STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2020 Association Health Plan Rating Program Filing	)))	GMCB-004-19rr

MEMORANDUM IN LIEU OF HEARING

Blue Cross and Blue Shield of Vermont (BCBSVT) requests the Green Mountain Care Board (GMCB) approve the filing reflected in the Blue Cross and Blue Shield 2020 Association Health Plan Rating Program Filing Actuarial Memo, (BCBSVT Memo), with the modification as recommended by the Board's independent expert Lewis and Ellis (L&E).[1]

This filing provides the formula, manual rate and factors that will be used to determine the rates of experience-rated fully-insured association health plans (AHPs). The factors in the filing are medical and pharmacy trends, benefit relativities, administrative costs, federal fees, contribution to reserves, and large claim factors that will be applied to association health plan rates for the period covered by the filing. The actual rate impact for any particular association health plan will be driven by the claims experience in the period used to develop rates, premium currently in force, and underwriting judgment and management discretion applied to the case.

[1] See L&E Memo at p. 9, recommending that the non-specialty unit cost trend change from 3.5% to 0.0%. This is a typographical error – it is the generic unit cost trend that should be adjusted from 3.5% to 0.0%, to which BCBSVT has agreed. *See* BCBSVT Response to L&E March 13, 2019 Questions re: 2020 Association Health Plan Filing, Q. 8, p. 4.

ARGUMENT

I. Despite the current uncertainty surrounding "new" association health plans, bona fide association health plans will continue to be legal in 2020.

At this time, the legal status of the newly formed AHPs remains unclear. While BCBSVT recognizes the Department of Financial Regulation (DFR) has halted the current marketing of these plans and may ultimately permanently disallow the sale of the current AHP plans, we requests that the Green Mountain Care Board (the Board) approve this formula and factor filing because some AHPs remain legal in 2020.

The United States District Court for the District of Columbia recently held that the United States Department of Labor (DOL) newly promulgated association health plan rule[2] was inconsistent with the Employee Retirement Income Security Act of 1974 (ERISA). *State of New York v. United States Department of Labor,* 18-1747 (JDB), (D.D.C. 2019). On April 29, 2019, the DOL issued a statement indicating that Department of Justice had filed an appeal of the decision and the DOL will not pursue enforcement actions against parties for potential violations taken in reliance on the DOL rule.[3]

However, even if the district court's invalidation of the DOL rule is not overturned on appeal, the association health plan market is not eliminated. Before the new rule, pursuant to statutory language in ERISA, "bona fide" associations made up of small groups can operate as a single large group employer for the purposes of offering a group health plan. *State of New York v. United States Department of Labor,* 18-1747 (JDB), (D.D.C. 2019), pages 6-7. Thus, even if ultimately Vermont requires fully insured small group health plans currently participating in the

[2] Definition of "Employer" Under Section 3(5) or ERISA – Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018).
[3] See: https://www.dol.gov/newsroom/releases/ebsa/ebsa20190429 (accessed April 29, 2019).

"new" AHP market to participate in the combined risk pool and the new federal regulation is invalidated, this formula and factor filing would still apply to "bona fide" association health plans under former DOL guidance that would remain intact.

The lack of clarity with respect to AHPs is appropriately handled by DFR. On April 23, 2019, DFR issued Insurance Bulletin No. 204 indicating that while the outcome of the litigation remains unclear, DFR will not allow the enrollment of new groups into the current AHP market.[4] Thus, DFR is managing the legal landscape, and it is anticipated that before the beginning of the 2020 plan year, DFR will have made a final decision on what is permissible in the Vermont market. As of the date of the Memorandum, it appears the Vermont Legislature will take a similar approach to existing AHPs. While it's possible that the new AHP market will be definitively prohibited by law for 2020, the failure to have an AHP rating mechanism established timely in the event the market is permitted to continue to exist is unduly burdensome. Further, as noted above, even if the new rule remains invalidated, "bona fide" association health plans under prior DOL guidance are still permitted.

II. Approving this filing is the most operationally efficient solution for managing the uncertainty surrounding the AHP market.

The bulk of the filing work (done by the actuaries) has been completed. To require all such work to be re-done or re-examined after the legal questions are resolved would require all parties to perform a new analysis or at least refresh their understanding and assessment of the existing analysis, is inefficient and increases costs for the entire system. Furthermore, as this is a formula and factor filing, the filing does not establish rates, but the parameters of how rating will

[4] See https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-bulletin-insurance-204-ahp-ruling.pdf (accessed April 29, 2019).

be produced if or when there is legal clarity. Therefore, the rating will be adjusted in accordance with the formula and factors established in the filing to recognize any structural changes to the market. In other words, there is no new knowledge about market structure that will cause the filing, which applies to both "new" and bona fide associations under former DOL guidance, to be changed. BCBSVT expressly acknowledges the current AHP market may be unable to avail itself of this filing if existing AHPs are no longer available to small Vermont businesses. However, at this stage it will be more efficient to make a decision on the filing record, both to potentially serve the existing AHP market and to serve as a resource for any bona fide AHPs that may be available in the future.

III. This filing satisfies all of the actuarial criteria.

BCBSVT herein incorporates by reference all arguments made in the May 8, 2019 Memorandum in Lieu of Hearing for 3Q 2019 Large Group Rating Program Filing (SERFF #BCVT-131835151). These arguments are repeated below, with the updated references to the record.

L&E has recommended that the GMCB approve this filing with a single modification.[5] (L&E Actuarial Memorandum dated April 22, 2019, hereinafter "L&E Memo".) L&E concludes that each factor in this filing is reasonable. Specifically:

- L&E noted the filed medical trend is reasonable (L&E Memo, p. 7);
- L&E found the pharmacy trend, as modified, is reasonable (L&E Memo, p. 8);

[5] L&E noted that the generic cost trend as originally calculated could result in some drugs "going generic" to be double counted. BCBSVT agreed with this suggested modification. *See* BCBSVT Response to L&E March 13, 2019 Questions re: 2020 Association Health Plan Filing, Q. 8, p. 4.

- L&E found BCBSVT administrative costs are reasonable and appropriate (L&E Memo, p. 9);
- L&E found federal fees are reasonable and appropriate (L&E Memo, p. 9);
- L&E opined that the filed contribution to reserves is reasonable and appropriate (L&E Memo, p. 9); and
- L&E found that the filed manual rate is reasonable. (L&E Memo, p.6.)

In fact, L&E notes that the medical trend may even be understated. L&E writes: "(w)e note that BCBSVT could plausibly have assumed a higher number based on historical experience alone." (L&E Memo, p. 7.) L&E concludes its review by stating; "L&E believes that this filing, modified to address the errors referenced above, does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing with the modifications described below..."[6] (L&E Memo, p. 9.)

Thus, from an actuarial perspective, this filing is actuarially sound and reasonable and should be approved as modified.

The Department of Financial Regulation's Solvency Impact of "2020 AHP Filing (SERFF # BCVT-131835459)" of Blue Cross Blue Shield of Vermont of April 19, 2019 ("DFR Opinion") concludes that the range of surplus targeted by BCBSVT is reasonable and necessary for the protection of its members and that BCBSVT is below the range determined to be necessary. (DFR Opinion, p. 2.) DFR further cautions "there is significant risk that BCBSVT's surplus will further erode" unless rates are adequate and "set at a level that maintains adequate surplus." (DFR Opinion, p. 2.)

[6] Again, this modification refers to the reduction in the generic pharmacy trend, as noted above.

DFR notes that that BCBSVT's risk based capital has been in decline since 2014 and "is at its lowest point since the establishment of the" GMCB. (DFR Opinion, p.1.) In reviewing this filing, DFR determined that downward adjustments to rating components in this filing that are not actuarially justified will "negatively impact [BCBSVT's] financial position and ultimately its solvency." (DFR Opinion, p. 1.) Additionally, due to the volatile nature of the federal health care policy, DFR emphasizes that there is an elevated risk of solvency concerns. (DFR Opinion, at 1.)

DFR actively monitors BCBSVT's surplus and solvency, as well as potential threats to surplus and solvency, using all available tools. (DFR Opinion, p. 2.) In establishing Vermont's rate review process, the General Assembly explicitly recognized DFR's vital role in supervising the solvency of BCBSVT. DFR examines and monitors BCBSVT for the protection of the insurance buying public who ultimately will be adversely affected by inadequate rates. To this end, the GMCB's rate determination "shall" consider the analysis and opinion of DFR. 8 V.S.A. § 4062(a)(3). Nothing in the DFR analysis and opinion, which the GMCB is required to consider, indicates that a non-actuarially justified rate reduction should be allowed.

In the context of DFR's statutory obligations, and that of the GMCB to take into account insurer solvency, it is important to note that DFR cautions: "any downward adjustment to the filing's rate components that are not actuarially supported will further reduce BCBSVT's surplus and will negatively impact its solvency over time, thus impacting access to health insurance in Vermont." (DFR Opinion, p. 4.) DFR further cautions that RBC has fallen below target range,[7]

[7] Note that this is true irrespective of whether one considers the old RBC range of 500-700% or the new RBC range referred to in footnote 2 of the DFR Opinion.

"and any departure from the filed rate that is not actuarially justified should be made with great caution." (DFR Opinion, p. 4.)

As noted above, with a minor modification, this filing is wholly actuarially justified. Reductions to the filing components would produce unreasonable solvency risk. Thus, the GMCB must approve the filing.

On review, the Board must determine whether the proposed rate is affordable, promotes quality care,[8] promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading or contrary to law, and is not excessive, inadequate, or unfairly discriminatory. GMCB Rule 2.000, § 2.401.

Some of these rate review criteria must be balanced against each other because they cannot all be maximized at once. This is true of traditional actuarial standards that rates not be "excessive" or "inadequate." These two factors must be balanced with each other, to ensure the best possible rate. Similarly, promoting "access to health care" often comes at the expense of compromised "affordability." On the other hand, "protection of insurer solvency," which is among the review criteria, is demonstrably *not* in conflict with affordability. BCBSVT maintains reserves for the benefit of its current and future members. DFR notes: "A sufficient surplus is crucial to an insurer's solvency." (DFR Opinion, p. 2.) When rates that are not excessive are reduced, the shortfall must be paid from policyholder reserves.

Much like solvency, affordability must be reviewed from a long-term perspective. Because policyholder reserves are held for the direct benefit of current and future members, any

[8] The NCQA, an organization that measures health care quality, has consistently found BCBSVT to be a high performing plan under its HEDIS measures. *See* http://healthinsuranceratings.ncqa.org/2018/Default.aspx (accessed May 7, 2019).

reductions of reserves to fund additional affordability in the short term must ultimately be replenished by future policyholders in order to maintain an adequate level of solvency. Rate reductions solely in the name of affordability are therefore temporary and do not promote long-term affordability; rather, such rate reductions simply shift costs from current policyholders to future policyholders while threatening "access to care" and "quality care" by threatening insurer solvency. BCBSVT's ability to promote quality care, promote access to health care, and maintain an adequate surplus are necessitated by charging premiums that are adequate to cover expected costs.

DFR notes: "Over the long term, charging inadequate premium rates can result in assets that are too low and liabilities that are too high, which presents a material and direct threat to the solvency of the insurer." (DFR Opinion, p. 2.) As noted above, BCBSVT has fallen below its target RBC range. The rating factors filed are adequate and not excessive; therefore, any reductions would produce inadequate rates, which would further erode necessary reserves, further compromise insurer solvency, and fail to promote long term affordability.

In a recent memorandum filed in conjunction with a different rate request, the Health Care Advocate opined: "The proposed rate does not promote access to care because it includes an excessive profit margin which diminishes premium affordability."[9] As noted by the Board's independent expert, L&E, the components of this filing, as well as the filing as a whole, have been found to be reasonable and not excessive. As the filing is not comprised of any excessive rate components, it promotes affordability to the greatest extent possible without compromising access to care.

[9] Office of the Health Care Advocate Memorandum In Lieu Of Hearing, Cigna Health and Life Insurance Company – Large Group Filing, GMCB-001-19rr, p. 5.

The BCBSVT actuarial memorandum also provides a Medical Loss Ratio (MLR) projection of 89.3. (BCBSVT Memo, p. 29.) As this filing covers the insured large group market, BCBSVT is subject to a minimum MLR requirement of 85 percent. 45 C.F.R. § 158.210(a). Said differently, federal rules establish that a rate producing non-claim items of greater than 15 percent is unaffordable, and refunds must be distributed to policyholders. The anticipated MLR are in excess of the MLR requirement. This reflects that premiums are projected to cover a greater percentage medical care and health care quality improvement than required, which further supports a finding that the filed rating factors produce affordable rates.

BCBSVT has fully justified the rate factors before the Board as evidenced by the recommendations of Board's own actuarial consultant and the Department of Financial Regulation's solvency opinion. Therefore, the Board must approve the filing, after amending in accordance with the modification recommended by L&E.

Dated at Berlin, Vermont this 20th day of May, 2019.

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CERTIFICATION OF SERVICE

I, Rebecca Heintz, hereby certify that I have served the above MEMORANDUM IN LIEU OF HEARING on Amerin Aborjaily, Green Mountain Care Board Staff Attorney; Thomas Crompton, Green Mountain Care Board Health Systems Finance Associate Director; Christina McLaughlin, Green Mountain Care Board Health Policy Analyst; Michael Barber, Green Mountain Care Board General Counsel; Kaili Kuiper and Eric Schultheis, Office of Health Care Advocate in the above-captioned matter, by electronic mail, return receipt requested, this 20th day of May, 2019.

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