STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Cigna Health and Life Insurance Company Large Group Filing	)))))	GMCB-002-24rr SERFF: CCGP-134009857

OFFICE OF THE HEALTH CARE ADVOCATE
MEMORANDUM IN LIEU OF HEARING

The Office of the Health Care Advocate (HCA) submits this memorandum in lieu of hearing to the Green Mountain Care Board (GMCB) in response to Cigna Health and Life Insurance Company's (CHLIC) 2024 Large Group rate filing. CHLIC proposes a 9.6% increase to the manual rating methodology for its Vermont large group book of business which currently has 15 policyholders with 3,914 members. These Vermonters would experience rate changes between 1.3% and 18.1% if the Board were to approve the rate request as filed.[1]

I. CHLIC Bears the Burden to Justify Its Proposed Premium Increase.

Prior to selling a major commercial health insurance policy in Vermont, a health insurer must submit the proposed premium change to the Board for review.[2] The health insurance company "bear[s] the burden to justify the rate request."[3] To justify the rate request, an insurer must offer evidence regarding the rate review criteria and prove, by a preponderance of the evidence,[4] that a balancing of the criteria weighs in favor of the Board approving the rate.

[1] GMCB-002-24rr, Lewis & Ellis Actuarial Mem. at 1.
[2] 8 V.S.A. § 4062(a).
[3] Code Vt. R. 80-280-002, GMCB Rule 2.104(c).
[4] E.g., In re Smith, 169 Vt. 162, 169 (1999); Other evidence in rate review proceedings include the Department of Financial Regulation's solvency opinion, the analysis of Board's actuary, and evidence offered by the HCA.

The rate review criteria are an assortment of factors, often in tension, which the Board must balance.[5] They include statutory factors—that the 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" Vermont.[6] And they include actuarial factors—that the proposed rate is not "excessive, inadequate, or unfairly discriminatory."[7]

The Board examines the sufficiency of the evidence presented, engages in a balancing test, and ultimately determines the rate. The Board's process of examining, balancing, and determining is hampered when an insurer seeks to justify its rate requests almost exclusively through an actuarial lens. In such instances, the Board should find that the carrier has failed to justify the proposed rates and reduce them accordingly.

II. CHLIC Has Failed to Justify the Proposed Rate Increase.

CHILIC's large group filing presents three primary issues. The first issue, pharmaceutical adverse tiering, is both complicated and touches on a variety of non-actuarial rate review factors that the Board must consider. The second and third issues, the lack of evidence related to affordability and the promotion of access and the justification of the CHILC's proposed profit margin, are, unfortunately, issues that our office frequently raises in rate filing memoranda.

A. CHLIC offers plans with adverse tiering in the prescription drug benefit—producing rates that are inequitable and discriminatory, and that undermine affordability and access for plan members with chronic conditions.

CHLIC acknowledges offering its Vermont subscribers a 4-tier prescription drug benefit that places most or all drugs for treatment of HIV on the highest cost-share, specialty drug tier.[8]

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[5] E.g., GMCB-009-18rr, Decision at 17.
[6] 8 V.S.A. § 4062(a)(2)(A).
[7] Code Vt. R. 80-280-002, GMCB Rule 2.301(b).
[8] GMCB-002-24rr, Obj. 3, Q. 2. We understand CHLIC's reference to "some [drugs] that are subject to PPACA mandates" and therefore available for "$0 cost share" to be about drugs for the prevention of HIV infection, which are required to be provided as preventive care.

The HCA encourages the Board to consider this action to be adverse tiering, a practice that negatively impacts affordability and access, in addition to being inequitable and discriminatory. The Board should signal to CHLIC that adverse tiering will not be tolerated in Vermont and cut CHLIC's proposed rate accordingly.

Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability by "any health program or activity, any part of which is receiving Federal financial assistance …."[9] In the 2024 Final Rule, HHS reasserted that the provision of health insurance is a "health program or activity." [10] Furthermore, the "any part of which" clause encompasses even those segments of a covered health insurer's business operations that do not receive federal financial assistance, "including, for example, large group market plans" when the health insurer sells other products that do receive federal financial assistance.[11]

Although HHS has declined to describe benefit designs that would constitute *per se* discrimination, it has described benefit design features that could be discriminatory, including so-called adverse tiering, which is the practice of "placing most or all prescription medications that are used to treat a specific condition on the highest cost formulary tiers."[12] CMS later strengthened its position against adverse tiering, labeling it "presumptively discriminatory" in the

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[9] 42 U.S.C. § 18116(a); 45 C.F.R. § 92.3(a)(1).
[10] Nondiscrimination in Health Programs and Activities, 89 Fed. Reg. 37,522, 37,538–39 (May 6, 2024), https://www.govinfo.gov/content/pkg/FR-2024-05-06/pdf/2024-08711.pdf. The 2024 Final Rule supersedes the 2020 Final Rule, which superseded the 2016 Final Rule. In the 2020 Final Rule, the Trump Administration narrowed the definition of "health program or activity" to exclude health insurers principally engaged in the provision of insurance. The 2024 Final Rule restores the original broad definition contained in the 2016 Final Rule.
[11] Id. at 37,617–18.
[12] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375, 31,434 n.258 (May 18, 2016) (citing Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822), https://www.govinfo.gov/content/pkg/FR-2016-05-18/pdf/2016-11458.pdf.

2023 Notice of Benefit and Payment Parameters.[13] For the 2024 plan year, CMS began conducting adverse tiering reviews of qualified health plans to "check that QHPs cover sufficient drugs or drug classes prescribed to treat chronic, and high-cost medical conditions at lower cost tiers."[14] CMS will again conduct adverse tiering reviews for plan year 2025.[15] Less clear is what happens when adverse tiering is found. CMS states that "plans will be flagged for possible adverse tiering."[16] In other instances, regulators have simply asked insurers to correct adverse tiering violations, and insurers have been publicly pressured by advocacy groups to correct violations.[17]

As the name implies, adverse tiering negatively impacts the affordability of life-saving prescription drugs for people living with some of the most expensive-to-treat, chronic conditions. Consequently, adverse tiering also negatively impacts patient access to those medications. With respect to medications for the treatment of HIV, for example, the list price of these medications ranges from roughly $2,000 to nearly $5,000 per month.[18] While the lowest formulary tiers frequently require copayments, of $25 or $50 per script, for example, the highest formulary tiers more often require coinsurance. A coinsurance of 50% or more is quite common for specialty tier medications. With adverse tiering—when all or most treatments are placed on the highest cost

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[13] Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 27,208, 27,303 (May 6, 2022), https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf.
[14] CMS/CCIIO, 2024 Final Letter to Issuers in the Federally-facilitated Exchanges 19 (May 1, 2023), https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf. The conditions CMS included in the 2024 adverse tiering reviews were hepatitis C, HIV, multiple sclerosis, and rheumatoid arthritis.
[15] CMS/CCIIO, 2025 Final Letter to Issuers in the Federally-facilitated Exchanges 24 (April 10, 2024), https://www.cms.gov/files/document/2025-letter-issuers.pdf.
[16] Id.
[17] See, HIV+HEP Policy Institute, Comments on 2025 Draft Letter to Issuers in the Federally-Facilitated Exchanges 2–4 (Jan. 2, 2024), https://hivhep.org/wp-content/uploads/2024/01/2025-letter-to-issuers-HIVHep-comments-1.2.24.pdf.
[18] See, e.g., Tim Murphy, How Much Does HIV Treatment Cost?, The Body (April 26, 2024), https://www.thebody.com/article/hiv-treatment-cost.

tiers—a person with HIV could easily face out-of-pocket costs of over $1,000 in a single month. Even with Vermont's out-of-pocket limit on prescription drug expenditures in fully insured plans, currently $1,600 for an individual and $3,200 for a family annually, such costs could cause a person to forgo treatment, to incur medical debt, or dissuade a person from enrolling in a plan altogether—which would be strong evidence of discriminatory impact.

The presence of adverse tiering in a health plan is also inequitable. Chronic illnesses such as diabetes, HIV, and hepatitis disproportionately impact communities of color.[19] The prevalence of chronic health conditions among BIPOC individuals itself can be traced to systemic discriminatory policies which have resulted in BIPOC individuals having less wealth, living in worse environmental conditions, and having less access to health care than White people.[20] Indeed, in a "study of Medicare beneficiaries without drug coverage"—a decent proxy for adverse tiering under which beneficiaries face exorbitant coinsurances—it was found that "Black and Latinx individuals used 10 to 40 percent fewer medications than their White counterparts did for the same illnesses."[21]

CHLIC is an "international, for-profit health services corporation that is a subsidiary of the Cigna Corporation."[22] CHLIC offers products nationally that receive federal financial assistance, including Medicare supplement policies in Vermont.[23] Therefore, Section 1557 applies to CHLIC.

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[19] NASHP, States Curb Racial Inequities in Rx Drug Affordability with Targeted Legislation, https://nashp.org/states-curb-racial-inequities-in-rx-drug-affordability-with-targeted-legislation/.
[20] Id.
[21] Id.
[22] GMCB-002-24rr, Lewis & Ellis Actuarial Mem. at 1.
[23] Dep't Fin. Reg., Medicare Supplemental Rates, https://dfr.vermont.gov/document/medicare-supplemental-rates.

In this filing, CHLIC proposes a rate which incorporates plan designs under which most or all medications for the treatment of HIV are placed on the highest cost sharing tier. Quite simply, this is adverse tiering of HIV treatment.[24] Any member on a policy where the subscriber has elected a 4-tier plan will face higher costs for HIV treatment as a result—costs which might lead to treatment disruption, medical debt, or to the person opting not to enroll in the plan at all. This is precisely the discriminatory impact that Section 1557 of the ACA is meant to prohibit.

The Board should find that, due to adverse tiering, CHLIC's proposed rate is inequitable and discriminatory, and additionally undermines affordability and access. Further, whether the adverse tiering contained in the filing implicates the proposed rate or is instead a forms issue within the Department of Financial Regulation's jurisdiction should not stop the Board from using the tools at its disposal to discourage CHLIC from offering this particular benefit design in Vermont. Adverse tiering undermines Vermonters' ability to afford and access needed health care; it is also highly inequitable and discriminatory. We encourage the Board to cut CHLIC's rate request accordingly, if not deny the rate request altogether.

B. CHILIC's rate should be reduced because the carrier produced no evidence that the rate is affordable or promotes access.

CHLIC offers no evidence that its proposed rate is affordable or promotes access to care. Considering that some Vermonters will experience premium increases as high as 18.1% if the Board approves the proposed rate, CHILIC's omission alone should give the Board pause. In

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[24] To simplify our analysis, the HCA only reviewed CHLIC's specialty formulary list for HIV medications. However, the sheer length of CHLIC's specialty formulary list raises concerns that adverse tiering may be present for other conditions as well. CHLIC's specialty formulary spans 2,344 rows in the Rx Data template. By comparison, Blue Cross Blue Shield of Vermont submitted two specialty formulary lists in their most recent large group filing, one spanning 771 rows and the other 660 rows (neither of which have we evaluated for adverse tiering). MVP Health Care appears not to have submitted a specialty formulary list in their most recent large group filing.

counter point to CHLIC's silence, we offer below uncontested evidence that increases in rates are neither affordable to Vermonters nor do they promote access.

The latest government data indicates that prices rose 3.4% from April 2023 to April 2024.[25] Of particular interest, is the price inflation of necessities. Since March 2023, after a period of record growth:

- the price of food is up 2.2% overall, fresh vegetables are up 2.3%, uncooked ground beef is up 6.0%, and chicken is up 0.7%, but milk is down -1.2%;
- the cost of energy is up 2.6% overall, with electricity being up 5.1%, and gasoline being up 1.2%, but fuel oil is down by -0.8%;
- medical care commodities are up 2.5%;
- the cost of shelter is up 5.5% overall, rent of a primary residence is up 5.6% and owners' equivalent rent of primary residence is up 5.7%.[26]

Additional evidence that Vermonters cannot afford employer sponsored insurance (ESI), such as CHLIC offers, comes from the 2021 Vermont Household Health Insurance Survey. One-third of Vermont's uninsured population have access to ESI but choose not to take it.[27] Seventy-six percent of Vermonters who decline ESI cite cost as the primary reason for electing not to purchase their employer's plan.[28]

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[25] U.S. Bureau of Labor Statistics, April 2024 Consumer Price Index Summary, May 15, 2024, Table A, https://www.bls.gov/news.release/cpi.nr0.htm.
[26] U.S. Bureau of Labor Statistics, April 2024 Consumer Price Index Summary, May 15, 2024, Table 2, https://www.bls.gov/news.release/cpi.t02.htm.
[27] Vt. Dep't of Health, 2021 Vt. Household Health Insurance Survey. at 31 (2022), https://www.healthvermont.gov/sites/default/files/documents/pdf/VT%20Household%20Health%20Insurance%20Survey%202021%20Report%205.6.22.pdf.
[28] Id.

Affordability, amongst other necessary but insufficient factors, is critical to ensuring access to care. Care that is too expensive to use is not accessible. As such, to the extent that the rate is not affordable, as demonstrated above, the rate also does not promote access to care.

Far from establishing by a preponderance of the evidence that their proposed rate is affordable and promotes access, CHLIC offers no evidence at all addressing these two factors. CHLIC does not provide evidence that Vermonters can afford the cost of their large group health insurance plans, or that, after paying their share of the premium, members can afford to access care when they or their loved ones need it. The evidence shows that Vermonters struggle to afford their health care and that many limit their access to care as a result. The Board has the power to make health insurance more affordable and to promote access for CHLIC's Vermont customers and should do so.

C. CHILIC's proposed profit margin should be reduced because it is not needed to protect solvency nor does it advance affordability or access.

CHLIC has not demonstrated by a preponderance of the evidence that a 2% profit is necessary to maintain solvency or that it is appropriate given other rate review factors. In fact, the evidence offered shows that CHLIC's requested 2% profit does not meet the standard the Board uses to evaluate carrier solvency.

First, the Department of Financial Regulations (DFR) noted in its report on this filing that CHLIC's primary solvency regulator, the Connecticut Insurance Department, has not told DFR of any concerns related to CHLIC.[29] Further, because CHLIC's Vermont premium constitutes such a small percentage of its written premium, less than 1%, it is undisputed that the rates CHLIC charges Vermonters will not materially affect CHLIC's solvency one way or the other.[30]

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[29] GMCB-002-24rr, Dep't Fin. Reg. Solvency Op. at 2.
[30] Id.

Second, Lewis and Ellis (L&E) detail that a reasonable profit margin would be between 0.5% and 3%.[31] CHLIC's proposed profit margin is at the high end of this range.[32] L&E's opinion on the "reasonable" profit range, however, does not consider affordability and access, subjects that actuaries neither consider nor have any expertise in. As such, L&E's suggested range is an overestimate of what is a valid range under Vermont law. The Board should also consider the fact that CHILC has consistently underestimated profit. Over the period of 2020 to 2022, CHILIC's annual average expected profit margin was -0.83%, but it realized an average annual profit margin of 7.16%. CHILIC's performance in 2022 is particularly notable. Its expected profit margin was 0.5%, but its actual margin was 14%.[33]

Lastly, as described in Section B above, there is concrete evidence from reliable sources that Vermonters cannot afford CHLIC's profit assumption. This evidence contrasts with the lack of evidence CHLIC presents to support its 2% profit assumption, a burden of proof CHLIC bears pursuant to Board rule.[34]

Given the extent of the access issues facing Vermonters that we detail above and both the lack of solvency concerns, the overestimated "reasonable" CTR range, and the failure of CHLIC to support its profit assumption, the Board should order a 0.25% profit assumption based on CHLIC's failure to carry its burden of proof and a balancing of rate review factors.

III. Conclusion

For the reasons stated above, the Board should:

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[31] GMCB-002-24rr, Lewis and Ellis Actuarial Mem. at 2.
[32] Id.
[33] Id.
[34] Code Vt. R. 80-280-002, GMCB Rule 2.104(c).

- deny the proposed rate, or reduce the rate by at least two percentage points, because the product incorporates adverse tiering into the benefit design and thus the proposed rate is discriminatory and inequitable, and does not promote access or affordability;
- deny the proposed rate, or reduce the rate by at least two percentage points, because the proposed rate is not affordable and does not promote access, and CHLIC failed to provide any evidence on these points to the contrary thereby failing to meet its burden of proof;
- reduce CHLIC's profit to 0.25 percent, because the proposed CTR is not needed to ensure CHLIC's solvency.

Dated in Rutland, Vermont, this 17th day of May 2024.

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CERTIFICATE OF SERVICE

I, Charles Becker, hereby certify that I have served the above HCA Memorandum in Lieu of Hearing on Michael Barber, Laura Beliveau, and Tara Bredice at the Green Mountain Care Board; and upon Lauren Longley, CHLIC representative of record, by electronic mail, delivery receipt requested, this 17th day of May 2024.

/s/ Charles Becker
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