STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont	)	
3rd Quarter 2018 Large Group Rating Program Filing	)	GMCB-003-18rr
	)	
In re: The Vermont Health Plan	)	
3rd Quarter 2018 Large Group Rating Program Filing	)	GMCB-004-18rr

OFFICE OF THE HEALTH CARE ADVOCATE MEMORANDUM IN LIEU OF HEARING

We thank the Green Mountain Care Board (Board) for the opportunity to respond to the Blue Cross Blue Shield of Vermont (BCBSVT) 3rd Quarter 2018 Large Group Rating Program Filing and The Vermont Health Plan (TVHP) 3rd Quarter 2019 Large Group Rating Program Filing (collectively, Filings). We also thank the Board for its commitment to containing health care costs and making quality health care accessible for Vermonters. In this memorandum, we use "BCBSVT" to refer to BCBSVT and TVHP collectively because TVHP is a wholly-owned subsidiary of BCBSVT.

The Office of the Health Care Advocate (HCA) submits the following Memorandum in Lieu of Hearing in opposition to BCBSVT's proposed 11.2% rate increase. BCBSVT failed to meet its burden of proof to justify the proposed rate. Further, the Filings are not affordable because they (a) fail to adequately demonstrate system cost containment efforts and (b) unreasonably exacerbate the health insurance affordability crisis experienced by Vermonters. Therefore, BCBSVT's proposed rate fails to conform to the applicable statutory standard for health insurance rate changes and should be modified downward.

We respectfully ask the Board to reduce the total proposed premium by, at a minimum, one percent. Such Board action will hopefully motivate BCBSVT to submit filings that minimally address the relevant statutory criteria while simultaneously encouraging meaningful participation in Vermont's efforts to contain cost, provide quality medical care, and ensure an accessible and affordable health care system.

We also ask the Board to define carrier rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria in future filings. Regulated entities will only pay lip service to cost containment and affordability until the Board mandates new processes and holds the regulated entities accountable to conform to the applicable statutory and/or regulatory standards.

Lastly, we note that the proposed 11.2% will apply in the second year of Vermont's all-payer model (APM) agreement. The Board endorsed this agreement as an "opportunity to move forward towards a more efficient health care system that rewards quality care and positive health outcomes."[1] Further, in that agreement, the Board noted that continuing health system cost growth will place "unsustainable financial burdens on Vermonters and their families…" and it will "cripple [Vermont's] economy."[2] The Board must apply its regulatory oversight to ensure carriers are doing everything they can to lower costs while maintaining quality care and access to care if the Board wishes for Vermont to meet the APM targets. A downward reduction of the proposed premium and the imposition of filing standards that track the statutory rate criteria would advance the Board's stated goal.

Before proceeding to the substantive sections of this memorandum, we first detail the applicable standard of review and the procedural history of the Filings.

STANDARD OF REVIEW

The insurer bears the burden of justifying the requested rate change when filing a rate request.[3] Neither the Board nor the HCA must present an alternative rate scheme to remedy a deficient proposed rate. Absent an adequate justification for the proposed rate, the rate scheme, or an element thereof, should be disproved or the Board may, in its discretion, modify the proposed rate or rate element.[4]

When "deciding whether to approve, modify, or disapprove each rate request," the Board is charged to "determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[5] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[6]

[1] GMCB Decision, In re Vermont All-Payer Accountable Care Organization Model Agreement (Oct. 26, 2016) at 11.
[2] Id. at 1.
[3] GMCB Rule 2.104(c).
[4] See e.g., GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to reserve based on the insurer failing to meet "its burden for the requested increase…")
[5] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207 (Vt. 2016).
[6] 18 V.S.A. §9375(b)(6).

Procedural History

On March 19, 2018, the Board posted the Filings on its website. The Fillings request an average rate increase of 11.2%.[7] This increase would impact 14,200 Vermonters.[8]

On March 22, 2018, the HCA filed notices of appearance to represent the public's interests.[9]

On May 14, 2018, Lewis & Ellis (L&E), the actuarial firm retained by the Board, submitted actuarial recommendations related to the Filings. L&E's recommendations, consistent with its charge and expertise, relate only to the actuarial soundness of the proposed rate and not the broader and complex set of statutorily-defined factors that the Board is charged to weigh when reviewing proposed rate changes.[10]

On May 15, 2018, the Vermont Department of Financial Regulation (DFR) submitted a solvency opinion regarding the Filings. DFR "does not expect the proposed rate will have a significant impact on [its] overall assessment of BCBSVT."[11] DFR references that BCBSVT is currently at or near the low end its RBC target.[12] We note, however, that BCBSVT's stated RBC target of 500% to 700% is substantially above both the 200% RBC level that triggers DFR oversight and the minimum RBC of 375% to avoid triggering monitoring by the BlueCross BlueShield Association.[13]

ARGUMENT

BCBSVT HAS FAILED TO MEET ITS STATUTORILY DEFINED BURDEN OF PROOF BECAUSE THE FILINGS ONLY ADDRESS WHETHER THE PROPOSED RATE IS ACTUARIALLY JUSTIFIED.

BCBSVT has failed to offer any evidence other than an actuarial justification for the proposed rate. BCBSVT chose such a course of action despite (1) clear statutory language that actuarial justification is only a subset of the factors that the Board is charged to consider when evaluating proposed rates and

[7] GMCB-003-18rr, SERFF Filing.
[8] GMCB-003-18rr, Lewis & Ellis Actuarial Opinion at 1; GMCB-004-18rr, Lewis & Ellis Actuarial Opinion at 1.
[9] GMCB-003-18rr, HCA Notice of Appearance; GMCB-004-18rr, HCA Notice of Appearance.
[10] GMCB Rule 2.301(b); GMCB Rule 2.401; In re MVP Health Insurance Company, 155 A. 3d 1207; 18 V.S.A. §9375(b)(6); see also, 8 V.S.A. §4062(a)(3).
[11] GMCB-003-18rr, May 15, 2018, Department of Financial Regulation Solvency Opinion at 3; GMCB-004-18rr, May 15, 2018, Department of Financial Regulation Solvency Opinion at 3.
[12] Id. at 1.
[13] Consumers Union, How Much is too Much: Have Nonprofit BlueCross and BlueShield Plans Amassed Excessive Amounts of Surplus? (July 2010), available at http://consumersunion.org/wp-content/uploads/2013/02/prescriptionforchange.org-surplus_report.pdf; Vermont Legislative Joint Fiscal Office, Issue Brief: Surplus and Risk-Based Capital for Health Insurance Companies (Sept. 2017).

(2) the unambiguous rule that BCBSVT bears the burden of proof to justify the proposed rate. Absent an adequate justification for the proposed rate by the insurer, the rate scheme, or an element thereof, must be modified by the Board.[14]

The legislature mandated that the Board review a proposed rate in terms of the rate's system impact, actuarial soundness, and impact on Vermonters. As stated above in the Standard of Review section, the legislature charged the Board to "determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[15] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[16] We recognize the difficulty of executing that charge. Regardless, the proper execution of the charge lies at the heart of Vermont's future.

Here, BCBSVT failed to adequately address multiple factors that the Board must evaluate when reviewing a proposed rate. Although BCBSVT has, in the past, only offered actuarial justification for proposed rates, such past practices do not negate the underlying statutory and regulatory frameworks that set out the factors and burden of proof that a carrier proposing a rate change must meet.

Further, BCBSVT's practice of only offering actuarial justification for the rates attempts to direct the Board's rate review towards a narrow subset of factors that best justify the proposed rate. The Vermont Supreme Court, however, has made clear that affordability and other non-actuarial factors that take into account health system function and the needs of Vermonters are mandated components of the Board's rate review.[17]

1. BCBSVT Failed to Adequately Address System Cost Reduction Efforts or the Financial Burden on Vermonter's of the Proposed Rate Increase

The legislature charged the Board to "determine whether a proposed rate is affordable…"[18] In cases such as this where there is no statutory or regulatory definition of a term and the statute deals with a specialized subject, the meaning ascribed to the term should be that meaning which is used in the

[14] See e.g., GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to reserve based on the insurer failing to meet "its burden for the requested increase…")
[15] Id.; GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3).
[16] 18 V.S.A. §9375(b)(6).
[17] See, In re MVP Health Insurance Company, 155 A. 3d at 1214.
[18] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207.

relevant technical field or policy community. [19] Here, the relevant policy community the Board should look to in ascribing meaning to the word "affordability" are similarly situated state actors.

We are aware of only one other state or jurisdiction that defines affordability in its health insurance rate review process, namely, Rhode Island.[20] In broad terms, Rhode Island applies a two-prong affordability test. The first prong of the affordability test is that a carrier must demonstrate that it is working to reduce health care costs by undertaking cost containment activities in line with health care system reform. [21] The second prong of the affordability test is that a carrier must demonstrate that lower-income consumers have "the ability … to pay for health insurance." Both prongs are necessary because carriers lack a financial incentive to reduce system costs or premiums. [22] Neither prong is sufficient because premium reductions absent system reform will risk carrier insolvency and absent system reform premiums will increase placing ever greater financial burdens on Vermonters. BCBSVT failed to adequately addresses either affordability prong.

a. BCBSVT is not engaging in adequate system cost reduction efforts.

In its actuarial memorandum, BCBSVT offers no evidence that the proposed rates are affordable in terms of implementing health care system reform. BCBSVT does not even discuss potential or early-stage health system reform efforts such as the implementation of cost containment measures or alternative payment methodologies that have the potential to reduce system costs in its original large group filing as it does in its 2019 BCBSVT Vermont Health Connect filing.[23]

As part of the filing review process, the HCA asked BCBSVT to explain how it is controlling costs for this book of business through alternative payment methodologies with or outside of OneCare Vermont. We asked for this explanation both because of the relevant statutory criteria for rate review

[19] E.g., William N. Eskridge, J., Philip P. Frickey, & Elizabeth Garret, Cases and Materials on Legislation: Statutes and the Creation of Public Policy (3d. ed. 2001).
[20] R.I. Gen, Laws § 42-14.5-2 (the Rhode Island legislature created a regulatory entity, the Office of the Health Insurance Commissioner (OHIC), with numerous charges including the review of proposed health insurance rates.); Office of the Health Insurance Commissioner Regulation 2 (Originally Effective December 15, 2006) at 14-16 (OHIC issued regulations defining the technical usage of the word "affordable."), available at http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf.
[21] Id. at 15 (activities examined under this prong include reform efforts such as improved primary care supply, reduced emergency room visit incidence, reduced re-hospitalization, and the "implementation of effective strategies by the health insurer to enhance the affordability of its products.").
[22] Marshall Allen, Why Your Health Insurer Doesn't Care About Your Big Bills, NPR (May 25, 2015) (describing how health insurance carriers lack incentives to reduce system costs), available at https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills,
[23] GMCB-009-18rr, BCBSVT Actuarial Memorandum at 22.

and the Board's policy statement that Act 48 "makes clear that health insurers, Medicaid, Medicare, and other payers should reimburse health care professionals with consistent payment methodologies that provide incentives to coordinate care and control cost growth."[24]

BCBSVT's response to our question was nonspecific and noncommittal.[25] BCBSVT stated vague plans to expand alternative payment programs and that it is "evaluating potential inclusion of BCBSVT's large group insured population for 2019" with OneCare.[26] BCBSVT also pointed out that approximately 50% of its contracts with network primary care providers include capitated payments. We note, however, that BCBSVT has stated that it sets its primary care capitated payments to be equal to the amount it would have spent under fee for service.[27] Although we explicitly asked BCBSVT about controlling costs, BCBSVT did not provide adequate information to evaluate whether any of the provider agreements it referenced in its response to our inquiry are designed to save money. Further, BCBSVT did not attempt to quantify current savings due to system reform efforts or to predict any specific cost savings in the future due to system reform efforts.

Because BCBSVT has offered insufficient evidence that they are making reasonable efforts to control costs for the population in this book of business, the Filings are, by definition, not affordable. In light of this fact, the Board must engage in the difficult task of balancing the carrier's needs against Vermonters need for health care cost containment and health care system reform. The result of this balancing should be a reduction of the proposed rates.

b. <u>BCBSVT failed to adequately demonstrate, or even minimally address, how the carrier has attempted to reduce the financial burden of the proposed rates on Vermonters.</u>

Affordability, as discussed above, contains a second component, namely, whether Vermonters can afford the premium charged. This second component is, as discussed above, a necessary but insufficient component of affordability meaning that an affordable rate must incorporate both insurer cost saving efforts and align with Vermonters' ability to purchase health insurance.

Many Vermonters, whether employers or employees, cannot afford the premium increase proposed in the Filings. We note that, for this book of business, an employee will likely pay a share of the

[24] GMCB Decision, <u>In re Vermont All-Payer Accountable Care Organization Model Agreement</u> at 2.
[25] GMCB 03-18rr, BCBSVT Response to Objection Letter #3 at 3 (Q4).
[26] <u>Id</u>. at 3 (Q4.b).
[27] GMCB 08-17rr, BCBSVT Vermont Health Connect 2018 Rate Filing, Hearing Transcript, Schultz Testimony at 80 (lines 4-24).

increased premium. In light of this fact, an observer might conclude that the primary burden of the proposed rate will be on Vermont employers.

Vermont employees will also significantly bear the burden of the proposed rate increase. Substantial evidence shows that employers view an employee's total compensation as a whole when setting wages. Thus, if the employer premium share increases, the employee's wage is offset by increased employer premium share.[28] Wage suppression due to premium growth likely also impacts employers in so far as they are unable to offer competitive a wage. Increases in the rates for these books of business thus have the dual effect of placing Vermont employers at a competitive disadvantage and creating an unsustainable financial burden for Vermont employees.

Although the Filings do not address the financial affordability of the proposed rate, we use a simple comparison of the historical premium rate growth for this book of business to real Vermont Gross Domestic Product (VTGDP) growth and real Vermont wage growth (VTWG) to demonstrate that the proposed rate is unaffordable for Vermonters.[29]

Rate growth for these books of business compared to VTGDP growth and VTWG demonstrate that the premiums have substantially outpaced Vermont's economic growth. Further, this comparison shows that health insurance premiums for these books of business have substantially outpaced the ability of individual Vermonters to afford them. The trend is clear, Vermonters are spending an ever larger percentage of their income for health insurance of the same or lesser benefit richness.[30]

BCBSVT's premium growth for this book of business has substantially outpaced the growth of Vermont's economy as measured by VTGDP growth. Between 2015 and 2017, BCBSVT's premium growth was 433% of real VTGDP growth.[31]

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[28] See e.g., Gary Burtless & Sveta Milusheva, Effects of Employer-Sponsored Health Insurance on Social Security Taxable Wage, Social Security Bulletin, 73(1), 83-107 (2013); Priyanka Anand, Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey, Health Economics, 26(12) (2017) (describing that a $1 increase in health care costs causes a larger than $1 decrease in total hourly compensation).

[29] We present real VTGDP growth and real VTWG, as opposed to nominal growth, because real growth is adjusted for differences in price levels (inflation) between time periods. Real VTGDP growth and real VTWG allow us to examine whether Vermonters' are actually better or worse off when making comparisons with premium increases across time periods.

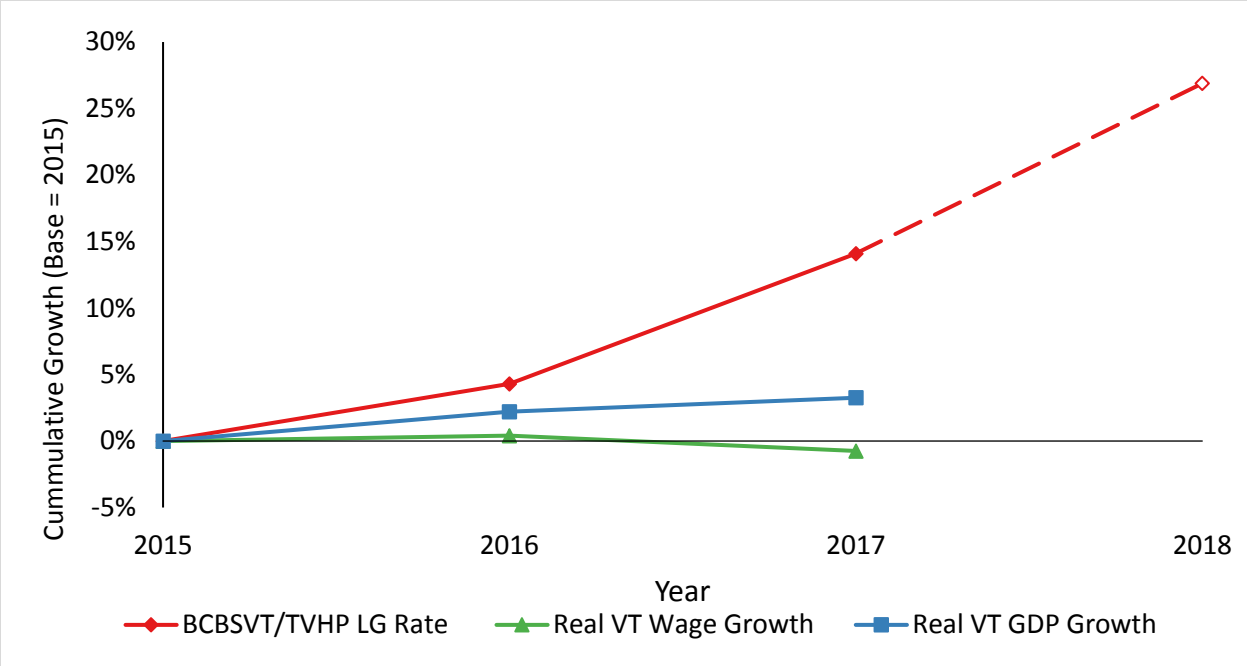
[30] Davis I. Auerbach & Arthur L. Kelermann, A Decade of Health Care Cost Growth has Wiped Out Real Income Gains for an Average US Family, Health Affairs, 30(9), 1630, (Sept. 2011), available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0585.

[31] 2015 to 2017 is the period starting with the first year that average rate increase for the book of business is available on the Board's website and ending at the most recent year for which VTGDP data is available. U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Vermont, retrieved from FRED, Federal Reserve Bank of St. Louis, available at https://fred.stlouisfed.org/series/VTNGSP; U.S. Bureau of Labor Statistics, Northeast Region CPI, Series ID: CUUR0100SA0. As discussed in note 21, we use real growth as opposed to nominal growth because real growth accounts for differences in price levels (inflation) between time periods. It was not possible to

BCBSVT's premium growth for this book of business also outpaced VTWG. Between 2015 and 2017, BCBSVT's premium growth was 14.1% compared to the real VTWG of -0.75%.[32]

The proposed rate increase would be less troubling if the historical trend of rate growth for this book of business was not increasing at an ever-faster rate. Indeed, between 2015 and 2018, assuming the rate increase in the Filings, the cumulative premium growth is a disturbing 26.88%.[33] Chart 1 presents the unsustainable trend of rate growth for this book of business compared to real VTGDP growth and VTWG.

Chart 1. Rate growth, real VTGDP growth, and VTWG.[34]



We note that the trend of premium outpacing VTGDP growth and VTWG has multiple possible effects. First, the growth of premium substitutes for wage increases as the total employee

calculate the carrier's real historical and proposed rate because inflation statistics for 2018 are not currently available. In light of this fact and a desire not to have a graph element represent both real (2016 and 2017) and nominal (2018) growth, we choose to present the carrier's nominal rate increase. We did, however, calculate the real rate growth for 2016 and 2017. The difference between the real and nominal rate growth from 2016 to 2017 was small and did not materially change the import of the comparison between rate growth, VTGDP growth, and VTWG.

[32] 2015 to 2017 is the period starting with the first year that average rate increase for the book of business is available on the Board's website and ending at the most recent year for which VTWG data is available. U.S. Bureau of Labor Statistic, Vermont Average Weekly Earnings (total private), SMU50000000500000011; U.S. Bureau of Labor Statistics, Northeast Region CPI, Series ID: CUUR0100SA0. Please refer to Note 23 for justification of decision to present real VTWG but nominal rate growth.

[33] GMCB-003-18rr, SERFF Filing.

[34] Id.; note 24; note 23; GMCB-004-17rr, Decision; GMCB-003-16rr, Decision.

compensation package increases even when wages remain flat due to rising premium. This essentially means that health insurance premium growth suppresses wage growth leaving Vermonters both paying more premium and having less money to purchase health insurance and other necessities. [35] Wage suppression due to premium growth also likely inhibits Vermont employers' ability to offer competitive wages.

Second, the increasing share of a household's income paid towards health insurance premium may influence a household's decision to not participate in the health insurance market. The result of such a decision undermines the risk pool and, if it happens at scale, leads to higher health insurance premiums for those remaining in the risk pool. Further, if a household chooses to forgo health insurance, this may increase the incidence and amount of bad debt that hospitals experience serving the uninsured. The incidence of bad debt may in turn increase the unit cost for health care services and increase the medical trend and further increase premium cost.

In the Filings, BCBSVT fails to offer any evidence that the proposed rate is affordable to Vermont policy holders and subscribers. In fact, federal government statistics unambiguously show that the rate growth has substantially outpaced Vermont domestic product and wage growth. Perhaps even more troubling, between to 2016 and 2017, with a base year of 2015, Vermont wage growth declined to a negative growth rate while the premium growth rates for this book of business have exponentially increased.

The proposed rate is not affordable to Vermonters as demonstrated by the unambiguous evidence presented in the above analysis. Therefore the Board should exercise its discretion to modify the rate downward.

CONCLUSION

BCBSVT has failed to meet its burden of proof for a rate increase because it has failed to adequately address the factors that the Board is charged to use when evaluating rate changes. These factors help advance the goals of the APM and ensure that health insurance rates are affordable for Vermonters. In fact, BCBSVT failed to even minimally address a substantial portion of the required statutory factors in the Filings that the Board is charged to weigh when evaluating a rate proposal.

[35] See, Burtless & Milusheva, supra note 28.

We respectfully ask the Board to define carrier rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria. Regulated entities will only pay lip service to cost containment and affordability until the Board holds them to be accountable for their actions.

Further, we respectfully request that the Board reduce the total premium by, at a minimum, one percent based on an analysis of BCBSVT's failure to meet its burden of proof and on a balancing of the statutorily mandated factors the Board is charged with evaluating when exercising its authority related to rate modification.[36]

Dated at Montpelier, Vermont this 31st Day of May, 2018.

/s/ Eric Schultheis
Eric Schultheis, JD Ph.D.
Health Care Law and Policy Analyst
Office of the Health Care Advocate
Email: eschultheis@vtlegalaid.org

/s/ Kaili Kuiper
Kaili Kuiper, Esq.
Staff Attorney
Office of the Health Care Advocate
Email: kkuiper@vtlegalaid.org

[36] E.g., GMCB-03-15rr, Decision at 5 (reducing a proposed rate for a large group filing due to a carrier failing to meet its burden of proof; GMCB-04-17rr, Decision at 5 (reducing a proposed rate for a large group filing based on a balancing of the carriers' needs against the needs of Vermonters' for affordable rates).

CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above Memorandum in Lieu of Hearing on Judith Henkin, Green Mountain Care Board General Counsel; Sebastian Arduengo, Green Mountain Care Board Staff Attorney; Agatha Kessler, Green Mountain Care Board Health Policy Director; and Jacqueline Hughes, Blue Cross Blue Shield of Vermont representative, by electronic mail, return receipt requested, this 31st day of May, 2018.

/s/ Eric Schultheis

Eric Schultheis, JD Ph.D.
Office of the Health Care Advocate
Montpelier, Vermont 05601
Email: eschultheis@vtlegalaid.org