

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES AND HEALTH CARE ADMINISTRATION

In re: Blue Cross Blue Shield of Vermont)
Request for Increase in Subscriber Rates) Docket No. 09-131-H
Filing Nos. 45346 and 45347)

Commissioner's Decision

Based upon consideration of the entire record in this matter, the Commissioner hereby issues the following Findings of Fact:

Findings of Fact

1. Blue Cross Blue Shield of Vermont (“the Company”) filed a request for an overall 34.6% increase in its rates for the insured members of Business Resource Services (“BRS”), a business association exempt from certain requirements of Vermont’s community rating law under 8 V.S.A. § 4080a(h)(3) and (4). The proposed rate increases vary from 7.4% to 47%, depending upon the product chosen by the association member or subscribers. Exhibit A (2010 Rate Development Filing for BRS, No. 45347)

2. The Company also filed a request for an overall 24.9% in its rates for the insured members of the Vermont Health Services Group Association (“VHSG”), a business association exempt from certain requirements of Vermont’s community rating law under 8 V.S.A. § 4080a(h)(3) and (4). The proposed rate increases vary from – 4.3% to 49.6%, depending upon the product chosen by the association member or subscriber. Exhibit B (2010 Rate Development Filing for VHSG, No. 45346).

3. The Company’s proposed rate increases were calculated using a base trend factor approved by the Department of 8.4% for combined medical and pharmacy claims. Applied to the BRS and VHSG association experience pools, however, the trend factor results in a 10.9% trend factor for BRS, and an 11.1% trend factor for VHSG. Exhibit C (1Q 2010 Trend Factor Filing No. 44507); Exhibits A and B.

4. The Company’s proposed rate increases were also calculated using an overall 5% annual administrative cost trend approved by the Department. Applied to the BRS association and the VHSG association, however, the trend factor results in a significantly higher increase in administrative costs for BRS and VHSG. Exhibit D (2010 Admin Charge Schedule and Contribution to Reserve Filing No. 44670); Exhibits A and B.

5. Three additional factors have contributed to the magnitude of the Company’s proposed rate increases. First, for many years the Company failed to measure and timely file benefit relativity factors on a regular basis. Benefit relativity factors are needed in order that premiums charged to subscribers accurately reflect the cost of the benefit design included in the subscriber’s insurance product. Because of this failure, the Company is essentially “catching up” for years when benefit relativity factors were not applied as they should have been, resulting in significant rate increases in the current year. These significant rate increases resulted notwithstanding the application of a

formula designed to mitigate the impact on rates in the first year. Exhibit E (Benefit Relativity Methodology Filing).

6. The second additional factor contributing to the significant rate impact on the BRS and VHSG associations is the decision of the Company to reduce the number of the Company's insurance product offerings in order to reduce the Company's administrative costs. For many years the Company's administrative costs have been higher than necessary because of the multiplicity of insurance products offered to subscribers. The reduction in insurance products is in accordance with recommendations of the Company's auditor, in September 2007 (Exhibits F, Report and Analysis of the Administrative Expenses of Blue Cross Blue Shield of Vermont, Deloitte Consulting LLP), but because of its historical decision to maintain a multiplicity of insurance products, and because of the manner and timing in which the number of products offered to BRS and VHSG have been reduced, the results are a substantial impact on subscriber rates. Exhibits A and B.

7. The Department has supported, and continues to support the Company's efforts to reduce the number of its insurance product offerings in order to reduce the Company's administrative costs which are included in subscriber rates. Exhibit G (Commissioner's letter dated November 2, 2007). The Department also has supported, and continues to support, the Company's decision to measure and apply benefit relativity factors to the various benefit plans offered by the Company, so that the premiums charged to subscribers will more accurately reflect subscribers claims and costs. Exhibit H (Department's approval of the Benefit Relativity Methodology Filing, July 22, 2009). Nevertheless, the impact of implementing these decisions has contributed to significant rate increases for most of the BRS and VHSG members. While the Company's Benefit Relativity Methodology Filing includes a transition methodology, the Filing does not provide adequate notice to the Department that applying the benefit relativity factors contribute in a substantial manner to rate increases of 34.6% and 24.9% for the respective associations. 1,943 of the total of 2,941 subscribers face rate increases in excess of 40% under the Company's BRS filing, and 1,340 of the total of 2,382 subscribers face rate increases in excess of 40% under the Company's VHSG filing. Exhibits A and B

8. The third additional factor contributing to the significant rate impact on the BRS members is a combination of volatility and adverse selection in the BRS association experience pool. As explained by the Department's actuarial consultant, BRS subscriber contracts insured by the Company have decreased from 4,460 at the 2009 renewal date to 2,941 at the 2010 renewal date. While subscribers have been leaving the BRS association, the subscriber claims per month has increased from \$745.34 to \$933.19. This phenomena is a classic demonstration of adverse selection, where healthier members leave a group, leaving behind less healthy and more expensive insured subscribers. Exhibit I (Harrington letter of October 22, 2009).

9. Rate increases of these magnitudes are likely to produce two equally undesirable results: either the significant rate increases will exacerbate the existing volatility in the association and small group markets, as employers seek ways to mitigate significant

increases in their business costs by migrating to another association or market; or, faced with business cost increases that cannot be absorbed, the employer will choose to drop coverage for his or her employees and their dependents. While employers who drop coverage face an adjustable assessment of \$365 annually per uncovered full time equivalent employee (21 V.S.A. §§ 2001-2003), if the Company's proposed rate increase request for the BRS association is approved, annual subscriber plan premiums will range from \$7,116.52 (single, \$2,250 deductible)/\$18,474.48 (family, \$4,500 deductible) for the lowest cost HSA plan, to \$8,136.12 (single)/ \$21,966.84 (family) for a preferred provider organization product with a \$500 deductible, \$2,500 annual out of pocket maximum, \$30 office co-payment. Assuming that a typical employer contributes 83% of the cost of single coverage, and 63% of the cost of family coverage¹, the business cost to the employer if the Company's rate increases are allowed to be implemented is \$5,906.71/\$11,638.92 for HSA coverage or \$6,752.98/\$13,839.10 for PPO coverage, far in excess of the cost of the \$365 annual FTE assessment.

10. The Company's other rate increases in its other lines of business are relatively modest when compared to the rate increases proposed by the Company for its BRS and VHSG subscribers. See Exhibit J (TVHP approved filing).

11. The Company's current reserves, which must be adequate in order for an insurance company to be financially stable, are at a level representing a 18.2% SAPOR ratio. This level of reserves is adequate. Exhibit K (Department's calculation of the Company's SAPOR ratio).

Based upon the Commissioner's Findings of Fact and the applicable law, the Commissioner hereby issues the following Conclusions of Law:

Conclusions

12. Pursuant to 8 V.S.A. §§ 4062, 4513(b), and 4584(a), the Company is prohibited from using rates and premiums without the approval of the Commissioner. The Commissioner may disapprove requested rates if the Commissioner finds that such rates are unjust, unfair, inequitable, excessive, inadequate, or discriminatory.

13. The Company, as a hospital and medical service corporation, has special statutory obligations and responsibilities to its subscribers which the Legislature has not expressly imposed on other health insurance companies. See 8 V.S.A. § 4512(a) ("It [the Company] shall be maintained and operated solely for the benefit of the subscribers thereof * * *.") See also 8 V.S.A. § 4513(c) ("In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation.") As was explained by the Vermont Supreme Court, " * * * Blue Cross is not a private business operating freely within the competitive marketplace; it is a quasi-

¹ Employer Health Benefits, 2009 Annual Survey, Kaiser Family Foundation-Health Research and Educational Trust. Section 6, Worker and Employer Contributions for Premiums.

public business subject to the regulation of the commissioner.” In re Vermont Health Service Corporation, 144 Vt. 617 (1984).

14. The Commissioner is authorized to consider factors other than strictly actuarial analysis in determining whether the Company’s proposed rates are “excessive.” While other states have enacted statutes different from Vermont’s, the consensus of courts reviewing the exercise of an insurance commissioner’s rate decisions is that a wide variety of factors beyond the mathematical and actuarial can and should be considered by an insurance commissioner. See Blue Cross and Blue Shield of Michigan, 139 Mich. App. 109, 112-116 (1985); Insurance Commissioner of the State of Maryland v. Carefirst of Maryland, 816 A.2d at 135-136; In re Rate Filing of Blue Cross Hospital Service, Inc., 158 W.Va. 725, 730 (1975).

15. The Commissioner concludes that the overall 34.6% rate increase filed by the Company for BRS subscribers, as well as the significantly higher increases for some association members, is excessive, unjust, unfair, and inequitable. Among the relevant facts and circumstances, the rate increases are primarily attributable to factors in the control of the Company: (a) the failure of the Company for many years to use approved benefit relativity factors for its association products, and the application of a transition formula that has a significant rate impact in the first year of implementation; (b) the multiplicity of insurance products offered by the Company for many years, the decision by the Company to reduce the number of insurance products offered to its subscribers, and the application of an inadequate transition period has a significant rate impact on the associations subscribers; and (c) the decision of the Company to apply its administrative cost charge, reserve charge, and medical and pharmacy trend to BRS association rates in a manner, and at a time when those rates are already under considerable stress as a result of the other factors described herein. While each of these decisions may be reasonable when viewed in isolation, as applied collectively to BRS subscribers, the resulting rates are excessive, unjust, unfair and inequitable.

16. The Commissioner concludes that the 24.9% rate increase filed by the Company for VHSG subscribers, as well as the significantly higher increases for some association members, is excessive, unjust, unfair, and inequitable. Among the relevant facts and circumstances, the rate increases are primarily attributable to factors in the control of the Company: (a) the failure of the Company for many years to use approved benefit relativity factors for its association products and the application of a transition formula that has a significant rate impact in the first year of implementation; (b) the multiplicity of insurance products offered by the Company for many years, the decision by the Company to reduce the number of insurance products offered to its subscribers and the application of an inadequate transition period has a significant rate impact on the association subscribers; and (c) the decision of the Company to apply its administrative cost charge, reserve charge, and medical and pharmacy trend to VHSG association rates in a manner, and at a time when those rates are already under considerable stress as a result of the other factors described herein. While each of these decisions may be reasonable when viewed in isolation, as applied collectively to VHSG subscribers the resulting rates are excessive, unjust, unfair and inequitable.

17. As an alternative to imposing excessive, unjust, unfair and inequitable rates on its subscribers, the Company can moderate the rate impact on these associations' subscribers by (i) modifying its Benefit Relativity Methodology to include a longer transition period or different transition formula; (ii) temporarily suspend its contribution to reserves for these two pools of subscribers; and (iii) temporarily increase its contribution to reserves in other lines of business, and thereby diminish its impact on the associations' subscribers. The Commissioner concludes based on the entire record in this matter the Company's rates for the BRS and VHSG associations are excessive, unjust, unfair and inequitable if any subscriber's rate increase for the product he or she purchases exceeds 25%.

18. The Commissioner recognizes that rate decisions must not result in significant negative financial consequences for the Company. Vermont needs efficiently operated, financially stable and sustainable health insurance companies, including the Company, in order to offer Vermonters access to health insurance and affordable health care. 18 V.S.A. § 9401(a). The Commissioner concludes, however, that the decision made herein will not result in any significant or materially negative financial consequences for the Company.

19. The Commissioner acknowledges that her rate decisions with respect to these two filings do not address more fundamental problems facing the Company and the association-small group health insurance market in general. These problems include persistent medical inflation, and a segmented small group and association market that invites adverse selection and manipulation. The Commissioner also continues to be exceedingly troubled by the award to the Company's former Chief Operating Officer of over \$6 million upon his retirement in December 2008. The Commissioner concludes that there is cause to believe that this excessive monetary award is contrary to the insurance laws of this state, contrary to the laws regulating the Company and its obligations to subscribers, and contrary to the Company's obligations to its subscribers as a non-profit corporation. The Commissioner acknowledges and supports the continuing efforts of the current management of the Company to reduce the total retirement compensation paid to the Company's former Chief Operating Officer.

20. In order to insure that the Company is maintained and operated solely for the benefit of its subscribers, and to insure that benefits and services are provided at minimum cost under efficient and economical management of the Company, the Commissioner concludes that the Company should be subject to supplemental orders designed to address the above-referenced fundamental problems.

Rate Order

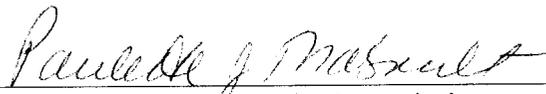
Wherefore, based upon the Commissioner's consideration of the entire record in this matter and the applicable law, the Company's rate increase filings for the BRS and VHSG association are hereby DENIED. The Commissioner intends to reconsider rate filings for these two associations if the filings are consistent with the criteria established in Para. 17, above, or if the filings moderate the rate impact on these subscribers in a similar manner.

Order to Show Cause, and
Notice Relating to Supplemental Orders

Now comes the Commissioner, pursuant to her authority under 8 V.S.A. § 15, and 8 V.S.A. §§ 4513(c) and 4584(c), and hereby ORDERS the Company to SHOW CAUSE why the Commissioner should not issue the following reasonable supplemental orders, terms and conditions necessary to insure that benefits and services are provided to subscribers at minimum cost under efficient and economical management of the Company, and to insure that the Company is maintained and operated solely for the benefit of subscribers. The Company is hereby given NOTICE that a hearing will be held on a date to be scheduled by the Commissioner on or after November 13, 2009, to offer the Company the opportunity to be heard concerning the issues set forth below, following which, and after consideration of the evidence offered by the Company and the Department, and the entire record in this matter, the Commissioner may thereafter issue one or more supplemental orders:

- A. Should the Company be ordered to file a plan approved by the Commissioner designed to lower the Company's trend for health care costs? The Commissioner acknowledges that a similar order issued in January 2007, but the Company's efforts to lower trend to a reasonable and sustainable level have not been successful. Should the Company's plan include cost containment benchmarks proposed by the Company and approved by the Commissioner?
- B. Should the Company be ordered to file an actuarial adjustment methodology approved by the Commissioner to reduce volatility in membership and rates in the association and small group markets?
- C. Should the Company be ordered to file an approved plan to recover that portion of post-employment compensation of the Company's former Chief Executive Officer deemed by the Commissioner to be excessive under the insurance laws of this state, under the health insurance laws specifically applicable to the Company, and under Vermont's non-profit corporation laws?
- D. Should the Commissioner assert continuing jurisdiction over this proceeding, and issue such further supplemental orders as are necessary to insure that benefits and services are provided to subscribers at minimum cost under efficient and economical management of the Company?

Dated at Montpelier, Vermont this 3rd day of November, 2009.


Paulette J. Thabault, Commissioner