STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing	)))))	GMCB-005-21rr SERFF No. BCVT-132829271
In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing	)))	GMCB-006-21rr SERFF No. BCVT-132829562

BLUE CROSS'S POST-HEARING MEMORANDUM

For the reasons set forth below and based upon the evidence and arguments in the record and presented at hearing, Blue Cross and Blue Shield of Vermont respectfully asks that the Board approve its proposed rates as modified by the adjustments recommended by Lewis & Ellis (L&E) and by Blue Cross's adjustment reflecting hospital budget submissions.[1]

INTRODUCTION

In his brief testimony at this year's hearing, Health Care Advocate Michael Fisher related an anecdote about how, by doing it himself rather than listening to his plumber, he was able to extract an unfortunate snake that had gotten caught in his hot water heater and restore hot water to his house. Tr. 338:6-339:3. His conclusion: "Sometimes the experts don't get it right." *Id.* at 339:4-5. His meaning: Because the Vermont Legislature created this Board, and not "a board of actuaries," *id.* at 339:11, this Board should "come up with your own definition of

[1] References to the "proposed rates" should be understood to mean the rates proposed in the filing as modified if L&E's recommendations are accepted and as modified by Blue Cross's adjustment reflecting hospital budget submissions. Those rates are reflected in Exhibit 29.

reasonableness" in deciding this case (even though Mr. Fisher quickly recognized that 8 V.S.A. § 4062 authorizes no such thing, *see* Tr. at 342:1-8).

It is plain enough why the HCA would urge the Board to commit reversible error by overlooking the overwhelming record evidence: Unlike the lone plumber Mr. Fisher consulted before fixing his own hot water heater, three different actuaries weighed in about the propriety of the proposed rates, and they unanimously agree that the proposed rates should be approved. And perhaps most importantly, the proposed rates represent an average overall *decrease* across the individual and small group markets considered together, and will result in a net premium decrease for individual market participants with income below approximately $95,000 (or $265,000 for families) and a substantial premium decrease for small groups. The HCA does not dispute either of these critical points. Indeed, the HCA has not offered a single concrete recommendation for reducing Blue Cross's proposed rates.

However, as explained below, the evidence here powerfully demonstrates that the proposed rates satisfy the governing statutory criteria, and must be approved, for two main reasons: First, the record contains no evidence supporting any reductions to any of the actuarial assumptions used to develop the proposed rates. That follows from the information and testimony Blue Cross has presented, beginning with the filings themselves, and from L&E's conclusions after they reviewed Blue Cross's work. Second, Blue Cross has justified its requested 1.5% contribution to reserve, as confirmed by the Department of Financial Regulation's solvency analysis. The HCA's mistaken attempts to portray that request as 3%

and/or as an increase from prior years founder in light of the undisputed evidence. The evidence points inexorably to one result: The proposed rates set forth in Exhibit 29 should be approved.[2]

LEGAL FRAMEWORK

The rate review process requires the Board to balance a set of interdependent criteria to assess "whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State." 8 V.S.A. § 4062(a)(3). Given the complexities of the health care system, the Board must grapple with the inevitable push and pull among cost, access, quality, and solvency. *See In re BCBSVT Large Group Filing et al.*, GMCB-002/003-19rr, at 6 (May 23, 2019) (observing that the statutory standards "are 'general and open-ended,' the result of 'the fluidity inherent in concepts of quality care, access, and affordability'" (quoting *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16)). Indeed, the Board has recognized that failing to properly balance these factors "imperils Vermonters' access to care." *Id.* Further, recognizing that at its core a proposed rate is an actuarial projection of future health care costs, the Board's rate review rule added that the Board must also find that the proposed rates are not excessive, inadequate, or unfairly discriminatory. Rule 2.000, § 2.301(b).

I. There is no evidentiary basis for reducing any assumptions in the rates beyond the recommendations submitted by the Board's actuary and agreed to by Blue Cross.

The Board should approve Blue Cross's proposed rates, as modified by Lewis & Ellis and adjusted based on hospital budget submissions. The bottom line: the proposed rates represent

[2] Blue Cross notes that the following statutory criteria were not discussed, let alone disputed, at the hearing, and are easily satisfied by the evidence in the record: that the proposed rates are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; are not unfairly discriminatory; promote quality care; and promote access to care. The memorandum primarily focuses on the criteria that the parties and the Board discussed at the hearing: whether the rates: are affordable; protect Blue Cross's solvency; and are adequate and not excessive.

an overall rate *decrease* in the combined individual and small group market. The Board's actuary, Lewis & Ellis, thoroughly reviewed the filed rates and proposed only minor adjustments. Blue Cross agrees with those adjustments. And, as explained below, there is no basis in the record for reducing any assumptions in the rates.

First, the HCA's efforts to suggest isolated, out-of-context reductions to rate components have no evidentiary support. The Board's actuary, Jackie Lee of L&E, did not *recommend* cutting any of those assumptions. Instead, she merely agreed with the uncontroversial notion that, for each of several trend assumptions, a range of reasonable values exists, and that some of those ranges contain values lower than the one chosen by Blue Cross. *See, e.g.* Tr. at 165:8-20 (noting that the value chosen by Blue Cross and a "slightly" lower value noted in L&E analysis fall within "a range of reasonable results"). Further, on examination by Blue Cross's counsel, Ms. Lee rounded out the incomplete picture painted by the HCA's questioning, testifying: first, that Blue Cross could also have chosen *higher*, but still reasonable, values for each of the assumptions the HCA asked her about, Tr. at 175:23-176:7; second, that a proposed rate must be considered in the aggregate, *id.* at 176:3-10; and third, that "[i]f you were to use the low end of the range on every assumption, it is likely that it would push towards becoming inadequate." *Id.* at 176:11-19. Indeed, L&E recognized that Blue Cross's use of a new "matched population method" for calculating medical utilization trend "is a substantial enhancement to BCBSVT's trend modeling and produces trend estimates that appear to better represent the covered population." Ex. 16 at 8. Coupled with L&E's conclusion that Blue Cross's trend calculations were "reasonable and appropriate," *id.*160:4-11, there is simply no basis for the Board to second-guess the proposed rates, and every reason to approve them.

Second, Blue Cross made a critical, pro-consumer actuarial decision in its treatment of population morbidity. As the Board is well aware, 2020 was a unique experience period, with the COVID-19 pandemic severely curtailing Vermonters' ability to utilize medical services for a significant period of time. However, rather than chalk up Blue Cross's favorable 2020 experience to the pandemic—a reasonable assumption, *cf.* Ex. 17, at 12; Tr. 141-44—our actuarial team dug deep into the data and observed "a significant shift in morbidity from the 2019 to the 2020 population. When we compare those populations, we can see even after adjusting for the pandemic, the 2020 population used far fewer medical services than did the 2019 population." Tr. 23:3-7 (Schultz direct); *see also id.* 39:1-12. Following the data rather than an urge to maximize revenue, Blue Cross assumed that the morbidity shift drove its 2020 experience (rather than attributing it to the pandemic), an assumption that *decreased* its proposed rates 4.6 percent. *Id.* at 23:10-13. DFR Commissioner Michael Pieciak confirmed that "it's an approach that benefits Vermont consumers," Tr. 129:7-8, because "the rate actually might be on the lower end of what it needs to be" if "that improved morbidity wasn't as significant as Blue Cross Blue Shield believes that it is." Tr. 128:19-129:5.

Third, the record this year (as in past years) shows that Blue Cross continually adapts, improves, and adds programs intended to reduce costs and/or improve the quality of care and, critically for present purposes, *builds those savings into the proposed rates*. Vermont Blue Rx illustrates this point. After months in development, the program rolled out just last month. Blue Cross built the projected savings (about $15 million) into the proposed 2022 rates even though, as of the May 7, 2021 rate filings, those savings were only anticipated and the program had not yet been implemented. Ex. 1 at 5 ("Through this program, BCBSVT has achieved rate relief of 5.6 percent, or a projected $15.0 million."), 18, 34; Tr. 22:16-23:2 (Vermont Blue Rx reduced

proposed rates by "about 5.6 percent" or "about $15 million dollars based on current enrollment"), 118:6-11. Likewise, Blue Cross projected savings from fraud, waste, and abuse (FWA) and other payment integrity programs and build those savings into the proposed rates. Ex. 1 at 4, 25, 31 ("We expect that the 2022 FWA activities will return to the 2018 levels of recoveries."); Tr. 117:24-118:5.And as Mr. Schultz testified, when a provider contract negotiation yielded a better-than-anticipated result after the filing date, we revised the rates to reflect that outcome. Tr. 89:17-90:15. Blue Cross takes this approach because it serves two of the most critical goals of this review process: (1) it prioritizes affordability by building expected savings into, and thereby lowering, proposed rates; and (2) it fosters the transparency the Board rightfully expects of this review process .

Critically, it is neither appropriate nor logical to impose rate cuts based on the notion that Blue Cross can find additional savings beyond the savings built in to the filed rates. Nor is that the way to "replenish" policyholder reserves, as suggested by Board member questions at the hearing. *See, e.g.,* Tr. 116:21-117:17, 119:19-25. First, this approach is implausible given the practical, and undeniable, reality that a carrier cannot develop, communicate, and implement new cost-reducing programs with stakeholder buy-in within the five months between the Board's rate decision and the start of the plan calendar year.

Perhaps more importantly, this approach undermines affordability—in order to use cost-saving programs as a means to replenish reserves, Blue Cross would have to, by definition, hold those projected savings back when developing the rates. In other words, Blue Cross would have to make the proposed rates *less* affordable, in order for the cost-saving programs to flow into reserves—a bad result for consumers and a poor choice for a carrier in a competitive market. Instead, Blue Cross has chosen to heed the Board's consistent emphasis on affordability by

reflecting in the proposed rates projected cost savings from programs like Vermont Blue Rx or efforts to eliminate fraud, waste, and abuse. In a sense, this is a zero-sum dynamic: If the Board would prefer that Blue Cross use savings from programs to fund policyholder reserves, then those savings cannot also be used to reduce proposed rates. If the Board would prefer that Blue Cross use those projected savings to make proposed rates lower than they would otherwise be (the better option, in our view), then those savings are unavailable to fund policyholder reserves.

Finally, Blue Cross's rate development, the changes brought about by ARPA, and the unmerging of the markets have combined this year to reduce small group rates and reduce net premiums for most Vermonters in the individual markets—assuming the Board approves the carriers' rates as modified by L&E. *See* Ex. 18 at 8-12; Ex. 21 at 3:1-7:3. This year, the rates as independently developed by the carriers and as modified by L&E—meaning, the actuarially supported rates in the individual market—leave most Blue Cross consumers better off in terms of net, post-subsidy premiums. Meanwhile, the proposed rates in the small group market will result in an average decrease of 6.2 percent; unsurprisingly, the public comments from groups representing a large segment of this market unanimously and unequivocally ask the Board to approve the proposed rates. *See* 8 V.S.A. § 4062(c)(2)(B) ("The Board shall review and consider the public comments prior to issuing its decision."). The fact that the Board can approve actuarially supported rates—rates consistent with insurer solvency—while assuring most Vermonters in these markets a lower premium—thereby promoting affordability—is a good thing.

The Chair inquired at the hearing whether the "ends justify the means" with respect to considering the impact of ARPA subsidies on net premiums. Tr. 113:18-24. What Blue Cross advocates is that the Board approve the actuarially supported rates, because that outcome

promotes both affordability and solvency. Respectfully, it would not be appropriate for the Board to adjust rates specifically to manage the impact of federal subsidies, particularly if doing so risks DVHA de-certifying existing silver plans. De-certifying an existing plan would be disruptive and harmful for consumers. Moreover, if the Board chooses to reduce rates below the actuarially supported levels in the name of affordability, the result would be *higher* net premiums for some lower-income consumers.

Blue Cross's response to the Board's post-hearing questions powerfully amplifies this point: The analysis there shows that "if gross premiums in all plans are reduced below actuarially supported levels, all members with incomes between 300 and 800 percent of FPL enrolled in a Bronze plan (Blue Cross or MVP) will face a net premium increase as compared to approving rates as recommended by L&E." Blue Cross Resp. to GMCB Post-Hearing Questions (July 27, 2021) at 3. Indeed, that analysis confirms that "nearly the entirety of the savings of the modeled rate reductions benefits the government and higher-income Vermonters. The average net premium reduction for Vermonters earning below $95,000 as a single individual or $265,000 as a family of four amounts to less than two cents of every dollar of the modeled rate reductions." *Id.* at 4. Regressive cuts of that nature would undermine affordability, access to care, and insurer solvency, and are without an iota of support in the record.

II. There is no evidentiary basis for cutting Blue Cross's 1.5% contribution to reserves.

Blue Cross's proposed rates include its usual, modest request for a 1.5% contribution to reserves. The Board's actuary, once again, has pointed out that 1.5% is low compared to other similar insurers. Ex. 16 at 19-20. The reasons given above apply with equal force to Blue Cross's CTR assumption: no record evidence supports cutting the 1.5% assumption built into the filed rates. Indeed, both independent actuaries support the proposed CTR. *Id.* at 20 ("L&E believes the

CTR assumption is reasonable and appropriate."); Ex. 17, at 11 ("The projected RBC ratio is at a level that does not appear to provide a rationale for reducing the filed Individual or Small Group rates.").

At hearing, the HCA pointed variously to 2020 gains, projected RBC at year-end 2021, and the pension losses as supposed bases reducing CTR. None of these contentions has merit. The Board should follow the recommendations of both independent actuaries and should not cut Blue Cross's proposed rates by reducing its CTR.

A. The HCA's assertions in its closing were factually inaccurate and provide no basis for reducing CTR.

The HCA appeared to advocate in its closing argument for reducing Blue Cross's rates by cutting CTR an unspecified amount. The HCA's counsel, however, made numerous points that are inaccurate and unsupported by any record evidence:

- Blue Cross did not ask for an "increase in its CTR factor" in the filed rates. Tr. 352. Nor is Blue Cross asking for "another 1.5 after they have already gotten about a 3 percent CTR." Tr. 352-53. The filed rates assume a 1.5% CTR—exactly the same assumption as in 2021, 2020, and 2019. *E.g.*, Ex. 5, at 1.
- The HCA contends that the Board should reduce the CTR assumption because Blue Cross projects a negative 2022 RBC impact from the change in allocation of administrative costs. Tr. 353. That is not logical. The change in allocation of administrative costs *reduced 2022 rates in these markets*. Ex. 18, at 5-6; Tr. 39 (Mr. Schultz: "we allocated less administrative cost to these lines of business for 2022"); Tr. 187 (Ms. Greene, noting that "1 and-a-half percent CTR" is offset by COVID-related costs and "reduction in allocated expenses to the segment"). The change thus represents a

savings for consumers that Blue Cross will absorb through reserves. The HCA has not explained, nor could it, why that provides any basis for cutting CTR.

- Contrary to the HCA's assertion, the Board cannot "add [back] in the 163" percent impact of losses in pension assets on RBC and make other "assumptions" to calculate an imaginary "high RBC ratio." Tr. 354. RBC is a measure of insurer solvency. The Board must base its decision on Blue Cross's actual RBC and reserves, not counterfactual speculation.
- Likewise, there is no basis for the Board to assume that Blue Cross's RBC will increase in 2022 because it will lose members. The only relevant evidence in the record indicates that Blue Cross will gain members in 2022 due both to the ARPA subsidies attracting more people to the individual market and a much narrower pricing gap with MVP. Ex. 16, at 13; Ex. 19, at 10-11; Ex. 21, at 8-9.
- There is no record evidence of "subsidization by small group policyholders and individual policyholders of the large group market." Tr. 355. Mr. Schultz testified that Blue Cross is able to offer "lower administrative fees to the ACA market" because of the ASO business. Tr. 82. He further testified that "there is no cross subsidization" and "each line of business stand[s] on its own." Tr. 83.
- The HCA wrongly asserted that Blue Cross bears some responsibility for purported "accounting losses in connection with the pension loss." Tr. 355. That appears to be a reference to the RBC impact of changes in pension funded status separate from the Allianz investment losses. Ex. 15, at 6. Blue Cross explained both at hearing and in its post-hearing question responses why changes in liability valuation are driven by changes in the discount rate—which has nothing to do with the Allianz losses and is entirely out

of Blue Cross's control. Blue Cross Response to GMCB Post-Hearing Questions, Question 5 (July 26, 2021); Tr. 191:6-192:20, 210:17-211:25.

- Although the HCA focuses on projected RBC at year-end 2021, this is a 2022 rate filing. Both our initial filing and revised outlook show that we will be within our target RBC range at the end of 2022. As Oliver Wyman opined in its solvency opinion, the projected RBC ratio for year-end 2022 does not provide a basis for reducing rates. Ex. 17, at 11.

The Board's decision must be based on the record evidence, not on unsupported arguments and counterfactual speculation. The evidence shows that a modest 1.5% CTR is reasonable and appropriate.

B. The fact that Blue Cross currently projects being slightly above its target RBC range at year-end 2021 is not a reason to reduce CTR—because we already plan to use $11.9 million from reserves to reduce rates in these markets and we anticipate membership growth in 2022.

The HCA's myopic focus on Blue Cross's 2021 RBC projection is also wrong because it mistakenly treats RBC as a static value rather than a current projection of a metric that changes based on real-world inputs over time. The HCA also ignores Blue Cross's *response* to that projection. Blue Cross has taken two steps that reduce 2022 rates for consumers: it is directly absorbing COVID-related costs from reserves, and it changed the allocation of administrative costs across lines of business in a way that reduces costs in these markets. Ex. 18, at 5-6; Ex. 19, at 13; Tr. 39; Tr. 187. Together, these two actions are expected to cost $11.9 million, all of which will be funded from reserves.

Because of these steps that reduce rates, Blue Cross is not projecting any gains in these markets in 2022. As Ms. Greene testified at hearing, our requested 1.5% CTR "will result in no gain on this business in 2022" because it will be "offset by not including the COVID related costs for . . . vaccines, tests and treatments in 2022 in rates." Tr. 187; *see also* Ex. 19, at 12.

Further, even a modest shift in market share will reduce projected RBC at year-end 2022. Ex. 21, at 9-11; Tr. 189 (explaining that membership growth reduces RBC absent growth in reserves); Tr. 274 (providing estimated RBC impact for 10% shift in market share). If the Board accepts L&E's recommendations with respect to the filed rates, the pricing gap will narrow to 3.1% in the small group market and 1.4% for gross premiums in the individual market. The last time the rate differential was under 5%, Blue Cross had a 87.6% market share. Given that past experience, we reasonably anticipate a shift in market share to Blue Cross in 2022. Ex. 21, at 8-9.

C. There is no basis to reduce Blue Cross's modest CTR request as a response to the RBC impact caused by losses in pension assets.

The HCA's arguments and Board member questions require a further response regarding the impact of the pension losses on RBC and reserves.

First, and most critically, Blue Cross reiterates the point made above: that the Board must assess solvency and CTR based on Blue Cross's actual RBC position. Looking at RBC allows the Board to assess the impact of its rate-setting decision on an insurer's reserves and solvency position. The pension losses cannot be ignored because the Board is (understandably) dismayed that they occurred. Blue Cross is also dismayed—an understatement—that the losses occurred. So are numerous other retirement plans that have sued Allianz alleging wrongdoing and breach of fiduciary duty.[3] But the losses happened and they affect Blue Cross's reserves and thus its

[3] *See, e.g., Raytheon Tech. Corp. Pension Admin. & Investment Committee v. Allianz Global Investors U.S.*, No. 1:21-cv-03116-KPF, Doc. 1, ¶¶ 5, 9, 10 (S.D.N.Y. filed April 9, 2021) (alleging that Allianz "abandoned the hedging strategy that was the supposed cornerstone of Structured Alpha" and breached its fiduciary duties, and seeking damages of $280 million); *Arkansas Teacher Retirement System v. Allianz Global Investors U.S.*, No. 1:20-cv-05615-KPF, Doc. 1, ¶¶ 9, 18 (S.D.N.Y. filed July 20, 2020) (alleging loss of at least $774 million and alleging "negligent and imprudent trading strategies"); *Boards of Trustees for the Carpenters Health And Security Trust Of Western Washington et al. v. Allianz Global Investors U.S.*, No. 20-cv-9479, Doc. 4, ¶ 3 (S.D.N.Y. filed Nov. 12, 2020) (alleging that "AllianzGI's extraordinarily risky and self-interested gamble resulted in massive losses for Carpenters Trusts, wiping out, in a matter of

solvency. And protecting insurer solvency protects consumers, who count on Blue Cross to pay their health care costs. Making regulatory decisions as if the pension losses didn't happen puts Blue Cross's solvency, and thus its customers, at risk. It is not clear why an entity charged with "[r]epresenting the interests of the people of the State," 18 V.S.A. § 9603(b)(3), would advocate for such an incautious outcome. The Board should not do so.

Second, efforts to blame Blue Cross for the pension losses, Tr. 355, and the suggestion that Blue Cross's RBC should be viewed as if the pension loss did not happen, Tr. 295, share a similar flawed premise: that for some reason, it is appropriate with hindsight to construct a counterfactual world in which Blue Cross experiences all of the favorable financial impacts associated with the pandemic (e.g., lower 2020 claims, accelerated AMT refunds) but none of the negative impacts (market volatility, unexpected losses, lower discount rates, COVID-related costs, return of deferred care and potential morbidity impacts). In reality, like most Vermonters, Blue Cross's experience in 2020 and 2021 was a mixed bag—including financial ups and financial downs. We can't pretend otherwise. And as the Board well knows, regulators have to base their decisions on facts.[4]

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weeks, hundreds of millions of dollars" in fund assets); Teamsters Members Retirement Plan vs. Allianz Global Inv. U.S., No. 1:20-cv-07154-KPF, Doc. 1, ¶¶ 1, 131 (S.D.N.Y. filed Sept. 2, 2020) (alleging, inter alia, AllianzGI "breached its fiduciary duties by concealing material information" and asserting loss of almost a billion dollars).

[4] A Board member suggested at the hearing that last year, Blue Cross "testif[ied] that the impacts of the pension plan would not impact ratepayers with the increase of rates." Tr. 228. Blue Cross represented last year, accurately, that the pension losses—which happened just weeks before the rate filing—had no impact on the 2021 proposed rates. 2020 Tr. 124-25. That was true: Blue Cross proposed the same rates that it would have if the pension losses had not occurred, with the same 1.5% CTR request. Blue Cross did not, however, represent that the pension losses would never impact ratepayers. Mr. Schultz and Ms. Greene both testified that they could not make such guarantees. 2020 Tr. 262 (Ms. Greene) ("we're doing everything in our power to make sure that we can see if we can recoup some of the losses, but I can't make any guarantees about the future"); *id.* 127 (Mr. Schultz) ("I personally cannot make that guarantee one way or the other."). As we have shown in our filings, for example Ex. 19, at 16; Ex. 19, at 14-15 & Attach. D; Tr. 39-

Third, only 163 points of the 222-point RBC impact for pension funding status was caused by the Allianz investment losses. Blue Cross has provided a detailed explanation of the remaining 59-point impact in its responses to post-hearing questions. As Blue Cross has explained, changes in the liability valuation are driven by changes in the discount rate—entirely out of the control of Blue Cross. Blue Cross Response to GMCB Post-Hearing Questions, Question 5 (July 26, 2021).

III. The Board's prospective concerns about payment reform do not justify a rate cut below actuarially supported levels.

Blue Cross heard, loud and clear, the message that the Board is concerned about progress toward payment reform and specifically, toward fixed prospective payments. Blue Cross's commitment to payment reform cannot be doubted: it is the only private payer fully engaged with OneCare (and has been since OneCare's inception); it stands ready to offer fixed prospective payments to all Vermont hospitals; it is an active and eager participant in the current work group sponsored by the Agency of Human Services; and it continues to devote substantial resources to partnering with the state on payment reform efforts. The past 18 months, however, have been extraordinarily challenging for nearly everyone in the health care system. Changing how health care is delivered and paid for is hard work—for providers and for payers. Businesses and organizations necessarily have only a certain amount of bandwidth to devote to high-level, creative, difficult thinking about this kind of systemic change. And since last winter, that bandwidth has nearly all been taken up by a crisis response to the pandemic.

That does not mean that payment reform is indefinitely stalled. Blue Cross will be ready to reinvigorate reform efforts with providers as their resources become more available to turn

40, Blue Cross is working to shield ratepayers from the impact of the pension losses. But we have not and cannot represent that there will be no impact whatsoever on rates.

their attention to this important work. Blue Cross's commitment remains as strong as ever. The hard work needed for real change will continue.

What is clear, however, is that reducing Blue Cross's 2022 rates would not do anything to promote real progress toward payment reform. It would do nothing to push hospitals still coping with the pandemic to agree to give up fee-for-service reimbursement. It would not give Blue Cross any leverage in provider negotiations. It would not generate new resources that can be used to develop creative programs or new initiatives. It would not progressively enhance affordability in the individual market. It would not be responsive to consumer requests in the small group market. It would simply force Blue Cross to absorb a likely loss in these markets from policyholder reserves. And the weaker Blue Cross's financial position, the less able we are to support meaningful change in the health care system.

CONCLUSION

For all of the foregoing reasons, and based on the evidence in the record, Blue Cross respectfully requests that the proposed rates be approved.

Dated: July 28, 2021

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CERTIFICATE OF SERVICE

I certify that I have served the above Post-Hearing Memorandum on Michael Barber, Laura Beliveau, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and on Jay Angoff, Kaili Kuiper, and Eric Schultheis, counsel for the HCA, by electronic mail, Delivery Receipt requested via Microsoft Outlook, on July 28, 2021.

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