STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2023 Individual Filing	)))	GMCB-003-22rr SERFF No. BCVT-133243519

In re: Blue Cross Blue Shield of Vermont 2023 Small Group Filing	)))	GMCB-004-22rr SERFF NO. BCVT-133243509

BLUE CROSS AND BLUE SHIELD OF VERMONT'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 final proposed rates, which reflect Blue Cross's consideration of adjustments recommended by Lewis & Ellis (L&E), including the effect of recent hospital budget submissions. *See* Ex. 31.

INTRODUCTION

Blue Cross recognizes that the rate increases being requested this year are substantial. Blue Cross also understands that the underlying cost of health care is a difficult burden for many Vermonters to shoulder, and has been for years. The public comments the Board has received this year, as in past years, give voice to that struggle. The Health Care Advocate's recitation of these comments at the conclusion of the hearing powerfully underscored these harsh realities. Those comments also made clear that access to and quality of care—in addition to cost—are significant concerns for many Vermonters.

The requested rates strike the best available balance among these competing concerns while also satisfying mandatory insurer solvency requirements. Reducing Blue Cross's proposed rates will neither advance the goal of a more sustainable health care system nor decrease underlying health care costs. To the contrary, doing so will threaten access to quality care, jeopardize Blue Cross's solvency, and lead to less affordable rates in the future.

As explained below, the evidence in the record and the hearing testimony each confirm that the final proposed rates should be approved.

First, the rates strike the best balance available between the competing concerns of affordability on the one hand and access to and quality of health care on the other.

Second, the rates are actuarially sound and are necessary for Blue Cross to serve its members' current health care needs. Insurance premiums cannot be divorced from the cost of health care. As long as providers continue to charge more for health care services, higher insurance premiums will be necessary to cover those costs. It is undisputed that more than 90% of the proposed premiums will go to paying the cost of health care for Vermonters.

Third, Blue Cross's proposed nominal 1.5% contribution to policyholder reserves (CTR) is amply justified and is at the far low end of what is needed to maintain Blue Cross's risk-based capital within the range required by the Department of Financial Regulation (DFR), particularly given Blue Cross's ongoing

commitment to pay COVID-related claims from its reserves. Evidence provided by DFR and the Board's actuary, Lewis & Ellis (L&E), supports this conclusion.

And *finally*, as L&E has concluded, Blue Cross's administrative costs are reasonable and appropriate and well within the range of the company's peers.

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 Third Quarter 2022 Large Group Rating Program Filing et al.*, GMCB-001/002-22rr, at 9 (May 18, 2022) (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)). There is "inherent tension" among the factors the Board must consider as it seeks "to strike an appropriate balance between achieving the most affordable rates possible while also safeguarding the financial solvency of [Vermont's] health insurers." *Id.* at 10. And the Board has recognized that failing to properly balance these factors "imperils Vermonters' access to care." *See In re BCBSVT Large Group Filing et al.*, GMCB-002/003-19rr, at 6 (May 23, 2019). 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).

ARGUMENT

I. The rates strike the best available balance between affordability and access to and quality of care.

The concepts of affordability, quality, and access are the statutory criteria most obviously interrelated and often in tension. "For example, lowering rates to make them more 'affordable' can render the rates insufficient to cover members' claims, which in turn threatens both access to care and quality of care for the relevant insured population," and "excluding coverage for new, high-cost specialty medications would certainly make rates more affordable, but this would be at the expense of denying access to care for those in need of the medications." Ex. 1 at 9. These factors necessarily must be balanced, and Blue Cross's final proposed rates strike the best balance available.

A. The rates will allow Vermonters to access high-quality health care.

The final proposed rates will allow Vermonters to access high-quality health care. The quality of health care in Vermont is among the very best in the country, and the plans that Blue Cross offers in the individual and small group markets provide access to a broad national network of providers, including over 97 percent of the providers in Vermont. Tr. 51. Moreover, the company provides world-class customer service and a variety of clinical programming that helps members efficiently and effectively access the health care system. *Id.* That Blue Cross's plans

provide access to high-quality health care is undisputed. The market reflects this reality. Individuals with greater health care needs overwhelmingly choose Blue Cross coverage. Tr. 25; *see also id.* at 238-39. That choice reflects Vermonters' confidence in Blue Cross—that Blue Cross will help them navigate what can be a confusing health care landscape and it will pay for their health care needs.

B. The rates are affordable.

Affordability is necessarily relative to the product at issue and cannot be analyzed in the abstract. $100,000 may be an affordable price for a house but not for a car. And although some consumers might consider $30,000 an affordable price for a new electric vehicle—considering the technology involved, the cost of competing products, and the offsetting impact of reduced fuel expenses—other consumers would undoubtedly find that price tag out of reach. Thus, to address affordability, it is necessary to examine what the product is, what benefits it provides, and what it would cost to obtain comparable benefits elsewhere. The Vermont Supreme Court has recognized this dynamic. *See In re MVP Health Ins. Co.*, 2016 VT 111, at ¶ 23 ("We understand that high insurance rates that may be unaffordable to some do not promote access to health care, but we find that obvious conclusion incomplete without some evaluation of the alternative methods of obtaining health care coverage that might be more affordable.").

Moreover, affordability must be analyzed at the community level. There is no escaping the painful truth that health care costs are unaffordable for many Vermonters and continue to grow faster than most other economic measures. But

because of Vermont's longstanding community-rating laws, rates must be developed and assessed for the entire population or community that purchases the plans, not on the circumstances of specific individuals. *See* 33 V.S.A. § 1811(f)(1); DFR Reg. H-99-4. As Paul Schultz explained at the hearing, community rating means that "[t]he healthy member who never sees the doctor pays the exact same gross premium as the member who needs a million-dollar specialty drug to maintain their quality of life." Tr. 52. For a Vermonter who needs a specialty drug that costs over $80,000 a month, an $875 monthly premium is clearly affordable—it is far, far less expensive than the cost of their health care. But it requires other Vermonters with lesser health care needs to support their neighbor. Those healthier Vermonters may view their premiums as unaffordable. But what they contribute is what it takes to pay for the cost of health care for the community, and to pay for the assurance that they, too, will be covered if an accident or illness changes their circumstances.

Considering these realities, Blue Cross's final proposed rates are affordable. More than 90% of the proposed rates are driven by the expected cost of health care in the coming year. As Mr. Schultz testified, "[t]he only way to make that portion of the premium more affordable is to reduce the actual cost of care that is delivered by hospitals and other providers." Tr. 52.

The remaining 9% to 10% of premium goes to required taxes and fees and to Blue Cross's administrative expenses and contributions to reserves—the cost of insurance. Tr. 52-53. As discussed further below, Blue Cross's cost of insurance is less than half of what is permitted under federal and state law. Tr. 29 (MR.

SCHULTZ: "In total, our cost of insurance comes to 8.7 percent of premium in the individual market and 7.4 percent of premium in the small group market. And that number is less than half of the maximum 20 percent cost of insurance that's allowable under state and federal law.").

Blue Cross has maintained its long-term request of a 1.5% CTR, which both L&E and DFR have found reasonable and appropriate. And Blue Cross's administrative expenses enable innovative programming that both reduces cost and makes it easier for Vermonters to navigate the health care system and access high-quality care. Blue Cross activity—in the form of Vermont Blue Rx, Civica Rx, payment integrity programming, and clinical programming like Better Beginnings—saves more premium dollars through reduced prices, avoided waste, and better outcomes than Blue Cross charges for its cost of insurance. "Put simply, Blue Cross's presence in the Vermont market makes health care more affordable," and those savings are reflected in the final proposed rates. Tr. 53; *see also* Ex. 1 at 10; Tr. 203-04.

Blue Cross shares the HCA's and the Board's concerns about the impact Vermont's mandated rating structure has on certain families, and particularly young families. Blue Cross would welcome an opportunity to jointly seek a legislative solution that creates a rating structure that is more affordable for all Vermonters. But in the meantime, an affordability reduction in these dockets that reduces rates below the actuarially recommended levels would create more problems than it solves. In the individual docket, every one-dollar affordability

reduction in gross premiums for subsidized members depletes policyholder reserves by a dollar while yielding only ten cents of net premium reductions, with the vast majority of the balance accruing to the federal government. Tr. 49. More broadly, inadequate rates undermine the health care system. The money that Blue Cross takes in as premiums *is* the money it pays out to providers. Because inadequate rates do not reduce the actual cost of health care, any supposed gain in affordability would be short-lived. Future policyholders will have to pay for the underfunded costs of current policyholders through higher rates.

II. The final proposed rates are actuarially sound and necessary to cover the expected costs of health care in 2023.

Blue Cross's final proposed rates are actuarially sound. Exs. 1-15, 21, 23; Tr. 20-54; 140-42; 195-99.

First, Blue Cross's projected unit cost trend is reasonable. It is undisputed that provider price increases and the cost of specialty pharmaceuticals are the key drivers of the requested rate increases. Ex. 1 at 10; Ex. 17 at 16; Ex. 18 at 15; Tr. 21-22.

As both Mr. Schultz and L&E explained, the Board must address the hospital budget process in determining the unit cost trend in the final rates. Tr. 150-51 (L&E: rates should "be modified by whatever the differences is between the unit cost assumptions made at the time of the filing and those updated for the more recent hospital budget information. . . . [T]he most reasonable way to set the rates is to use all information available at the time."); 152 (L&E: "A significant portion of the premium that we're discussing today will be paid to Vermont hospitals."); *see*

L&E Revised Addendum (July 26, 2022) (discussing potential impact of hospital budget requests). Blue Cross assumed in its final proposed rates that the Board would order reductions to hospital budgets in a similar magnitude to previous years' reductions. Ex. 30; Tr. 44-45. If, however, the hospital budget process results in higher unit cost trends, the final proposed rates will no longer be adequate. Future policyholders would have to pay for these underfunded costs through higher rates. In short, the Board must ensure that there is balance between its treatment of Blue Cross's rates and the hospital's commercial rate increases.[1]

The importance of the Board's regulatory authority over hospital budgets and rates was apparent from the candid discussion of negotiations in executive session, as well as Blue Cross's responses to the Board's written questions. *See* Ex. 14 at 5. These contradict the Board's prior claims that its "continued downward pressure on premium rate increases will foster vigorous contractual negotiations between the insurer and providers." In re BCBSVT Large Group Filing et al., GMCB-002/003-20rr, at (July 17, 2020); In re BCBSVT Large Group Filing et al., GMCB-002/003-19rr, at 7 (May 23, 2019); see also In re BCBSVT 2020 VISG Filing, GMCB-006-19rr, at 17 (Aug. 8, 2019) ("We expect BCBSVT to . . . us[e] its substantial bargaining power to reduce unnecessary utilization and negotiate lower prices with providers.").

[1] Actions taken with respect to hospitals' mid-year rate increase requests are not an appropriate basis to predict the future impact of annual hospital budget submissions. *See* Letter from B. Battles to M. Barber re: L&E Addendum at 1 n.2 (July 26, 2022).

Returning to the metaphor of purchasing a car, the Board—unlike a hypothetical automobile regulator—has authority to cap production costs. This is a far more direct and effective tool to ensure affordability than cutting Blue Cross's rates below actuarially supported levels.

Second, Blue Cross's utilization trend is reasonable. L&E has agreed with the majority of Blue Cross's projections. Ex. 17 at 9 (emergent care), 11 (mental health utilization), 14 (medical pharmaceutical), 15-16 (other pharmaceutical); *see also* Ex. 18 at 9, 10, 13, 15. Blue Cross has demonstrated that its aggregate utilization trend strongly aligns with recent experience. Ex. 1 at 26-39; Ex. 10 at 4; Ex. 13 at 3-5, 10; Ex. 23 at 3-5, 12; Tr. 31-32. Blue Cross also explained at hearing how its various trend exhibits can be understood in relation to each other. Tr. 195-98.

Although L&E has disagreed with Blue Cross's facility utilization assumptions, specifically that 2023 utilization will surpass 2019 levels, Blue Cross has explained the actuarial basis for those assumptions in detail. Ex. 11 at 4-5; Ex. 13 at 4-5, 10; Ex. 23 at 6-7, 13; Tr. 195-98. L&E, by contrast, has not addressed the actuarial necessity of discerning how future trend may differ from recent past trend, *See* Ex. 23 at 8-9; Tr. 140-41. Nor has L&E persuasively explained why Blue Cross's assumption of increased facility utilization is unreasonable, particularly given information contained in recent hospital budget submissions that has been made part of the record in this proceeding. *Compare* Tr. 163-64 (agreeing that facility utilization would increase during 2023 "to the extent that the backlog [of delayed care] is being addressed faster than it was being addressed in 2021") *with* Ex. 23 at

26 (UVMHM FY23 budget requests notes that "[w]orkforce challenges continue to create access issues across multiple service lines" but assumes that this and other pandemic-related pressures will "decrease" in FY23); at 52 (UVMHN budget requests "assume a stabilization of the long-term care and skilled nursing facility system," which is needed to address "significant backlog of patients" seeking care); 54 ("Pandemic impacts on [UVMHN] during the Omicron wave" included decreased volumes "for higher margin services … due to inpatient capacity and outpatient surgery constraints").

Blue Cross has sufficiently justified its utilization trend assumptions, both in the aggregate and specifically with respect to the facility utilization component. Accordingly, Board should find these assumptions adequate and not excessive.

III. The requested contribution to reserves of 1.5% is reasonable.

The Board should approve Blue Cross's requested CTR of 1.5%, which represents a "modest and appropriate contribution to policyholder reserves" that will allow Blue Cross "to navigate short-term fluctuations in order to maintain surplus levels that are within [the] mandated target range." Ex. 22 at 13.

As Ruth Greene testified, a minimum nominal CTR of 1.5% is necessary to keep Blue Cross's risk-based capital within the range required by DFR. Ex. 22 at 4; Tr. 205-11. In fact, a nominal 1.5% CTR is on the very low end of what Blue Cross needs to maintain sufficient reserves; Blue Cross could reasonably increase its effective CTR up to 3%, as L&E has found. Tr. 206-07; Ex. 17 at 24; Ex. 18 at 22.

Blue Cross's actual, effective CTR will be much lower than 1.5%. Blue Cross's commitment to continue funding direct COVID claims out of its reserves will reduce Blue Cross's net CTR by approximately half, to an estimated 0.75%, during 2023. Tr. 208; Ex. 1 at 57-58; Ex. 18 at 22; Tr. 28; Tr. 188. Moreover, if federal ARPA subsidies are not extended, Blue Cross's effective CTR in the individual market could be reduced by an additional 0.8%—putting the CTR in the negative range. *See* Tr. 161-62 (Q: [If federal ARPA subsidies are not extended], do you agree that Blue Cross's effect contribution to reserves [in individual market] will be reduced from its filed level by approximately .8 percent? MR. RUGGEBERG: I do."). A negative CTR would not be reasonable for Blue Cross. Ex. 17 at 24; Ex. 18 at 22; Tr. 188-89 (MR. RUGGEBERG: "I very much would not have been comfortable recommending that [Blue Cross's effective CTR] be reduced [to 0 percent] given what I know about Blue Cross's financial situation.").

Blue Cross is nonetheless committed to maintaining a long-term CTR assumption at 1.5% to limit the amount of volatility to premium rates. Tr. 205.

DFR agrees that Blue Cross's filed rates will preserve the company's solvency, and that any "downward adjustments to the filing's rate components that are not actuarially supported … will reduce [Blue Cross's] surplus and negatively impact its solvency. Ex. 19 at 3; Ex. 20 at 3; Tr. 234-35. L&E also agrees that the requested 1.5% CTR is reasonable and appropriate. Ex. 17 at 24 ("L&E does not recommend a change from the base CTR of 1.5%."); Ex. 18 at 21 (same).

The Board should approve Blue Cross's requested 1.5% nominal CTR. Any reduction to the requested CTR will result in inadequate rates.

IV. Blue Cross's administrative costs are reasonable.

Blue Cross's modest allowance for administrative costs must also be approved. L&E agrees that the "expense assumption" is "reasonable and appropriate." Ex. 17 at 23; Ex. 18, at 20. By national measures, Blue Cross's administrative costs are well within the norm: 10th out of 62 comparable plans on PMPM basis, and 31st out of 62 as a percentage of premium. *Id.* Although this a relative increase from prior years, L&E found these expenses remained reasonable considering that Vermont is a small state and that Blue Cross "has fewer members to spread fixed costs over than most other Blues plans." *Id.*; *see also* Tr. 203 (MS. GREENE: "[W]e have to spread our fixed costs over more – cover more than what other Blues plans cover. And we did have a shift in 2021 of membership out of one set of our platforms to a different partnership platform, which does have the effect of increasing the ACA PMPM basis.").

Ms. Greene testified that "Blue Cross has to have [staff] and technology to serve all segments that we provide coverage for in Vermont," and to meaningfully participate in the State's health care reform efforts and provide for innovative programming that reduces cost and increases access to health care for Vermonters." Tr. 203-04.

* * *

As the Vermont Supreme Court has made clear, a requested rate increase should not be denied simply because the requested increase is "substantial," particularly where—as here—the requested "rates are driven by claim costs." *See In re MVP Health Ins. Co.*, 2016 VT 111, at ¶ 23. Instead, the Board must evaluate whether the rates appropriately balance the sometimes competing concerns of affordability, quality, access, and insurer solvency. As set forth above and in the evidence in the record, Blue Cross's final proposed rates strike the appropriate balance.

CONCLUSION

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

Dated: July 27, 2022

/s/ Benjamin D. Battles

Benjamin D. Battles
Pollock Cohen LLP
50 Lakeside Avenue
Burlington, VT 05401
(802) 793-5512
ben@pollockcohen.com

CERTIFICATE OF SERVICE

I certify that I have served the above Post-Hearing Memorandum on Michael Barber, Laura Beliveau, Christina McLaughlin, Geoffrey Battista, and Jennifer DaPolito of the Green Mountain Care Board; and on Jay Angoff, Eric Schultheis, and Charles Becker, counsel for the Office of the Health Care Advocate, by electronic mail, this 27th day of July, 2022.

/s/ Benjamin D. Battles

Benjamin D. Battles
Pollock Cohen LLP
50 Lakeside Avenue
Burlington, VT 05401
(802) 793-5512
ben@pollockcohen.com