an increase in membership. Third, L&E recommends that the carrier recalculate its federal risk adjustment to account for a \$2.7M

---

<sup>11</sup> 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.

<sup>12</sup> Though often used interchangeably, “reserves” are costs that a health care insurer estimates it will be obligated to pay for services that its members will use during the course of coverage. In contrast, “surplus” (retained earnings) consists of funds that are not allocated to pay for known liabilities. Instead, surplus may be used to cover unexpectedly high claims costs or unforeseen adverse occurrences such as a flu pandemic. *See, e.g.,* Report by the Department of Financial Regulation, *When a Health Insurer Ceases Business in Vermont*, (July 15, 2014) at 16-20 (distinguishes reserves from surplus), *available at* [http://www.dfr.vermont.gov/sites/default/files/Act%20144%20DFR%20Surplus%20Report\\_0.pdf](http://www.dfr.vermont.gov/sites/default/files/Act%20144%20DFR%20Surplus%20Report_0.pdf) .For purposes of our decision, we employ the terminology as used by the carrier.

<sup>13</sup> Risk-Based Capital is a method of measuring the capital required by an insurer to support its overall business operations in consideration of its size and risk profile.

payment to BCBSVT from MVP. Last, L&E recommends that BCBSVT modify the insurer fee calculation, as proposed by the carrier. L&E calculates that the cumulative effect of the modifications would reduce the proposed annual rate increase from 8.6% to 7.3%. Exhibit 14 at 10. In addition, L&E opines that the requested 2.0% CTR is reasonable. *Id.* at 9.

24. BCBSVT agrees to each of the recommended modifications, and calculates that the rates will decrease from 8.6% to 7.2%. BCBSVT Post Hearing Memorandum of Law (BCBSVT Memo) at 1; *see also* TR at 134-135 (Jackie Lee explains that BCBSVT's calculation is more precise than L&E's).

25. The HCA's independent actuary, Donna Novak, agrees with each of L&E's recommendations and proposes two additional modifications to the filing. First, Novak disputes BCBSVT's assumption that none of the small employers with 51-100 employees that do not realize a decrease in premiums will migrate to the exchange. Novak assumes that half of these employers will choose to enter the exchange, producing a 0.25% decrease in rates. Exhibit 16 at 8.

26. Second, Novak proposes that BCBSVT reduce the CTR, characterizing the carrier's solvency as "strong" and improving. *Id.* at 9. Although she does not recommend a specific decrease in her report, Novak testified that reducing the CTR to 1.52% could maintain the carrier's current level of solvency, and that if the CTR were eliminated entirely, BCBSVT would remain in its target RBC range. TR at 150-152; 156.

27. BCBSVT's witnesses each testified about the company's need for adequate surplus and reserves. Noting that BCBSVT has realized negative CTR of -0.4% over the past four years, BCBSVT's actuary testified that "reserves are a consumer protection" and that maintaining adequate reserves allows the company to continue to pay claims in the event of a significant adverse event. *Id.* at 84-87.

28. CFO Greene testified that the company's target range for RBC is between 500% and 700%, and that its "surplus and member reserves is hovering sometimes modestly above and sometimes below the midpoint of the target range." *Id.* at 16, 27.

29. Assistant General Counsel Chieffo discussed the Department's role in monitoring insurer solvency and the difficulty of projecting future solvency from a fixed point in the past. Chieffo testified that the Department's opinion that a 2.0% CTR is appropriate and necessary in

this filing had not changed, despite BCBSVT's agreement to modifications reducing the rate to 7.2%. *Id.* at 112-116.

30. Both witnesses for BCBSVT were questioned by Board members about the impact of the hospital budget process on the carrier's medical trend. After commenting that the rate review and hospital budget processes are "out of sync," Chair Gobeille asked CFO Greene about the importance of knowing the "commercial ask"<sup>14</sup> when determining BCBSVT's medical trend. Greene acknowledged that it is "very important," but due to timing of the respective processes, BCBSVT does not know what the projected hospital increases will be when it develops its rates. For the 2016 VHC filing, BCBSVT incorporated last year's actual hospital budget results into its rate projections. *Id.* at 53.

31. In response to questions from Board member Ramsay, BCBSVT's actuary suggested that the carrier's medical trend would have been lower had it known, at the time it was developing its 2016 VHC rates, the projected rate of increase in the recently submitted hospital budgets. *Id.* at 105 (a projected 4.3% median increase for hospital budgets "would have been great to know at the time.")

32. At the end of the hearing, the Board took comments from members of the public. Several speakers covered by BCBSVT plans through VHC underscored the impact of the rising costs of health insurance on their families and their household budgets. *Id.* at 160-175. One consumer told the Board that her family currently pays approximately \$20,000 annually for coverage through a BCBSVT gold plan, and that the percentage of her family income to pay for coverage will rise from 20% to 25% if the proposed rates are approved. *Id.* at 163.

### **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).

---

<sup>14</sup> The term "commercial ask" refers to the increase in rates that hospitals negotiate with commercial payers.

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. **BCBSVT Must Reduce its Medical Trend from 7.2% to 7.1%, the Low End of Probable Trend Factors, Because its Unit Cost Trend is Likely Overstated.**

We first address BCBSVT’s requested medical trend. Although the carrier reduced its initially-filed trend downward—its requested 7.4% trend was “unintentionally inflated due to methodology used,” *see* Exhibit 14 at 4—the resulting unit cost component does not account for recent hospital budget submissions, and therefore likely remains overstated.

Our questions at hearing, and the responses from BCBSVT, highlight the need to work towards alignment of the hospital budget and exchange rate review processes. Currently, the carriers cannot incorporate into their rate projections information garnered during the hospital budget process. At this point in time, however—well beyond the filing date for VHC rates—we reasonably expect that hospitals, as a group, will not raise the prices they charge their commercial payers as much as they have in the past, and know that this factor is not reflected in the proposed rates. Indeed, both witnesses for BCBSVT acknowledge that the hospital budget information is important and ideally should be reflected in the carrier’s projected medical trend. Findings ¶¶ 31, 32.

In addition, on review of this filing, neither the Board nor our actuary has a mechanism by which we can readily incorporate current hospital budget projections into the carrier’s proposed medical trend. It is not a one-to-one mapping; BCBSVT’s medical unit cost increase includes services in addition to those provided by the hospitals. We therefore acknowledge that our actuary’s recommended medical trend may be slightly overstated. Nonetheless, L&E calculated a recommended trend of 7.2% based on its extensive review of information and data provided by BCBSVT during the course of this filing, and based on its review, advises the Board that the highest probability of actual trend ranges from 7.1% to 7.3%. Finding ¶ 20. Accordingly,

we choose the lowest point within the range—7.1%—which further reduces the medical trend and produces more affordable rates for consumers.

This modification reduces the requested rate by 0.2 %.

II. BCBSVT's CTR Must be Reduced from 2.0% to 1.0%, Allowing the Carrier to Realize Growth in Surplus While Providing Lower Rates for Vermonters.

BCBSVT requests a 2.0% CTR for this filing. The Department has voiced its support of the requested CTR,<sup>15</sup> and L&E has stated that the request is reasonable. The HCA opposes the request, opining that BCBSVT's solvency won't be markedly impacted by a reduction to CTR. For the following reasons, we agree and reduce the requested CTR to 1.0%.

The testimony at hearing from BCBSVT, coupled with our continuing assessments of BCBSVT's financial condition, indicates that the company's RBC is stable and falls in the middle of its target range. Finding ¶ 28. While we recognize that adequate surplus is needed as a cushion against unforeseen adverse events, we find that a 1.0% contribution in this filing allows the carrier to add to its surplus, albeit by a smaller amount than requested.

In addition, we again express our concern that notwithstanding our decision to nominally reduce the medical trend, BCBSVT's trend and therefore its overall rates likely remain overstated; L&E's recommendation, from which we derived the trend value we approve today, was similarly made without the benefit of current hospital budget projections. *See* Section I, above. Adding to our concern, we find the HCA's contention that some portion of the expanded small group market will enter the exchange—despite higher premiums—to be credible, although we find no empirical evidence to conclude that half of such groups will do so. Rather, we find it reasonable to assume that some percentage of this population will migrate—more than BCBSVT's 0% assumption—and that as a result, BCBSVT's rate request is likely overstated. Based on the HCA's assertion that half of such groups migrating to the exchange reduces the rates by 0.25%, however, we expect that the actual impact on the rates will be minimal.

Accordingly, we conclude that reducing the CTR from 2.0% to 1.0% adequately protects BCBSVT's solvency and therefore its continued ability to provide health insurance coverage to Vermonters, offsets the rate impact of a likely overstated medical trend, and produces more affordable rates for consumers purchasing through VHC.

---

<sup>15</sup> The Department has supported each of the company's surplus requests since the Board began its expanded review of rate filings on January 1, 2014.

This modification reduces the requested rate by 1.1%.

**Conclusion**

The Legislature has charged this Board with ensuring that all Vermonters gain access to affordable, quality health care. Exerting downward pressure on health insurance rates, while remaining mindful of our obligation to protect insurer solvency, is one of the ways that we continue to move closer to achieving that goal. As a result of our decision today, BCBSVT’s average annual 2016 Vermont Health Connect rate increase is reduced from 8.6% to 5.9%.

**Order**

Based on the reasons discussed above, the Board modifies and then approves BCBSVT’s 2016 Vermont Health Connect Rate Filing. Specifically, we order that BCBSVT: (1) reduce its administrative costs by 0.1% to account for an increase in membership; (2) recalculate the federal risk adjustment to account for a \$2.7M payment to BCBSVT from MVP; (3) modify the insurer fee as proposed and agreed to by the carrier during review of the filing; (4) reduce the allowed medical trend to 7.1%; and (5) reduce the CTR from 2.0% to 1.0%.

As modified, the average annual rate increase is reduced from the proposed 8.6% to 5.9%.

**So ordered.**

Dated: August 13, 2015 at Montpelier, Vermont

s/ Alfred Gobeille )  
 )  
s/ Cornelius Hogan )  
 )  
s/ Jessica Holmes )  
 )  
s/ Betty Rambur )

GREEN MOUNTAIN  
CARE BOARD  
OF VERMONT

*\* Board Member Allan Ramsay has filed a separate dissent to this decision, which is attached.*

Filed: August 13, 2015

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@vermont.gov](mailto:Janet.Richard@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 with the Clerk of the Board within ten days of the date of this decision and order.*

**Ramsay, dissenting:**

For the following reasons, I do not agree with the majority's decision in this rate filing.

Health insurance plans offered on Vermont Health Connect (VHC) must be affordable for Vermonters. In addition, they must promote access to health care, promote quality, protect insurer solvency, and be fair. Rate increases that are excessive have a profound financial effect on Vermonters and their families, and limit access to high quality health care.

The Board's decision for VHC plans commencing in 2015 allowed BCBSVT to increase its rate by 7.7%. For 2016 plans, the Board is increasing BCBSVT rates for VHC products by close to 6.0%. I do not believe this large two-year increase is affordable; nor does it align with rising cost increases in other sectors of our economy. I also do not believe that a smaller rate increase for 2016 than the one now approved by the Board will threaten the solvency of the company, as outlined below.

I.

When developing the unit cost increase for determining its 2016 VHC medical trend, BCBSVT assumes providers within the BCBSVT service area will experience budget increases similar to the 5.9% hospital budget increase implemented for FY 2015. Based on that assumption, BCBSVT utilizes a 5.3% unit cost trend. In its 2015 VHC rate filing, however, BCBSVT utilized a lower unit cost trend of 4.4%. *See* BCBSVT 2015 VHC Rate Filing, GMCB-18-14rr at 6, ¶ 21, *available at* <http://ratereview.vermont.gov/sites/dfr/files/GMCB%20018-14rr.pdf>. Given that hospital budget rate increases for 2016 are projected at 4.3%—significantly lower than the 5.9% implemented for FY 2015—it is likely that BCBSVT's unit cost trend will also be lower than the 4.4% trend used in its 2015 rates. BCBSVT could not have known when it developed its proposed 2016 rates that the aggregate hospital rate increase would be lower than the prior year's; nonetheless, as BCBSVT's actuary testified at hearing, had it known, it may have used a lower unit cost trend in its calculations.

After review of BCBSVT filing, including a series of requests for additional information and responses from the carrier, Lewis & Ellis (L&E) estimated the range of actual allowed medical trend would be 4.5% to 10.0%. The wide range is due to random fluctuations and

unpredictable changes in the use of medical services. L&E determined the mid-range for medical trend would be 7.1% to 7.3%, and chose 7.2% as its “best estimate” which is 50% more likely to occur than the trends at either end of the range. L&E performed these calculations, as had BCBSVT, without knowing that the hospital rate increase would be lower for FY 2016 than in FY 2015. I therefore believe that a 4.3% unit cost trend—the estimated aggregate hospital rate increase for 2016—more closely reflects the unit cost trend than does L&E’s recommended medical trend as a result of the information contained in the recent hospital budget submissions.

In addition, BCBSVT originally proposed a higher medical trend of 7.4% and agreed with L&E that the error was due to a “flawed methodology.” Given the expected rate increase request of the Vermont hospital system and uncertain methodology employed by BCBSVT to calculate medical trend, I believe a 4.3% unit cost trend is most appropriate, reducing the overall medical trend to 6.4%.

## II.

During the hearing, BCBSVT was asked about its strategic vision for moderating the growth in health care costs. The Board has a responsibility for assuring that all those who pay for or provide health care in Vermont work toward the common goal of an affordable, high quality, and accessible health care system. Every commercial insurer in Vermont should be focused on investing in programs, such as primary care, that are likely to moderate the increase in health care costs, as well as work diligently to reduce the administrative costs in the system. BCBSVT described several important efforts to control rising administrative costs; *see* Exhibit 8 at 3; even with these efforts, the administrative costs in this filing rose from \$25.78 PMPM to \$28.43 PMPM, a 10.3% increase.

## III.

BCBSVT has requested a 2.0% increase in contribution to its reserve fund. Both BCBSVT witnesses testified that this increase would protect the company from unusual events that could threaten its solvency. These events included regulatory actions, epidemics or unusual events, membership growth, or new technologies. First, as a member of the regulatory Board, I fully understand the importance of maintaining the solvency of all commercial health insurers in Vermont. Second, as a physician with 34 years of practice experience in Vermont, I have not experienced an epidemic that could threaten the solvency of a health insurance plan. Third, though employers with 51-100 employees will be eligible for Vermont Health Connect in 2016,

BCBSVT did not calculate this rate filing with any expected increase in enrollees from this risk pool, unless they expect a savings in premium. If it had projected that any of these groups would enter the exchange, the rates would likely have been lower. Last, the only new technologies that BCBSVT describes as a threat to its solvency are the specialty drugs, including PCSK9 inhibitors and hepatitis C therapies. The Board and L&E agreed the proposed pharmacy trend increase of 6.5% is reasonable and appropriate and allows for the possible effects of specialty drug costs.

BCBSVT has accumulated a significant reserve fund over the past five years. In addition, the company has maintained its risk based capital (RBC) within a range that demonstrates its solvency. For these reasons I believe a reduction in the contribution to reserves from 2.0% to 1.0% is appropriate.

Adjusting the unit cost trend to 4.3% and reducing the contribution to reserve to 1.0% will reduce the overall rate increase to approximately 4.7%.

This year the Board received over 450 public comments relating to the rate increases proposed by MVP and BCBSVT. This is many more than we received last year. Similar to last year, the majority of the comments are based on a template provided to consumers by the Vermont Public Interest Research Group (VPIRG). In comparison, however, last year only 15% of the Vermonters who used the VPIRG template added a personal comment; this year over 40% took the time to add a personal note or story to the submission. Virtually all the comments focus on the fact that the rate increases and out-of-pocket costs of Vermont Health Connect are not affordable. Only a few mention specific issues of quality or plan benefit design.

The Board must rely on fact, opinion, and analysis when approving a rate increase. The most important opinion is that of Vermonters, who believe continued large rate increases in Vermont Health Connect are not affordable.

For these reasons, I respectfully dissent.

s/ Allan Ramsay