STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2024 Individual Market Rate Filing	)))	GMCB-002-23rr SERFF No. BCVT-133654578

In re: Blue Cross Blue Shield of Vermont 2024 Small Group Market Rate Filing	)))	GMCB-003-23rr SERFF NO. BCVT-133654592

BLUE CROSS VT'S POST-HEARING BRIEF

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Blue Cross VT is a small nonprofit health plan that does business in a state with a highly concentrated health care market, high health care costs, and high standards for quality care. We operate efficiently while providing excellent service to Vermonters and partnering with regulators and providers to improve quality and access to care. And we have offered plans in the ACA markets since inception—one of only two insurers that does so—at a loss. *See* Ex. 1, at 6.

Nearly every year, the Green Mountain Care Board reduces our proposed rates. It has reduced our CTR requests or reduced rates for affordability, which amounts to the same thing. It has found that medical trend should be reduced or that Blue Cross VT should use "bargaining power" to force hospitals to accept less money. It imposed CTR or affordability reductions during years that Blue Cross VT was already covering pandemic costs out of reserves.[1] Year after year, the Board has reduced our rates below actuarially adequate[2] levels, as shown by the financial losses Blue Cross VT has sustained in these markets since 2014. *See* Ex. 1, at 6.

The reason is no mystery: the Board is concerned about Vermonters' ability to pay for health insurance—a concern that Blue Cross VT shares. By many measures, Vermont's health care system performs well: the Commonwealth Fund ranks Vermont fifth in the United States on its 2023 scorecard,[3] based in part on our low uninsured rate and strong performance on certain quality benchmarks. This high-quality care is expensive, particularly in Vermont.

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[1] *E.g., In re 2023 Blue Cross Filing*, GMCB-003/04-22rr, at 18-20; *In re 2022 Blue Cross Filing*, GMCB-005/06-21rr, at 14-15; *In re 2021 Blue Cross Filing*, GMCB-005-20rr, at 20-22; *In re 2019 Blue Cross Filing*, GMCB-009-18rr, at 17-19; *In re 2018 Blue Cross Filing*, GMCB-008-17rr, at 11-14; Ex. 19, at 20 (L&E noting that Board ordered *negative* 0.8% CTR for 2023).

[2] Rates are actuarially adequate if they will generate revenue sufficient to cover "payment of claims, administrative expenses, taxes, and regulatory fees and have reasonable contingency and profit margins." Actuarial Standard of Practice No. 8 ("ASOP 8"), §§3.11.1, 3.11.2, *available at* https://www.actuarialstandardsboard.org/asops/regulatory-filings-healthplan-entities/ (last visited July 25, 2023). They are excessive if they exceed that amount. *Id.*

[3] *See generally* https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance (including Vermont download).

Our proposed rates reflect the best estimate of the costs of paying for members' health care and administering these plans in 2024. Our costs of insurance—administrative costs and CTR—are low compared to other insurers; *roughly 90% of premium dollars pay for health care services.* Ex. 1, at 49. The Board's actuary Lewis & Ellis did not quibble with any aspect of our rate development. *See generally* Exs. 14, 15. To the contrary: L&E found that Blue Cross VT could have supported a "*higher* total utilization trend level." Ex. 14 at 12 (emphasis added). Our risk-based capital (RBC) level, the primary measure of our solvency, is at an all-time low. Resp. Post-Hrg. Qs., at 6. Rate cuts that are not actuarially supported "will reduce BCBSVT's surplus and negatively impact its solvency." Ex. 16, at 3. We cannot continue to operate in these markets at a loss. Our proposed rates should be approved.

I. Blue Cross VT's proposed rates appropriately balance the statutory and regulatory criteria, including affordability.

The evidence shows that the proposed rates satisfy the statutory and regulatory criteria. In fact, most of the criteria are not in meaningful dispute: The actuaries agree that the rates are adequate, not excessive, and not unfairly discriminatory. Exs. 14, 15; Tr. 120. DFR confirmed that the proposed rates protect Blue Cross VT's solvency. Exs. 16, 17. The record one-sidedly shows that the proposed rates, if approved, will enable Blue Cross VT to promote high quality health care and maintain robust access to that care. *See e.g.,* Tr. 236, 240-41, 256-58, 270; Resp. Post-Hrg. Qs., at 14-15, 19. As a result, much of the focus during the hearing this year fell on the affordability criterion. The productive discussion of affordability throughout this year's hearing points to some useful guiding principles for the Board's deliberations.

Board Chair Foster suggested at the hearing that "affordable" must mean something different than "not excessive." Tr. 94. Affordability is not an actuarial standard, *see In re: Blue Cross 2018 Filing*, at 13 n.12, but that does not mean that the Legislature intended affordability

to be wholly distinct from actuarial review.[4] Instead of putting actuarial standards into the statute, the Legislature directed the Board to approve rates that are both affordable and promote insurer solvency. The most reasonable reading of the statute, from a plain language perspective, is that the Board should approve rates that are enough, but not too much. Enough to pay for health care claims and cost of providing insurance; but not too much, meaning, no unwarranted profit margins or unnecessary administrative costs. That suggests that two big-picture questions should frame the Board's assessment: Is Blue Cross VT's prediction of 2024 allowed charges based on sound actuarial analysis? Has Blue Cross VT appropriately controlled its costs of insurance (i.e., its administrative costs and CTR)? The record powerfully answers both in the affirmative.

A. The record strongly supports Blue Cross VT's projections of 2024 allowed charges.

As Martine Brisson-Lemieux explained in her prefiled testimony and at hearing, the rate development process starts with the actual claims experience from the most recent completed calendar year (2022, in this case) and applies actuarial science to predict the allowed charges Blue Cross VT will cover in the benefit year (2024). Although the resulting proposed rates can then be expressed as an increase over the current 2023 rates, the 2023 rates are not an input for the 2024 rate development process. Tr. 31; Ex. 18, at 6-8. As a result, the percentage change between one year's rates and the proposed rates for the following year cannot reasonably drive the Board's analysis of affordability. That analysis must be tethered to the actuarial evidence.

[4] The statutory criteria were adopted as part of an overall statutory scheme that envisioned a path to a single-payer system. They do not readily fit current circumstances, with the Board regulating insurance premiums in a long-term market rather than managing overall affordability (e.g. scope of benefits and provider payment levels) in a single-payer system.

Here, the record unequivocally supports Blue Cross VT's prediction of 2024 allowed charges, which comprises about 90% of the proposed rates. L&E did not dispute any aspect of our rate development. To the contrary: L&E found that Blue Cross VT could have supported a *higher* overall trend. Ex. 14, at 12. And the HCA failed to raise any legitimate actuarial dispute. Because no element of Blue Cross VT's actuarial analysis is higher than actuarially supported, the Board cannot cut this portion (again, comprising about 90%) of the proposed rate without rendering the rates inadequate—an outcome barred by the Board's own Rate Review Rule. Therefore, on this record, the Board must approve this portion of the proposed rates.

B. The record strongly demonstrates that Blue Cross VT has appropriately controlled its costs of insurance.

Our efforts to keep rates affordable go beyond the actuarial standards: we manage our costs efficiently and keep our administrative costs low compared to other insurers. Ex. 14 at 18-19; Tr. 153-54. We have documented our ongoing efforts to reduce cost growth and promote quality care and access to care. Ex. 1, at 9, 35; Tr. 236, 240-41, 256-58, 270; Resp. Post-Hrg. Qs., at 14-15, 19. The proposed rates are affordable measured against what they purchase: roughly 90% of each premium dollar goes to pay for health care costs. Ex. 1, at 49. We also proposed actuarially reasonable adjustments to the rates to maximize subsidies for our members.[5] Ex. 20, at 3-4; Tr. 42-43.

C. In this context, affordability of health insurance rates cannot be measured by economic indicators.

[5] Blue Cross VT and the HCA have asked the Board to take a consistent approach to CSR loading and membership movement with both carriers so that consumers benefit as much as possible from available subsidies. We agree with the HCA that the approach initially taken by Blue Cross VT is the better approach *if applied to both carriers*. Otherwise, we ask that the Board apply the approach recommended by L&E for MVP. *See* Ex. 20, at 2-3; Tr. 42-43, 118-20.

As in past years, the HCA suggested that Blue Cross VT should be developing rates and the Board should assess them based at least in part on economic factors such as household income or wage growth. The Legislature did not adopt and the Board has not promulgated any such requirement or meaning for the affordability criterion. The Board has, instead, consistently adhered to the Vermont Supreme Court's holding that the non-actuarial "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.'" *In re Blue Cross 2018 Filing*, GMCB-008-17rr, at 10 (Aug. 10, 2017) (quoting *In re MVP Health Ins. Co*., 2016 VT 111, ¶ 16). Nothing in the statute or rule requires Blue Cross VT to alter its rate development to somehow incorporate economic data that is unrelated to the cost of health care. *See In re Blue Cross 2021 Filing*, GMCB-005-20rr, at 17 (Aug. 14, 2020) (noting that Board must assess affordability "without specific statutory guidance or a standardized definition").

Nor would such a requirement make sense. The Board has struggled with the "tension" inherent in the "competing" rate review criteria for years precisely because there is no metric for developing rates other than the actuarial standards. *See*, *e.g.*, *id.* (noting "tension inherent" in standard of review); *In re Blue Cross 2020 Filing*, GMCB-006-19rr, at 16-17 (Aug. 8, 2019) (noting that Board has "remarked in prior decisions on the tensions inherent in the statutory standards governing our review" and describing review as "attempt[ing] to strike the best balance we can between these competing rate review standards"); *In re Blue Cross 2019 Filing*, GMCB-009-18rr, at 15 (Aug. 14, 2018) (similar). The Vermont Supreme Court has likewise recognized this tension, noting that although "high insurance rates that may be unaffordable to some do not promote access to health care," the fact that a "rate increase is substantial or unprecedented alone" is not "sufficient reason to deny" it. *In re MVP Health Ins. Co.*, 2016 VT

111, ¶ 23. Rates, after all, "are driven by claims costs." *Id.* An insurer cannot propose rates that are inadequate to cover the insurer's costs; that leads to insolvency. Interpreting the statute to require carriers to depart from actuarial standards and reduce proposed rates based on economic measures or individual ability to pay would be arbitrary, unreasonable, and ultimately self-defeating: it would drive carriers out of these markets and leave consumers without options.[6]

D. A framework for assessing affordability

In light of the record evidence and discussion of affordability during this year's hearing, we respectfully suggest the following framework for the Board's consideration of affordability:

- *Actuarial review of trend and other assumptions used to project 2024 allowed charges*. As discussed above, the record shows, and L&E agrees, that Blue Cross VT's assumptions are reasonable and therefore should be approved as proposed.
- *Monitor other rate components to insure that administrative costs are managed efficiently and any profit or margin is limited*. Our administrative costs are low by national standards, despite our small size. There is no profit in the rates. The requested contribution to reserves is well within national norms and critical to protecting the insurer's solvency, especially given its current historically low level. *See infra* 8-10.
- *Use the rate review process to monitor insurers' efforts to control costs*. Blue Cross VT, for example, documented reduced growth in drug costs through Vermont Blue Rx and CivicaRx and explained its plan to affiliate with Blue Cross Blue Shield of Michigan. Given the cyclical nature of the review process, these are examples of how the Board can

[6] Ordering consistently inadequate rates also invites constitutional challenge. *Cf., e.g., Duquesne Light Co. v. Barasch,* 488 U.S. 299, 307-10 (1989) (discussing impermissible confiscatory rates).

gather information in one year for use in assessing an insurer's projections in later years, even if that information cannot be used to alter the rates currently under review.

- *Use available tools to maximize subsidies for low and middle-income Vermonters.* The ACA was designed to be a subsidized system. Depending on the current regulatory environment, the Board may have tools available to maximize subsidies for eligible Vermonters. The Legislature unmerged the markets for the 2022 plan year for this reason. Silver-loading is another avenue to maximizing subsidies, if the Board adopts a consistent approach for both carriers, as proposed by Blue Cross VT and L&E. Further, the Board should recognize that increases in approved gross premiums do not necessarily increase net premiums in the individual market and in fact (and counterintuitively) reduce net premiums for many consumers. That is because (1) subsidies are based on the benchmark plan premium and a fixed percentage of household income; and (2) many consumers purchase less expensive plans. If the benchmark premium increases more than the premiums of less expensive plans, consumers benefit by receiving a larger subsidy.[7] And the contrary is true: artificially suppressing rate increases below actuarially supported levels not only causes the insurer to lose money, but also increases net premiums for many individuals. Understanding these counterintuitive dynamics is critical to assessing affordability under the ACA.

[7] The basic formula is: (maximum % of Income) + (Gross Plan Premium – Gross Benchmark Premium) = Net Premium. Suppose in year A, that calculation looks like this: $150 + ($300 - $400) = $50. In Year B, assume a 20% increase, so the Benchmark Premium increases to $480; and the individual's plan premium increases to $360. If their income remains the same, the individual pays less: $150 + ($360 - $480) = $30.

- *Use other regulatory tools to reduce the health care costs that drive premium increases.* This year's hearing featured a promising through-line about *systemic* change. The discussion highlighted the paramount importance of all oars pulling in the same direction, and the need for the Board to ensure that actions in one regulatory context align with others, including, for example, aligning both results and expectations across rate review and hospital budget review. And the Board has other regulatory authority that it could bring to bear; most notably its provider rate-setting authority under 18 V.S.A. § 9376.

II. The Board should approve Blue Cross VT's 3% CTR assumption.

Our RBC level, the accepted measure of insurer solvency, is far below the range ordered by the Department of Financial Regulation. Ex. 12, at 6-7; Tr. 150-51. Had we achieved 1.5% CTR in these markets for the past decade, the rates would have supported a $45 million contribution to reserves over that time. Tr. 221. Past Board decisions, however, reduced CTR and/or imposed affordability reductions. *E.g.*, Ex. 19, at 20 (L&E noting that Board approved *negative* 0.8% CTR for FY2023). We have sustained a cumulative loss of over $9 million in these business lines—meaning, a $54-55 million shortfall, the majority of it attributable to Board-ordered reductions. Ex. 1, at 6; Tr. 221. "The primary factor in an insurer's ability to maintain adequate solvency is whether the insurer consistently charges adequate premium rates." Ex. 16, at 3 (DFR). Losses in these markets are not the only factor that affects RBC. But had our rates achieved the target CTR, all else being equal, our year-end 2022 RBC level would be approximately 650 instead of 434 ($54 million represents approximately 216 RBC points).

A. During and after the hearing, the Board asked about other factors affecting RBC, suggesting that members in these markets should not have to contribute to member reserves if other factors caused losses. *E.g.* Tr. 178, 184, 232-33. We disagree with an approach that

attempts to isolate impacts on reserves in this way because it disregards the fundamental requirement that premiums be fully funded, including a contribution to reserves. Investment gains and losses, membership growth and loss, and operating gains and losses across all lines of business impact reserves and RBC over time. Those expected impacts are not a reason to reduce CTR in these rates. See Resp. Post-Hrg. Qs. 5-8.

Consider investment gains and losses. We invest some reserve funds in equities seeking to achieve higher returns. Over the past decade, that strategy has paid off. Tr. 185. But 2022 was a bad market year and investment losses reduced RBC. Because our reserves protect all of our lines of business, the 2022 losses cannot be cordoned off from the ACA markets (and, presumably, covered by other business lines). In fact, investment gains in prior years helped support the ACA markets, which have consistently lost money. The Board has never disregarded investment gains in assessing our solvency in prior years; it should likewise not disregard losses (which are inevitable when investing in equities) in assessing our solvency this year.

The same analysis applies to losses in the ASO line of business. In past years, gains in that line of business contributed to reserves (and helped offset losses in the ACA markets). More recently, Blue Cross VT had to accept less favorable ASO contracts or risk losing very large clients that provide needed scale to the overall enterprise. We have explained that dropping that business would require significant premium increases in the ACA markets to cover fixed costs and cause other long-term negative impacts across all markets. Ex. 13, at 6-7.

Likewise, the Board should not treat our investment in the Medicare Advantage market as a factor that must (or even can) be isolated from the ACA markets. Membership growth benefits all lines of business by increasing scale and spreading fixed costs across a larger membership base. Offering a Medicare Advantage product also furthers our mission by allowing us to meet

the needs of more Vermonters, including those of modest means. But we cannot expand offerings or grow membership in *any* market without adequate reserves. Entering a new market requires an upfront investment and means taking on additional risk, which lowers RBC. We could only expand into the new ACA markets in 2014 because our member reserves supported by *other* lines of business were sufficient to support that growth – and to weather losses caused by underfunded premiums and the federal government's failure to make required payments.

The point is that solvency, reserves, and RBC are enterprise-wide and not siloed by line of business. And the cornerstone of solvency is adequately funded premiums. Ex. 16, at 3 (DFR). If our premiums were fully funded including an adequate contribution to reserves, then we could weather a year of poor returns in the stock market and take on the initial costs of new product offerings without serious concerns about solvency. But a decade of underfunded premiums in these markets has taken a toll. Based on Blue Cross VT's overall solvency position; the warnings from our solvency regulator; and L&E's opinion deeming the request reasonable and well within a typical range, Ex. 14 at 19-20, the Board should approve a 3% CTR.

B. If the Board in fact wants to take a "siloed" approach to reserves and RBC, then it must be consistent and look solely at the impact of these markets. These markets require higher reserve levels but have not supported any CTR over the past decade. Ex. 14, at 19 (L&E chart showing cumulative ***negative*** 0.5% CTR in these markets); Resp. Post-Hrg. Qs., at 7. Cumulative losses are over $9 million. Ex. 1, at 6. Blue Cross VT would not still be in these markets if it weren't for reserves built up over time by members in other lines of business.

The solvency analysis cannot be a one-way street. It is not reasonable for the Board to rely on investment gains and reserves contributed by other markets as supporting Blue Cross VT's solvency—but simultaneously disregard investment losses and losses in other markets as

irrelevant to any CTR request in these markets. If the ACA markets are considered independently from a solvency perspective, this line of business is operating at a deficit and Blue Cross VT's 3% CTR request is readily justified. Ex. 14, at 19.

CERTIFICATE OF SERVICE

I certify that on July 28, 2023, I served the above Blue Cross VT's Post-Hearing Brief on Michael Barber, Geoffrey Battista, Laura Beliveau, and Tara Bredice of the Green Mountain Care Board and on Charles Becker and Eric Schultheis of the Office of the Health Care Advocate, by electronic mail.

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