BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Chair Black and Members of the Committee:

We have a simple mission: make health care work better for all Vermonters. Everything we do is driven to help Vermonters access and receive high-quality care with greater ease. We're proud to be Vermonters working to make reliable, high-quality health care available to improve the well-being of Vermonters. We held our annual employee recognition ceremony this morning. And, even though I am relatively new to our organization, I was struck by the passion, dedication, and commitment to our mission.

We oppose sections one and two of the bill, which propose changes to the governance structure and executive compensation oversight of nonprofit hospital service corporations, otherwise known as private health insurers. We understand that these provisions are intended to theoretically increase accountability and to prevent a repeat of the financial pressures BCBS of VT experienced over the last few years. However, onboarding certain BCBS internal controls (which we have started implementing to the tune of $7MM in administrative cost savings) combined with the existing and ongoing proper deployment of DFR's existing regulatory tools ensure accountability and financial security. Moreover, when our recent financial struggles are examined closely, they are in part explained by the exorbitant cost of health care services in Vermont combined with an unprecedented surge in claims since the pandemic.

At the outset, it is important to understand the regulatory and statutory requirements imposed on Blue Cross and Blue Shield of Vermont. We are required to be a nonprofit sharing corporation without capital stock; meaning, that we have neither stockholders nor owners of the company, let alone profits to share with those people if they existed. Further, our governing statutes mandate that we exist solely for the benefit of the Vermonters we cover. Therefore, we are already statutorily obligated to operate in the best interests of Vermonters. Indeed, DFR is currently legally empowered to disapprove any plans we offer, and even prohibit us from contracting with subscribers (essentially, akin to prohibiting us from operating), if such plans are excessive, inadequate, or unfairly discriminatory; fail to protect our solvency; or fail to meet the standards of affordability, promotion of quality care, and access that we all expect in Vermont.

With regard to section two and executive compensation, we understand the concerns raised, particularly when taking into account the totality of the health care system. We know these salaries are viewed as large, and it is our goal to be as open and transparent as possible. There has been a suggestion that a highly respected and contracted independent consultant like Sullivan Kotter would "cherry pick" from their own nationwide benchmarking analysis, and we certainly don't believe that to be the case.

I'd like to point to the results of an independent auditor contracted by the Green Mountain Care Board to examine the administrative and executive costs of BCBSVT, who determined that among individual and small group carriers nationwide, our administrative costs rank in the 1st percentile nationally. Meaning, out of 100 carriers nationwide, our administrative costs are lower than 99 of them. To quote the auditor, who was hired by the Green Mountain Care Board, it "appears that BCBSVT manages and limits administrative costs better

than the typical health plan nationally". We are proud to say that in 2025 more than 94% of all premium dollars went directly to paying claims. We shouldn't lose sight of the fact that our administrative costs result in real value for Vermonters. In fact, our member satisfaction scores are over 95% on a consistent basis.

We want to continue to be able to deliver the quality and service our members know and expect from us. I will add to this, to emphasize the record, that if BCBSVT were to eliminate ALL executive costs, which would include all salaries and benefits and related costs of our entire executive team, including their hundreds of years of combined experience, we would see a premium reduction of approximately 0.25%.

With that in mind, Blue Cross and Blue Shield of Vermont clearly and respectfully submit that the changes represented in this bill related to board governance and executive compensation do not meaningfully affect how health care is delivered, how claims are processed, how prices are negotiated, or how utilization is managed. Boards do not negotiate provider contracts. Boards do not set reimbursement rates. Boards do not determine claims policy or care management protocols. Changing who sits on a board does not change how health care costs are generated or controlled. Given current statute and the language of the bill regarding responsibilities of these proposed appointees, changing who sits on our board of directors does not change our mission, or our obligation to Vermonters.

We strongly support accountability, transparency, and strong regulatory oversight. We believe those goals are best achieved through existing statute, consistent enforcement of existing statute, and collaboration, not through politicizing nonprofit governance.

Site-Neutral Billing

We support the site-neutral billing provisions in H.585 because they directly address one of the most persistent and measurable drivers of health care costs in Vermont: price variation for the same service based solely on where that service is delivered. Vermonters should not pay materially different prices for a routine lab test, diagnostic imaging, or other common outpatient services simply because the service is performed in a hospital outpatient department rather than a lower-cost community setting.

As we saw in testimony from VAHHS last week, Site Neutral Billing alone has the opportunity to lower health care costs for Vermonters by as much as $200M. While we are acutely aware of the potential stress this change would place on our hospitals, we do strongly believe that there is a responsibility to Vermonters to phase in implementation to provide the immediate relief necessary.

Hospitals have both professional and outpatient fee schedules. The fees for professional visits are significantly lower than outpatient fees. That said, ideally when you go to an offsite office owned by a hospital, it should hit the professional fee schedule. But what often happens is that you go to an "office" (such as Tilley Drive or the CVMC PT office on the Barre Montpelier Road) and the provider considers it a "hospital outpatient department" and they charge the outpatient fee schedule. While the fee schedule exists, hospitals simply

charge the outpatient rate for nearly everything. We reviewed 5 examples from 3 different hospitals, and across 40,000 total claims, we only got charged 1 on the professional fee.

This variation is not a reflection of better quality or better outcomes. It is a pricing dynamic that increases total spending, raises out-of-pocket costs, and ultimately drives premium growth for employers and individuals.

Site-neutral payment, in combination with reference based pricing, is one of the clearest tools available to deliver near-term relief without reducing access or compromising quality, and it also discourages the financial incentive for services to migrate into higher-cost settings through consolidation or site-of-care shifts.

However, we are not ignorant of how site-neutral billing will decrease hospital revenue, especially when combined with other initiatives that decrease hospital revenue in the wake of Act 55 and the forthcoming implementation of reference-based pricing.

With all of this in mind, we encourage the Committee to move this critical cost reduction tool forward, so Vermonters can see the results in real terms, but to do it in a pragmatic way that maintains the stability of the hospital system.

High-Dollar Claims and Claims Editing

We recognize the value behind defining a “high-dollar claim” to refine claims editing practices. Thoughtful claims review can reduce waste and improve consistency but claims editing is highly technical and deeply intertwined with provider behavior, clinical judgment, and patient access. Although in the current statute there is no floor on high dollar claims, we currently use an automatic process to trigger a review on all claims over $100,000. In review of these claims, we find errors in roughly 97% of them. As assumed in this piece of the bill, we would presume that we would find similar errors if the review number were set at $25,000, a number that we would of course work from if put into statute. However, it could lead to hospital and insurer strain through higher volume claim reviews and administrative delays in providing patient care.

Prior Authorization Refinements

We support efforts to reduce unnecessary administrative burden. And while we of course did not like the complete elimination of prior authorization in primary care, and would welcome bringing some back, Chair Black raised an important question about the newness of Act 111 and what data we might have. We do not have readily available data on this that would concretely move beyond correlation and into causation. However, prior authorization exists largely because of the significant variation in cost and utilization across the system.

We support a targeted approach that removes low-value administrative burden while preserving oversight for high-cost or high-variation services that is far more likely to improve both access and affordability than broad changes.

Reinsurance Authority

Reinsurance can provide meaningful short-term premium stabilization and is a tool BCBSVT supports. However, it is important to be clear-eyed about what reinsurance can and cannot do. Reinsurance helps smooth volatility and can reduce year-to-year premium swings, but it does not address underlying cost growth.

If used without parallel cost containment efforts, reinsurance risks masking cost pressures rather than resolving them. We support reinsurance authority as part of a broader strategy, not as a standalone solution.

Association Health Plans

Association Health Plans present one of the greatest potential risks to insurance market stability because the individual and small group markets become unstable, premiums increase, and the risk pool weakens resulting from healthier groups being segmented from the broader market. We saw that years ago leading to an end of AHPs in Vermont.

In a state the size of Vermont, even modest shifts in risk composition can have significant downstream effects. We are particularly concerned that AHPs could inadvertently undermine the small group market, and differences in benefit design could lead to adverse selection, while also knowing the potential of migration toward less regulated products.

Everybody wants better coverage, and lower premiums. We've heard things like silver bullet, smoking gun, magic wand, and more. When I hear that there is no silver bullet, I wonder, frequently, why we say that. In fact, there is a silver bullet. The piece of this puzzle that drives all the others. That is the actual COST of services.

Short-Term, Limited-Duration Plans

Short-term, limited-duration plans are often positioned as a lower-cost alternative for consumers, and even a stop gap for folks in a pinch, but they present significant risks to market stability if not tightly regulated because folks migrate back-and-forth between plans rather than selecting the best plan at the outset. While these plans may offer short-term affordability for some individuals, they do so by design through limited benefits, medical underwriting, and exclusions for pre-existing conditions.

From a system perspective, these products do not reduce the cost of health care. They shift it. While short-term plans may appear affordable on the front end, they often:

- Exclude essential health benefits,
- Impose coverage caps,
- Deny claims for pre-existing conditions,
- Leave consumers exposed to significant out-of-pocket costs.

This can ultimately increase uncompensated care and shift costs back into the broader system, undermining the very affordability goals these plans are meant to support.

Short-term limited-duration plans do not address the root causes of health care cost growth. They risk destabilizing the market, increasing long-term premiums, and confusing consumers about the coverage they are purchasing.

Limited Age-Based Rating

The idea of Age Rating is one that we are intrigued by, and one that other states are already implementing, giving us much to learn from. We see the value of creating a limited age-rating pool for actuarial alignment, but we are particularly concerned that its benefits do not address the sustainability of the insurance market. Indeed, limited age-rating would create higher premiums for older Vermonters on fixed incomes that are likely to be unsustainable.

Will this materially lower premiums overall, or simply redistribute cost?

How will older Vermonters living on fixed incomes be protected from unintended affordability impacts?

How will consumers understand changes in premium structure?

In a small market like Vermont, even modest shifts can have outsized effects on enrollment behavior. If younger individuals perceive pricing changes as insufficient, or older individuals experience premium increases without adequate support, the market could destabilize rather than strengthen.

All of this to say, we have begun working on some modeling to better understand how age rating could potentially be implemented in a way that offers better options for younger Vermonters. That is our mission.

Short-Term Adjustments vs. Long-Term Stability

Across these sections, a common theme emerges. Many of the proposed changes adjust market mechanics, modify regulatory structures, or introduce new policy levers, but do not directly address the fundamental drivers of cost in Vermont's health care system.

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Vermont's health care system requires solutions that are durable, predictable, and grounded in long-term sustainability and not short-term fixes that may destabilize the market or confuse consumers. We have done well in focusing on costs, and how those costs affect premiums.

We remain deeply committed to working with the Legislature, regulators, providers, and stakeholders to improve affordability and access for Vermonters. We respectfully urge the Committee to proceed cautiously with structural changes while prioritizing policies that directly address cost drivers and ensure that reforms are aligned with long-term stability rather than short-term pressure.

With gratitude,

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