STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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| In re: Blue Cross and Blue Shield of Vermont<br>2020 Association Health Plan Filing | )<br>)<br>) | GMCB-004-19-rr |

**BCBSVT REPLY TO HCA MEMORANDUM IN LIEU OF HEARING**

Blue Cross and Blue Shield of Vermont (BCBSVT) submits this Reply Memorandum in response to the Office of the Health Care Advocate's (OHCA) Memorandum in Lieu of Hearing submitted in the above captioned matter.

**ARGUMENT**

**I. The association health plan market will still exist irrespective of the status of the new federal regulation or the actions of the Vermont Department of Financial Regulation.**

For the most part, the OHCA accurately describes the legal framework and challenges associated with the "new" association health plan market. Since the filing of the HCA Memorandum, H.524 has passed the House and Senate and awaits the Governor's signature; H.524 now includes a grandfathering provision relating to existing AHPs, allowing no new association enrollment, but continued coverage for existing members (and their new employees).

However, OHCA incorrectly asserts that due to the invalidation of the DOL rule AHPs "that were formed under the new rule no longer qualify as ERISA plans and must comply with ACA requirements for individuals and small groups." (OCHA Memo, p. 2.) Note, ERISA and the Patient Protection and Affordable Care Act (ACA) are both applicable to association health

plans, before and after the district court ruling. The issue is whether such AHPs formed under the invalidated DOL rule are subject to small group or large group market rules. Most small group health plans have always been, and are still, subject to ERISA.[1] Additionally, in Vermont, association health plans are generally subject to the consumer protections provided to small groups under the ACA. See DFR Rule I-2018-01, §§ 7 and 8.

As noted in BCBSVT's Memorandum in Lieu of Hearing, irrespective of the status of the AHPs that were created under the June 21, 2018 U.S. Department of Labor (DOL) rule,[2] bona fide associations, even with small group members, that satisfy certain (more stringent) criteria will still be allowed to offer health plans to their members as if they were a single large employer.[3] In fact, irrespective of what occurs with the newly formed associations, the Department of Financial Regulation's (DFR) activity relating to the association health plan market has introduced valuable consumer protections that did not exist previously.

## II. The association health plan market is not less expensive because only healthy groups participate, but rather because overall the small group market subsidizes the individual market.

The combined risk pool requires that both policyholders purchasing insurance through small employers and those purchasing insurance in the individual market are in one risk pool. Although some argue a larger risk pool reduces volatility,[4] OHCA appears to support the combined risk pool because the small group market members subsidize the individual market

[1] Contrary to common understanding, this is true regardless of whether the group is fully insured or self-funded. ERISA regulates employee welfare benefit plans for virtually all private sector employers.
[2] Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018).
[3] For a discussion of long-standing DOL policy regarding bona fide associations, see Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans (proposed rule), 83 Fed. Reg. 614 (January 5, 2018) at pages 616-617.
[4] BCBSVT disputes the assertion that the small group and individual market risk pools are not large enough to independently smooth out rate volatility.

members to the benefit of the individual market, albeit to the detriment of the small group members.[5] Specifically, OHCA notes that this subsidization supports Vermont's efforts to "fairly distribute the cost of health insurance among Vermonters." (OHCA Memo, p. 4.) OHCA incorrectly assumes that the AHP market attracts healthy groups, but the reality is that neither BCBSVT nor the associations themselves were permitted to deny membership based on health status. (DFR Rule I-2019-1, § 9.) Any rate differential is purely due to the removal of the subsidization of individual market premiums. BCBSVT leaves to other forums the policy question about whether it is best for the system as a whole to mandate that small group members bear this burden, but we do note that the primary beneficiary of this policy choice is the federal government, which pays reduced tax credits on artificially reduced individual market premiums.

To further coerce continued subsidization, OHCA requests that the contribution to reserve (CTR) factor in this filing be increased to its maximum allowable amount "in order to increase equity and fairness * * *." (OHCA Memo, p.4, fn. 19.) As BCBSVT has explained in other filings, CTR should be managed to an adequate long-term level to maintain sufficient risk based capital to protect policyholders. Actual CTR will naturally fluctuate with actual claims experience; applying a consistent factor allows for the most likely successful maintenance of reserves and the avoidance of rate shock.

BCBSVT also chooses to file consistent CTR across product lines. Many insurers file higher CTR for products with more inherent risk. For instance, the dynamic regulatory environment means that the individual and small group market is riskier than many other market segments. However, BCBSVT considers it to be more equitable to all Vermonters to use the

[5] The Office of the Health Care Advocate represents all Vermonters, not just those insured through the individual market. 18 V.S.A. § 9603.

same CTR target across filings. Advocating for an excessive rate for the AHP market, as OHCA appears to do, undermines these important financial safeguards and would appear to violate the applicable statutory criteria.

## III. "New" association health plans are not the cause of rising health care costs; AHPs are a symptom of the pressing need for health care system reform.

Although not necessarily germane to the legal issues associated with this filing, OCHA asserts that association health plans formed under the new DOL rule is "bad policy." (OHCA Memo, p. 4.) Specifically, OHCA notes that allowing small groups to move out of the combined risk pool "undermines Vermont's efforts to bend the cost curve and fairly distribute the cost of health insurance among Vermonters." (OHCA Memo, p. 4.) Nothing about the association health plan market has anything whatsoever to do with bending the cost curve. Until the ever increasing costs of health care services are *reduced*, premiums will continue to rise.[6] As noted above, small groups in the combined risk pool do pay higher premiums than required by their own experience in order to mitigate the higher costs in the individual market, but the combined risk pool itself does nothing to control the costs of health care.

OHCA also asserts BCBSVT did not offer a platinum level health plan and implies that BCBSVT nefariously made this decision in order to destroy the combined risk pool. (OHCA Memo, p. 4.) Logically, this makes no sense. As well established in numerous filings and other forums, BCBSVT policyholders are currently bearing the brunt of the underfunded and destabilized individual and small group markets. There is no benefit to BCBSVT to undermine

[6] Even if the actual unit cost of health care services remained entirely stagnant, and no new therapies or treatment options became available, there is the unavoidable truth that as Vermonters grow collectively older, the overall costs of our health care system will increase because our utilization will appropriately increase.

the combined risk pool.[7] Furthermore, associations determine the products they want to offer their members, not BCBSVT. If the associations felt that a platinum level plan would appeal to their members, no doubt they would offer such an option.

Finally, as noted in the BCBSVT Vermont Individual and Small Group filing, even an assumed continuation of the AHP market (that is, with ongoing new enrollment) adds only one percent to rates in the single risk pool. (BCBSVT 2020 BCBSVT Vermont Individual and Small Group Rate Filing, SERFF No. BCVT-131936226, May 10, 2019, Actuarial Memorandum, p. 5.) This impact is dwarfed by the impacts of specialty pharmaceuticals, preventive care, and the return of the federal health insurance tax. This relatively minor impact hardly "undermines Vermont's efforts to bend the cost curve," especially since the very existence of the AHP market does indeed lower the premium burden for Vermont small businesses that choose to participate.

For the above reasons, and those made in BCBSVT Memorandum in Lieu of Hearing, BCBSVT urges the GMCB to approve the filing with modification only for the change to generic cost trend recommended in the actuarial opinion of Lewis & Ellis.

Dated at Berlin, Vermont this 28th day of May, 2019.

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[7] This is not true for insurers who do not participate in the small group and individual markets.

## CERTIFICATION OF SERVICE

I, Rebecca Heintz, hereby certify that I have served the above BCBSVT REPLY TO HCA 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 28th day of May, 2019.

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