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 MOTION TO RECONSIDER AND AMEND OPINION

Blue Cross Blue Shield of Vermont (Blue Cross) timely moves the Board to reconsider and amend its opinion to remove unsupported and clearly erroneous findings and conclusions that the rates proposed by Blue Cross are "excessive." The Board heard evidence from three different actuaries in this proceeding, two of whom conducted an independent review of Blue Cross's proposed rates. No actuary opined that the rates proposed by Blue Cross are excessive.[1] Any such finding is thus unsupported by competent evidence and clearly erroneous.

BACKGROUND

The Board issued a decision on August 5, 2021 that requires Blue Cross to reduce its rates in the individual and small group markets. Decision & Order 13-15 (Aug. 5, 2021) ("Decision"). In that decision, the Board states generally as follows: "Based on our review of the

[1] Consistent with usage during the hearing and in Blue Cross's post-hearing memorandum, "proposed rates" means the rates proposed in Blue Cross's 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. *See* Blue Cross's Post-hearing Memorandum, at 1 n.1 (filed July 28, 2021); Decision 2 ¶ 5 (finding that "Prior to the hearing, BCBSVT agreed to make each of L&E's recommended changes.").

record, the testimony, and evidence presented at a hearing that was held on July 21, 2021, we conclude that the rates proposed by BCBSVT are excessive." Decision 13. The Board further states that "a CTR proposal of 1.5% strikes us as excessive during a time when individuals and small businesses are still struggling financially after a year-long economic slowdown." *Id.* at 14.

Prior decisions of the Board in the individual and small group market have recognized that the term "excessive" is a "defined actuarial standard[]." 2021 Filing Decision & Order, at 16; 2018 Filing Decision & Order, at 7, 10 (same). And in this year's Decision, the Board found that its actuary, L&E, "makes recommendations regarding the actuarial soundness of the rates," including whether the rates are "not excessive," while L&E "does not make recommendations regarding affordability, which is not an actuarial standard." Decision 7 ¶ 27.

Both the record evidence in this proceeding and accepted actuarial standards confirm that "excessive" is a defined actuarial standard. The Board's actuary Ms. Lee testified that "excessive" is a "defined actuarial term[]" that is "included as part of ASOP [Actuarial Standard of Practice] #8." Ex. 22, at 4. According to "actuarial standards of practice," rates "may be considered excessive if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees, and reasonable contingency and profit margins." *Id.* at 5. Blue Cross's chief actuary Mr. Schultz testified similarly, explaining that under Actuarial Standard of Practice No. 8, rates are "excessive" if they "exceed the amount necessary for" "payment of claims, administrative expenses, taxes, and regulatory fees and [] reasonable

contingency or profit margins." Ex. 18 at 25. *See also* Actuarial Standard of Practice No. 8, §§ 1.1 (applicability of the Standard), 3.12.2 (definition of "excessive" as applicable to regulatory benchmarks).[2]

All relevant evidence in this proceeding supports the conclusion that, consistent with actuarial standards of practice, the proposed rates are not excessive. As the Board found, Blue Cross agreed with and accepted the minor modifications recommended by L&E. Decision 2 ¶ 5. With those recommendations, L&E testified that the proposed rates are not excessive. Tr. 159:11-13; Ex. 16, at 23. Mr. Schultz likewise testified that the proposed rates are not excessive. *E.g.,* Tr. 41; Ex. 18, at 12-25. Commissioner Pieciak testified that, based on Oliver Wyman's review, the rate "appears adequate" and "does not appear excessive." Tr. 130. The Commissioner went on to recommend that "any diversions from the rate as filed . . . be actuarially supported because if they are not actuarially supported, it could result in Blue Cross Blue Shield not meeting its surplus target for the year. And could, again, in the long term impact Vermont consumers." *Id.* There is no contrary testimony.

Likewise, all relevant evidence in this proceeding supports the conclusion that Blue Cross's requested 1.5% CTR is not excessive. Blue Cross's Treasurer and Chief Financial Officer, Ms. Greene, testified that "a long-term CTR of 1.5% represents an adequate, yet not excessive, contribution to member reserves." Ex. 19, at 7. Her prefiled testimony explained in detail the basis for that conclusion. *See generally* Ex. 19 & Attach. C. The Board's actuary, L&E, advised that it "believes the CTR assumption is reasonable and appropriate." Ex. 16, at 20. The Board found that L&E believes Blue Cross's CTR position is "reasonable" and recommends no

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[2] Available here: http://www.actuarialstandardsboard.org/asops/regulatory-filings-health-benefits-health-insurance-andentities-providing-health-benefits/.

changes. Decision 11 ¶ 50. L&E also provided a detailed analysis of multiple benchmarks for comparing CTR and reserves among comparable insurers and showed that Blue Cross's CTR assumption is well below average and its reserves are quite low. Ex. 16, at 19-20; Decision 10-11, ¶ 43, 49-50. DFR's consulting actuary, Oliver Wyman, showed that Blue Cross's "RBC ratio has been the lowest of all of the comparative companies since 2018." Ex. 17, at 9. Oliver Wyman further explained that 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." Ex. 17, at 11. Again, there is no contrary evidence.

ARGUMENT

Because nothing in the record supports a finding or conclusion that Blue Cross's proposed rates are excessive, the Board should reconsider its decision and amend those statements. In reviewing administrative decisions, the Vermont Supreme Court has "been firm that adequate findings of fact are required, so that [the Court] may determine whether the sound discretion implicitly mandated by a statute was in fact exercised." *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 20, 203 Vt. 274, 285, 155 A.3d 1207 (cleaned up). It is black-letter law that findings of fact must be supported by admissible, relevant evidence and conclusions of law must be supported by findings. *See, e.g., Grievance of Rosenberg v. Vermont State Colleges*, 2004 VT 42, ¶ 9, 176 Vt. 641, 852 A.2d 599 (findings of administrative board must be supported by "more than a mere scintilla of evidence" and "not clearly erroneous"; conclusions must be supported by findings). Whether viewed as a finding of fact or a mixed question of law and fact, the Board's statements identified above have no evidentiary support. Blue Cross's motion should be granted and the Board's decision revised accordingly.

First, the Board's own precedent and the uncontroverted record in this matter establish that "excessive" is a defined actuarial standard with an established meaning. Blue Cross acknowledges that the Board's review is not limited to actuarial standards. *See, e.g.,* 2021 Filing Decision & Order 16 ("Although the latter terms–excessive, inadequate, or unfairly discriminatory–are defined actuarial standards, other standards by which the Board reviews rate filings 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)). But where the Board purports to apply a defined actuarial standard, it must do so in a manner consistent with those accepted actuarial standards. Otherwise neither the parties, the public, nor a reviewing Court will be able to understand what the standard is and how it is defined. Indeed, the Vermont Supreme Court has "consistently affirmed the necessity of the clear application of applicable standards in both judicial and administrative decisions." *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 20.

The "purpose of findings is to provide a clear statement as to what was decided and why." *In re MVP Health Ins. Co.*, 2016 VT 111, ¶ 20 (quoting *Richard v. Richard*, 146 Vt. 286, 287, 501 A.2d 1190, 1190–91 (1985)). As relevant here, there is a meaningful difference between a finding that a rate should be reduced as "excessive" and, for example, a finding that a rate should be reduced to promote "affordability." A reviewing Court assessing the former would necessarily look at the expert actuarial evidence to assess whether the Board had a basis for reducing a rate as excessive. A reviewing Court assessing the latter would consider whether the Board provided an appropriate "explanation of its reasoning" and explained how the relevant evidence "relate[s] to the statutory standards." *Id.* ¶ 22.[3] That is, the Court would look to see

[3] In Blue Cross's view, the reduction is not consistent with any statutory standard. In the Individual Market docket, it will for the most part reduce the premium tax credits paid by the federal

whether the Board provided a reasoned basis, supported by the evidence and findings, to "explain why" reducing the proposed rates to promote "affordability" better fulfills the statutory standards. *See id.* ¶¶ 22-23. The Board cannot and should not rely on inapplicable actuarial standards as a substitute for a clear explanation of its application of other statutory standards.

Second, the Board should revise its Decision to remove the statements indicating that Blue Cross's proposed rates and CTR assumption are excessive because there is no evidence in the record to support those statements. *No witness testified that the proposed rates are excessive.* The relevant actuarial evidence did not just come from Blue Cross but from the Board's independent actuary, Commissioner Pieciak, and DFR's independent actuary. While the Board's review is "not limited to actuarial considerations and mathematical calculations," Decision 13, to the extent the Board is applying defined actuarial standards, its decision must be based on relevant evidence from experts with appropriate education and experience to assess and apply those standards. On this record, the Board has no basis to conclude that the proposed rates are excessive.

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government, not the net premiums paid by low-income Vermonters. In both dockets, the reduction increases the likelihood of higher costs for future ratepayers.

CONCLUSION

For all of the foregoing reasons, and based on the evidence in the record, Blue Cross respectfully requests that its Motion to Reconsider and Amend Opinion be granted and the Decision be amended to remove any finding or conclusion that Blue Cross's proposed rates are excessive.

Dated: August 13, 2021

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CERTIFICATE OF SERVICE

I certify that I have served the above Motion to Reconsider 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 August 13, 2021.

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