WHEN A HEALTH INSURER CEASES BUSINESS IN VERMONT

LEGAL AND FINANCIAL CONSIDERATIONS

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ABBREVIATIONS

ACA – Patient Protection and Affordable Care Act.

ASO – Administrative Services Only.

BCBSVT – Blue Cross and Blue Shield of Vermont.

CHP – Community Health Plan.

CIGNA – Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company.

DFR – State of Vermont Department of Financial Regulation.

ERISA – Employee Retirement Income Security Act of 1974.

GMCB – Green Mountain Care Board.

IIA – Intermunicipal Insurance Association.

HMO – Health Maintenance Organization.

MVP – MVP Health Insurance Company and MVP Health Plan.

MVPNH – MVP Health Insurance Company of New Hampshire Inc.

TVHP – The Vermont Health Plan.

VEHI – Vermont Education Health Initiative.

VHC – Vermont Health Connect.

VT APA – Vermont Administrative Procedure Act.

INTRODUCTION

On May 27, 2014, Governor Peter Shumlin signed Act 144 of 2014 titled "An act relating to miscellaneous amendments to health care laws." Section 18 of this law requires that the Department of Financial Regulation ("DFR"), in consultation with the Office of the Attorney General, identify the legal and financial considerations involved in the event that a health insurer offering major medical health plans ceases doing business in this state. DFR submits this report to the House Committee on Health Care, the House Committee on Commerce, the House Committee on Ways and Means, the Senate Committee on Health and Welfare and the Senate Committee on Finance.

The circumstances surrounding an insurer's exit from the Vermont market can vary widely. Factors such as the type of insurer, its domicile, its ownership, its reasons and methods for ceasing to do business, and its financial health can all affect decisions and drive outcomes. To organize and inform this discussion, this report is broken into multiple sections. Section one provides an overview of the most pertinent statutes and rules, and section two does the same for relevant financial concepts and frameworks. Section three introduces the health insurers doing business in Vermont's major medical market. Section four analyzes the legal and financial considerations when a health insurer ceases business in Vermont, including the disposition of surplus funds.

Predicting the exact circumstances surrounding a health insurer's potential market exit is difficult. There are many possibilities around how ceasing business might occur. The analysis of financial and legal considerations in this report focuses on likely scenarios as well as those associated with the most significant consequences. These discussions are not intended to be exhaustive lists of all possible contexts or considerations.

SECTION 1:

REGULATORY FRAMEWORK

INSURANCE LAWS

Title 8 of the Vermont Statutes Annotated is home to Vermont's insurance statutes. The laws in Title 8 make up the primary regulatory structure for insurance and insurance companies because the United States follows a system of state-based regulation of the insurance industry.[1] In Vermont, DFR is the state department charged with the authority to regulate this sector. The following areas of Vermont's insurance statutes are particularly relevant for understanding the legal considerations should an insurer ceases business in Vermont.

LICENSING

Insurance companies cannot do business in Vermont without first being authorized to do so.[2] Insurance company licensing is often the first interaction a potential Vermont insurance company or an out-of-state insurance company will have with the State. It is also the primary mechanism by which Vermont regulates insurance companies—maintenance of a license requires the insurer to comply with all applicable rules. Vermont's licensing scheme differentiates between types of insurers, creating unique licensing requirements for traditional insurance companies, nonprofit hospital and medical service corporations, and health maintenance organizations ("HMOs").[3]

Traditional insurance companies, including health insurers, are licensed under Chapter 101 of Title 8.[4] Insurance companies are either for-profit or nonprofit entities. Vermont companies formed under Chapter 101 must receive a determination by the commissioner of DFR (the "Commissioner") that formation and maintenance of the company will be in the general good of Vermont. After additional requirements related to capital and subscriptions are met, the Commissioner will grant a certificate for the company to transact business.[5] Out-of-state companies are required to submit documentation related to its structure, organization, and

[1] 15 U.S.C. § 1011 *et seq.* The McCarran-Ferguson Act, passed by the United States Congress in 1945, exempts the business of insurance from most federal regulation (though some exceptions exist, including the Employee Retirement Income Security Act and federal flood and crop insurance).
[2] 8 V.S.A. §§ 3308-3309, 3361, 4513, 5102. Under 8 V.S.A. § 3368(a), certain policies issued outside of Vermont that cover only a minimum number of Vermonters or only Vermonters who work outside the state are exempt from this requirement.
[3] *See* 8 V.S.A. Chapters 101, 123, 125, 139 (promulgating licensing criteria for the various types of health insurers in Vermont).
[4] §§ 3308-3309, 3361.
[5] §§ 3305-3309.

financial health, as well as pay a fee to the Commissioner to consider whether to grant a license to transact business in Vermont.[6] The Commissioner then considers the same criteria established for approval of an in-state Vermont insurer.[7]

Both Vermont and out-of-state health insurers may elect to be incorporated as either stock or mutual companies.[8] A stock company has its capital divided into shares and owned by stockholders, while a mutual company has no capital stock and a governing body elected by its policyholders.[9] The form of incorporation is important in determining the requirements that must be met before a license is granted because mutual companies must show an adequate number of subscriptions in addition to minimum levels of capital, whereas stock companies must only meet the capital requirements. The corporate form also has implications for how the insurance company is run and, most important for purposes of this report, for how insurance company operations are wound down and the company dissolved.

Insurer	VT License Type
BCBSVT	Nonprofit Hospital Service Corporation
TVHP	HMO
MVP Health Insurance Company	Traditional Company (out-of-state)
MVP Health Plan, Inc	HMO
Connectivute General Life Insurance Company	Traditional Company (out-of-state)
Cigna Health and Life Insurance Company	Traditional Company (out-of-state)

Chapters 123 and 125 of Title 8 enable the formation of nonprofit hospital service corporations and medical service corporations, respectively.[10] The purpose of a hospital service corporation is to provide "hospital care . . . by a hospital maintained by a corporation organized for hospital purposes to such of the public who become subscribers to such plan under a contract which entitles each subscriber to certain hospital care."[11] Similarly, Chapter 125 of Title 8 enables the formation of medical service corporations for the purpose of "establishing, maintaining, and operating a plan whereby medical or medical and dental services may be provided at the expense of the corporation by duly licensed physicians and dentists to subscribers

[6] § 3361.
[7] § 3361(c).
[8] §§ 3302, 3365.
[9] § 3302.
[10] §§ 4511-4595.
[11] § 4511.

under contract, entitling each subscriber to certain medical services or medical and dental services as provided in such contract."[12] These statutes also provide that a hospital service corporation may operate both a hospital service plan under Chapter 123 and a medical service plan under Chapter 125.[13]

Nonprofit hospital and medical service corporations operate by entering into contracts with subscribers for hospital and medical care, respectively.[14] These corporations may not enter into any such contract until granted a permit to do so by the Commissioner.[15] To gain such a permit, an applicant must submit to the Commissioner the territory in which it will operate, the services it will provide, the number of subscribers it will serve, and the rates for its services.[16]

An HMO is a type of health insurance plan characterized by its contractual arrangements with providers. Doctors, hospitals, and other providers contract directly with the HMO, and a subscriber pays a set cost for coverage from that network of providers. In Vermont, HMO is defined in part as, "any person who furnishes, either directly or through arrangements with others, comprehensive health care services to an enrolled member in return for periodic payments."[17] HMOs must apply for and receive a certificate of authority from the Commissioner before transacting business in Vermont.[18] After receiving the required documentation from the proposed HMO, the Commissioner determines whether to issue the certificate of authority based on whether the HMO will promote the general good of the state and on the reliability and financial condition of the applicant.[19] An HMO must ensure the delivery, continuity, accessibility, and quality of the services provided remains satisfactory to keep the license.[20]

STANDARDS FOR OPERATION

After becoming licensed to transact business in Vermont, both out-of-state and Vermont insurers must conduct business in accordance with certain minimum standards to maintain those

[12] § 4583.
[13] § 4512(b).
[14] § 4511.
[15] § 4513(b).
[16] *Id.*
[17] § 5101(2).
[18] § 5102(a).
[19] § 5102(d).
[20] § 5102(e).

licenses. These standards, typical in a heavily regulated industry, are generally referred to in this report as standards for operation.

Vermont law includes standards for operation related to unfair and deceptive acts,[21] advertising,[22] and reporting and disclosure.[23] Requirements also address the substance of insurance policies, including required policy provisions,[24] appeals,[25] and mandated coverage for certain treatments and conditions.[26] As a general matter, health insurance companies licensed to do business in Vermont are subject to significant oversight in nearly all aspects of operation.

Failure to comply with any standards for operation, including rules passed pursuant to statutes, can result in an administrative action against the insurer by DFR. Such an action can lead to an injunction, penalties, and suspension or revocation of an insurer's authority to transact insurance business in Vermont.

SOLVENCY

The most fundamental protection for consumers is ensuring that health insurance companies are solvent. DFR regulates the solvency of health insurers in many ways, ranging from standards for minimum capital and surplus,[27] to strict judicially-authorized seizure of control of insurance operations.[28] DFR's analysis of company solvency is constant. The most utilized tools for regulating solvency are (1) ensuring insurer premium rates are adequate to maintain appropriate solvency levels; (2) monitoring the financial health of companies through examinations; (3) supervising or rehabilitating companies in financial distress; and (4) a guaranty association to pay claims when insurers cannot. Each of these are discussed below.

[21] § 4724.
[22] §§ 3368a, 4084.
[23] §§ 3561, 3684, 4516, 4588, 5106.
[24] §§ 4065-4066.
[25] § 4089f.
[26] Vermont law mandates many types of coverage, including mental health parity and prescription drug coverage. These mandates are generally found in 8 V.S.A. § 4088a-i and 4089a-l.
[27] §§ 3304, 3309, 3366, 5102b.
[28] § 7042. *See generally* §§ 7031*et seq*. (codifying rules for supervision, rehabilitation, and liquidation of insurers).

RATE REVIEW

All rates for major medical health insurance must be approved before policies using those rates are issued.[29] "Major medical" insurance generally refers to comprehensive health insurance, including for serious illness and hospitalization. Until 2012, DFR was solely responsible for approving rates for major medical health insurance. In 2012, part of that authority began transitioning to the Green Mountain Care Board ("GMCB"), and as of January 1, 2014, DFR's only remaining responsibility with respect to rates is to provide to GMCB its opinion on a proposed rate's impact on the insurer's solvency.[30] This is the main way Vermont enforces its mandated coverage requirements and ensures that each policy 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 this state."[31] Insurer revenue is generated from investment income and premiums. This means that a premium rate has a direct effect on an insurer's solvency.

Premium rates are generally proposed by insurers at a level that will cover claims and administrative expenses, as well as contribute a certain amount to the insurer's surplus. How solvent an insurer is depends to a large degree on the adequacy of the insurer's surplus. While DFR is the primary regulator of insurer solvency in Vermont, GMCB is the only agency with the power to reject proposed major medical premium rates by insurers and force them to be decreased (potentially decreasing the adequacy of surplus) or increased (potentially increasing the adequacy of surplus). GMCB's rate review responsibilities influence surplus and solvency of health insurers, particularly with respect to Vermont companies.[32] Because adequate surplus is the key to maintaining solvency, appropriate contributions to surplus are essential. DFR's solvency opinions address this vital piece of the rate review process by isolating the contribution to surplus proposed by an insurer for a given rate, and advising GMCB on the impact to solvency

[29] 8 V.S.A. § 4062; 18 V.S.A. § 9375(b)(6). Similar to the requirement that all insurers be authorized to transact business in Vermont, 8 V.S.A. § 3368(a) provides an exception for certain policies issued outside of Vermont.
[30] 8 V.S.A. § 4062(a)(2)(B).
[31] 8 V.S.A. § 4062(a)(3).
[32] In Vermont's private health insurance market, Blue Cross and Blue Shield of Vermont and The Vermont Health Plan are much smaller companies and operate exclusively in Vermont compared to MVP and CIGNA. The effects of premium rate adjustments are felt much more acutely by the Vermont insurers than by the much larger out-of-state insurers, for whom Vermont business represents a small part of overall premium.

of changes to that contribution. GMCB is ultimately responsible for approving appropriate contributions to surplus that avoid erosion of health insurer solvency.

EXAMINATIONS

At least every five years, and more often if the Commissioner chooses, DFR conducts examinations of Vermont insurance companies.[33] Examinations can cover all affairs of the insurer, and are intended to ascertain the insurer's financial condition, its ability to fulfill its obligations, and whether it has complied with all applicable laws.[34] Out-of-state insurance companies can be similarly examined, though DFR can and often will rely on the examination reports produced by an out-of-state company's domiciliary state.[35]

Examinations, coupled with review and ongoing analysis of quarterly financial and other reporting by health insurers, allows DFR to gain a deep understanding of the sufficiency of a health insurance company's surplus and its level of solvency. As importantly, examinations give DFR insight into what direction the company's surplus and solvency are likely to move in the future.

SUPERVISION, REHABILITATION, LIQUIDATION

If a Vermont insurance company's capital and surplus fall below certain minimum standards, DFR may deem that insurer to be in "hazardous financial condition."[36] Hazardous financial condition exists when the insurer's financial status "render[s] the continuance of its business hazardous to the public or holders of its policies."[37] The Commissioner may issue an order placing such a company under supervision and direct the company to take certain remedial measures to correct the deficiency in its finances.[38] If these measures do not correct the issue, and the value of an insurer's capital and surplus are insufficient to cover the company's liabilities

[33] 8 V.S.A. § 3563.
[34] *Id.*
[35] 8 V.S.A. § 3564.
[36] § 7041; Department of Financial Regulation Rule I-93-2, Defining Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition.
[37] *Id.*
[38] *Id.*

and policy holder claims, the company will be deemed insolvent.[39] The Commissioner may then seek an order of rehabilitation or liquidation.[40]

An order of rehabilitation allows the Commissioner to take possession of the assets of the insurer and administer them under the supervision of the court.[41] The goal is to reform and revitalize the insurer.[42] Reform can include reorganization, consolidation, merger, or other transformation of the insurer.[43] These extreme rehabilitation measures are in place as last-chance efforts to keep an insurer solvent and operating as a going concern. If they fail, the Commissioner can petition the court for an order of liquidation, and begin the process of winding down the insurer's operations and liquidating its remaining assets.[44]

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

In the event an insurer cannot perform its contractual obligations due to impairment or insolvency, some insureds and beneficiaries will be protected by the Life and Health Insurance Guaranty Association (the "Guaranty Association").[45] The Guaranty Association steps into the shoes of the insurer and provides protection by assessing its member insurers amounts necessary to make sufficient funds available to guarantee the payment of benefits and continuation of coverage,[46] though it will not pay more than $500,000 in benefits with respect to any one individual.[47] Generally, health and life insurers licensed to transact business in Vermont (both Vermont and out-of-state companies) are members of the Guaranty Association.[48] However, HMOs are not members of the Guaranty Association, nor is Blue Cross and Blue Shield of Vermont ("BCBSVT"), so there is not the same safety net for policyholders if those companies encounter financial trouble. Consequently, it is incumbent on DFR to ensure that BCBSVT has adequate surplus to pay claims and other expenses from its own assets.

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[39] Robert W. Klen, *A Regulators Introduction to the Insurance Industry*, 10-2, (Nat'l Ass'n of Ins. Comm'rs 1999).
[40] 8 V.S.A. §§ 7051, 7056. An order of rehabilitation can be sought based on other grounds, as well, including a lack of trustworthiness of control persons, willful violations of law, and failure to file an annual report. There are 13 different grounds permitting the Commissioner to seek an order of rehabilitation or liquidation in all. § 7051.
[41] § 7052.
[42] § 7053.
[43] *Id.*
[44] § 7056.
[45] § 4152.
[46] *Id.*
[47] § 4158(8)(B)(II)(cc).
[48] § 4155(9).

The Guaranty Association may levy three classes of assessments against members: (1) assessments for administrative costs; (2) assessments for protection of consumers in the event of an impaired or insolvent Vermont insurer; (3) and assessments for protection of consumers in the event of an impaired or insolvent out-of-state insurer.[49] Assessments against members to protect consumers are generally determined based on the amount of premium written by the member insurer in Vermont.[50] The Guaranty Association does not keep a surplus on hand in anticipation of the impairment or insolvency of an insurer.

The Guaranty Association serves the dual purpose of ensuring that consumers are not adversely affected in the event a health insurer is impaired or insolvent, and it is also authorized to assist the Commissioner in detecting and preventing insurer impairment or insolvency.[51] The Guaranty Association is yet another tool available to regulators to prevent consumer harm caused by insurer insolvency.

CORPORATE LAWS

Much of Title 8 is devoted to the formation and regulation of insurance companies. An insurance company (but not a hospital or medical service corporation) can be formed as a corporation, nonprofit corporation, limited liability company, or have some other organizational form. Each of these forms are governed by Vermont laws in Titles 11 (Corporations, Partnerships and Associations), 11A (Vermont Business Corporations) and 11B (Nonprofit Corporations). Vermont law is very clear that both the insurance laws in Title 8 and the corporate laws in Titles 11, 11A, and 11B will apply to insurance companies.[52] Where those laws conflict the provisions in Title 8 will control.[53] This dual framework comes into play most prominently in corporate structure and governance, as well as in winding down a company (and disposing of assets) in dissolution. Where both insurance and corporate laws are implicated, other state authorities may share jurisdiction with the Commissioner. The Secretary of State is

[49] § 4159(b).
[50] § 4159(c).
[51] §§ 4152(3), 4162.
[52] § 21.
[53] *Id.*

generally responsible for administering Vermont's corporate laws, while the Office of the Attorney General has jurisdiction with respect to certain aspects of nonprofit corporations.

HEALTH CARE REFORM LAWS

In addition to insurance and corporate laws, insurance companies are materially affected by Vermont's laws regarding human services, which are found in Title 33. Chapter 18 of Title 33 is entitled "Public-Private Universal Health Care System." Chapter 18 establishes Vermont Health Connect ("VHC") as the state's insurance exchange, where consumers in the small group and non-group[54] markets can shop for, compare, and purchase health insurance. VHC was established in connection with the federal Patient Protection and Affordable Care Act ("ACA") to, among other things, "facilitate the purchase of affordable, qualified health benefit plans in the individual and group markets."[55]

The establishment and operation of VHC in 2014 has dramatically changed how Vermont's health insurance market operates. Other than grandfathered insurance plans,[56] Vermonters purchase small group or individual health insurance plans through VHC in several ways: with a navigator or broker, directly through the insurer for small businesses, or on-line for individuals.[57] Insurance companies seeking to offer plans through VHC must go through a rigorous review for those plans before potentially being chosen.[58] VHC will expand in 2016 to include more groups,[59] and is intended to be a step toward consolidating risk groups before implementing Green Mountain Care—Vermont's system of comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents.[60]

[54] For simplicity, the non-group market is referred to in this report as the individual market.
[55] 33 V.S.A. § 1801(b).
[56] 42 U.S.C. § 18011. Grandfathered plans are those plans in existence before the effective date of the ACA and which have not undergone material changes to benefits or cost sharing. Grandfathered plans are exempt from certain requirements of the ACA and state health reform laws until they lose grandfathered status. *See also* 45 C.F.R. § 147.140 (promulgating regulations regarding grandfathered plans).
[57] 33 V.S.A. § 1811(b).
[58] 33 V.S.A. §§ 1805, 1806.
[59] 33 V.S.A. § 1804(b).
[60] 33 V.S.A. §§ 1801, 1821.

SECTION 2:

FINANCIAL FRAMEWORK

Regulating insurance companies, and specifically health insurance companies, requires sophisticated financial analysis to accurately determine, monitor, and influence the financial health of the company. The financial considerations that arise when a health insurer ceases business in Vermont are linked to the framework of financial tools and analysis utilized while the insurer is operating. The following briefly explains the financial framework underpinning the regulation of health insurance companies in Vermont.

RESERVES VS. SURPLUS

A health insurance company's reserves are not the same as its surplus. While sometimes used interchangeably, the terms represent very different concepts, and for purposes of this report they are treated separately. An easy way to distinguish each concept is to think of reserves as a checking account and surplus as a savings account. Sufficient funds are maintained in the checking account to pay for specific known liabilities or obligations, such as the invoice received for the new roof on the house, or the electric bill for last month's electricity use that hasn't yet been received in the mail. Money is deposited in the checking account to pay for both—the known liability (the invoice) and the unknown (the electric bill, which is predictable based on usage and bills from previous months). That deposited money is encumbered or restricted—it cannot be used for other things. Remaining money is deposited into the savings account to be sure that a safety net exists when it comes time to pay future contingencies. The extra money is needed in case there is a pay-cut at work, or an unexpectedly high electric bill next month. While oversimplified, the analogy illustrates that reserves (checking) are entirely separate from surplus funds (savings). They serve different purposes, have different implications, and tell a different story about an insurer's financial health, as detailed below.

Generally, an insurance policy is a promise by an insurance company to pay money when a covered event occurs within a certain amount of time. Health insurance is no different. When a covered service is utilized by a customer, the health insurer incurs a liability or legal obligation that it must pay. Once the individual makes a claim for payment, the exact amount of that liability is known with certainty. The insurance company can also predict, as of a given time, the liability for covered services that have been utilized, but for which a claim has not yet been

made. The amounts a health insurer must allocate, or reserve, to pay those already-incurred liabilities (both known and unknown) are the insurer's reserves.[61]

The defining characteristic of a health insurer's reserves is that it is money allocated to pay for claims that have already been incurred. Some of the claims are known with certainty, i.e., those claims that have been filed with the company, but for which payment has not yet been made. Other claims are not yet known, i.e., those claims arising from covered services that have already been rendered, but no claim has yet been filed with the insurance company. For those unknown claims, referred to as "incurred but not reported" or "IBNR," the insurance company utilizes historical claims data, actuarial analysis and other methods to predict the amounts of those unknown claims at any point in time. Finally, the insurer adds to the reserves the administrative costs needed to process and pay all of the incurred claims, both known and unknown—the salaries, utility bills, rent, etc. The final amount is the reserves that the insurer must allocate. Put another way, reserves are an estimated amount of money apportioned at a given time that will allow the insurer to pay all incurred liabilities as of that moment.

In contrast, an insurer's surplus consists of its available funds not already allocated to pay for an incurred cost. An insurer's financial position consists of three components: assets, liabilities, and surplus (or retained earnings). An insurer's surplus, according to basic accounting principles, consists of assets minus liabilities. Surplus is an essential part of an insurer's financial health and solvency. Unlike reserves, which are for events that have already occurred, surplus is available for potential events in the future, both predictable and unpredictable, that will require the health insurer to pay more money than expected. Surplus acts as a safety net (or savings account) to ensure that the company has enough money on hand in the event that claims are unexpectedly high or some other unanticipated event occurs.

[61] There is no consistent definition of "reserves" throughout the insurance industry, and the term "reserves" often includes different components across different lines of insurance. This report uses the term "reserves" in a fashion common to health insurance companies, and is explained herein.

FUNCTION OF SURPLUS

A sufficient amount of surplus is vital to the health and continuing existence of an insurance company. Insurance companies, by their nature, bear substantial risk of being required to pay for named events, both small and catastrophic. Insurance companies exist to bear risks that individuals cannot bear on their own. Very few people can afford to pay the full costs of a house fire, major car accident, flood, emergency medical treatment, etc. Insurance allows many people to pay set, predictable amounts in exchange for a single company to bear the risk of, for example, significant medical treatment for all of those people. To protect against the inherently volatile nature of insurance, and health insurance specifically, insurance companies must keep sufficient surplus.

Under accounting principles an insurer's surplus is no different than a corporation's retained earnings. After accounting for assets and liabilities, any remaining amounts are retained earnings used at the corporation's discretion. Corporations use retained earnings in any number of ways, including capital expenditures (e.g. technology improvements), distributions to shareholders, purchasing other companies, and keeping retained earnings on hand in the event of negative developments in the market. Because of the risky nature of insurance, and the highly regulated environment in which insurance companies operate, more retained earnings must be kept on hand compared to other types of corporations. But, the type of company does not change the fundamental character of retained earnings. The company sells a product, and part of the price a consumer pays for that product is intended to create retained earnings used at the company's discretion. In the context of health insurance, as long as management and regulators are satisfied that enough retained earnings (surplus) are available to counter the volatile nature of the insurance business, any additional retained earnings are available for use (subject to DFR approval in some cases) in the same way any other corporation would use retained earnings: capital improvements; dividends (in the case of a for-profit company); strategic acquisitions, etc.

HOW SOLVENCY IS DETERMINED

In the most academic sense, an entity is solvent when its assets exceed its liabilities. However, in the context of a health insurance company, on which many individuals and families rely for payment of medical claims, the question of solvency is more practical than academic. It is an intricate analysis of many factors to discern how close or far away from insolvency the insurer is, and in what direction it is likely to move in the future.

A major factor in an insurer's ability to maintain adequate solvency is whether the insurer consistently charges adequate rates. DFR considers a rate adequate if it sufficiently covers expected claims, expenses, and contributes to the insurer's surplus when appropriate. Over the long term, charging inadequate premium rates can result in a material and direct threat to the solvency of the insurer.

Rates are developed by predicting future behavior and future claims. Therefore, it is impossible to predict with certainty the exact rate to charge in a given year that will be both adequate and not excessive. Charging a higher or lower rate merely makes it more or less likely that the rate will be adequate. To protect against rates that turn out to be inadequate, whether due to unexpectedly high claims or some other factor, an insurer generally maintains a surplus. An insurer's surplus is the amount of assets remaining after accounting for all liabilities it must (or may have to) pay out. A sufficient level of surplus is a crucial piece of preserving an insurer's solvency.

The sufficiency of an insurer's surplus and its solvency generally is very sensitive to changes in circumstances and events. Some events that could place a health insurer's surplus and solvency at risk include adverse medical cost trends,[62] adverse utilization,[63] premium inadequacy,[64] and membership growth.[65] In Vermont's health insurance market, these risks are

[62] If the actual cost of medical services grows at a faster rate than anticipated by the insurer, the insurer's surplus may decrease as it is used to cover this shortfall.
[63] If consumers use more services than anticipated by the insurer, including because of a catastrophic event such as a pandemic flu, the insurer's surplus may decrease as it is used to cover this shortfall.
[64] In addition to adverse utilization, various other factors can lead to claims and expenses exceeding premiums, including rate caps, disapproval by regulators of necessary rate increases, or administrative costs exceeding the
(footnote continued)

compounded because it takes up to two years from the time it is evident that a rate adjustment is necessary to the time those adjusted rates are approved and implemented. Each of these events can decrease an insurer's surplus. To ensure a sufficient level of surplus is maintained despite these threats, it is usually appropriate for a premium rate to include a contribution to surplus. The resulting premiums charged for insurance products account for the insurer's best estimate of future claims, the cost of operations, and a contribution to surplus to ensure that changes in circumstances and unpredictable events, both inevitable, do not jeopardize the insurer's financial health.

An adequate level of surplus is necessarily different for every insurer, since it depends heavily on both the volume and type of the insurance business conducted, as well as the quality and nature of the insurer's underlying assets and the environment in which the insurer operates. DFR uses a number of tools to assess the adequacy of an insurer's surplus, including periodic financial examinations, review of corporate governance, and analyses of such areas as risk-based capital, claims reserve development, and risk mitigation strategies. The assessment of surplus, and whether that surplus is sufficient, is a dynamic prospective assessment. Solvency is a measure of the sufficiency of surplus.

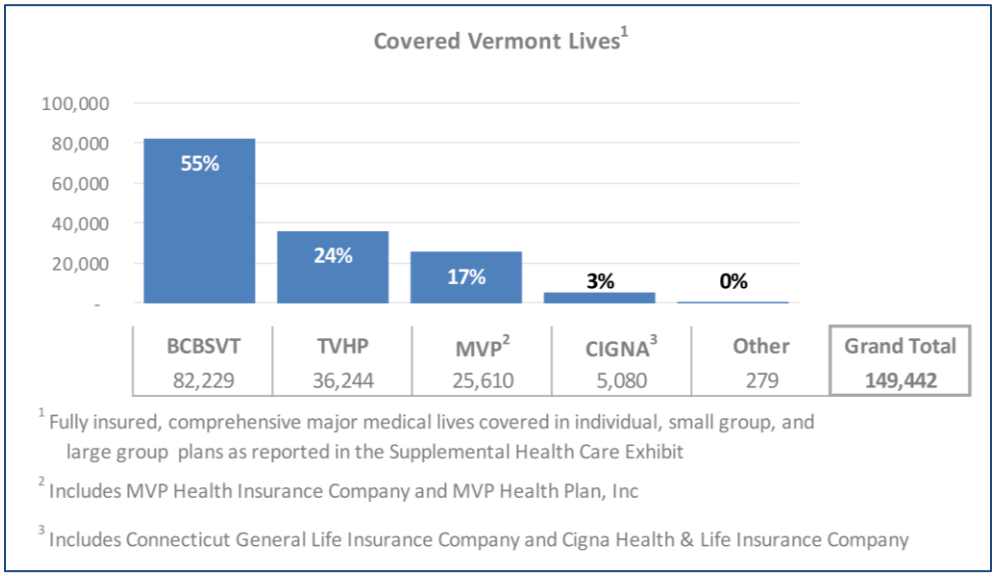
insurer's projections. If claims and expenses exceed premiums, the insurer's surplus may be used to cover this shortfall.

[65] The sufficiency of an insurer's surplus is relative to the size of the population covered by the insurer. Thus, if an insurer doubles the number of people it covers, its existing surplus would only provide half of the protection against insolvency it previously did.

SECTION 3:

HEALTH INSURERS IN VERMONT

Vermont's commercial health insurance market is very concentrated. As of December 31, 2013, approximately 150,000 Vermonters received coverage in the commercial health insurance market.[66] BCBSVT, The Vermont Health Plan ("TVHP"), MVP and CIGNA covered 99 percent of those Vermonters.[67] Of those companies, BCBSVT and TVHP share a parent/subsidiary relationship and collectively insured approximately 79 percent of those 150,000 Vermonters.[68] MVP and CIGNA collectively insured approximately 20 percent, while the remaining insurers covered approximately one percent, or fewer than 300 Vermonters.[69] This report focuses on the health insurance companies with the largest presence in Vermont. This section will provide a brief overview of each such company, as well as an introduction to the organization that purchases health insurance coverage for nearly all of Vermont's teachers and school employees.



[66] This statistic is illustrated on the chart of "Covered Vermont Lives." This statistic, and all other statistics used on charts in this report, is derived from reports that health insurers provide to DFR known as "Supplemental Health Care Exhibits" and "Annual Statement Supplemental Reports."
[67] *Id.* For purposes of this report, the term "MVP" refers to both MVP Health Insurance Company and MVP Health Plan Inc. unless otherwise noted. "CIGNA" refers to both Cigna Health and Life Insurance Company Inc. and Connecticut General Life Insurance Company Inc. unless otherwise noted.
[68] See *supra* note 66.
[69] *Id.*

BLUE CROSS AND BLUE SHIELD OF VERMONT

BCBSVT is a nonprofit hospital service corporation formed in Vermont under Chapter 123 of Title 8.[70] It is not a traditional insurance company. It is Vermont's largest health insurer and one of only two health insurers domiciled in Vermont.

STATUS OF BCBSVT UNDER VERMONT LAW

Title 8 lays out the regulatory authority of DFR and the legal requirements by which an insurance company must abide. Within Title 8, Chapters 123 and 125 provides for a unique type of entity distinct from typical insurance companies.

BCBSVT incorporated in Vermont in 1980 after previously providing services to Vermonters as a New Hampshire company.[71] It was and remains licensed as a hospital service corporation under Chapter 123 that is also permitted to provide medical services under Chapter 125. At the time of its incorporation in Vermont, BCBSVT provided fully insured hospital and medical service plans to subscribers.[72] Since its incorporation and with the permission of the Commissioner, BCBSVT has adapted its business by forming multiple subsidiaries and providing more varied insurance products and administrative services.[73] BCBSVT is now subject to regulation not only as a hospital and medical service corporation, but also as an insurance holding company under Chapter 101 of Title 8 because of those adaptations. An

[70] BCBSVT Articles of Incorporation, (1980).

[71] The New Hampshire-Vermont Hospitalization Service and the New Hampshire-Vermont Physician Service was similarly subject to Chapters 123 and 125. However, the extent of the Commissioner's authority over an out-of-state corporation under those statutes was the subject of much litigation. *See, e.g., In re New Hampshire-Vermont Hospitalization Serv. (Blue Cross)*, 132 Vt. 66, 313 A.2d 6 (1973) (Hospital service corporation incorporated in New Hampshire and operating in Vermont was not exempt from rate regulation in Vermont); *New Hampshire-Vermont Physician Serv. v. Comm'r, Dep't. of Banking & Ins.*, 132 Vt. 592, 326 A.2d 163 (1974), *superseded by statute*, 8 V.S.A. § 4513(c) (Vermont commissioner exceeded statutory authority in issuing supplemental orders to nonprofit hospital service corporation operating in both Vermont and New Hampshire, while New Hampshire commissioner was within its statutory authority to issue the same orders).

[72] To commence business, the new Vermont company and the existing New Hampshire company executed a Subscriber Transfer Agreement and Administrative Services Agreement on October 31, 1980 in which subscriber contracts and associated liabilities attributable to Vermont were assigned to the Vermont company, while the New Hampshire company continued to provide nearly all administrative services. These agreements were approved by both the Vermont and New Hampshire Commissioners of Insurance, and each had significant input in the content of the agreements. No reserves or surplus changed hands as part of the agreements.

[73] BCBSVT is the parent company of Catamount Insurance Services Inc. and The Vermont Health Plan LLC. Catamount Insurance Services Inc. is the parent of multiple subsidiaries that generally provide administrative services. The Vermont Health Plan, discussed later in this report, is licensed as an HMO in Vermont.

insurance holding company system is generally one in which a company is affiliated with at least one other company, and one of those affiliates is an insurance company. [74] As a holding company, BCBSVT is subject to additional requirements regarding reporting, examinations, and sanctions in addition to all applicable rules and requirements under Chapters 123, 125, and elsewhere in Title 8.

Hospital and medical service corporations are distinct from traditional insurance companies in a number of important ways. Hospital and medical service corporations must be formed as nonprofit companies with no capital stock. [75] BCBSVT thus does not have stockholders. However, it is not a mutual company (where policyholders would have an ownership interest), nor is it a nonprofit with members.[76] Rather, it is governed by a board of directors, each of whom is elected by the other directors.[77] BCBSVT must be maintained solely for the benefit of subscribers,[78] and is exempt from all forms of taxation by the state.[79] The Vermont Supreme Court has stated that "by virtue of the enabling legislation . . . Blue Cross is not a private business operating freely within the competitive marketplace; it is a quasi-public business subject to the regulation of the commissioner."[80]

BCBSVT is also part of a national federation of 37 independent, locally operated Blue Cross and Blue Shield companies. The Blue Cross and Blue Shield Association owns, manages, and licenses the associated trademarks and names used by BCBSVT.[81] The Association also provides a worldwide network of doctors and hospitals to subscribers. BCBSVT must pay the Association for access to the trademarks and larger affiliation.[82] The Association also encourages its members to maintain certain minimum standards regarding solvency, and these standards are often more stringent than those required by state regulators.

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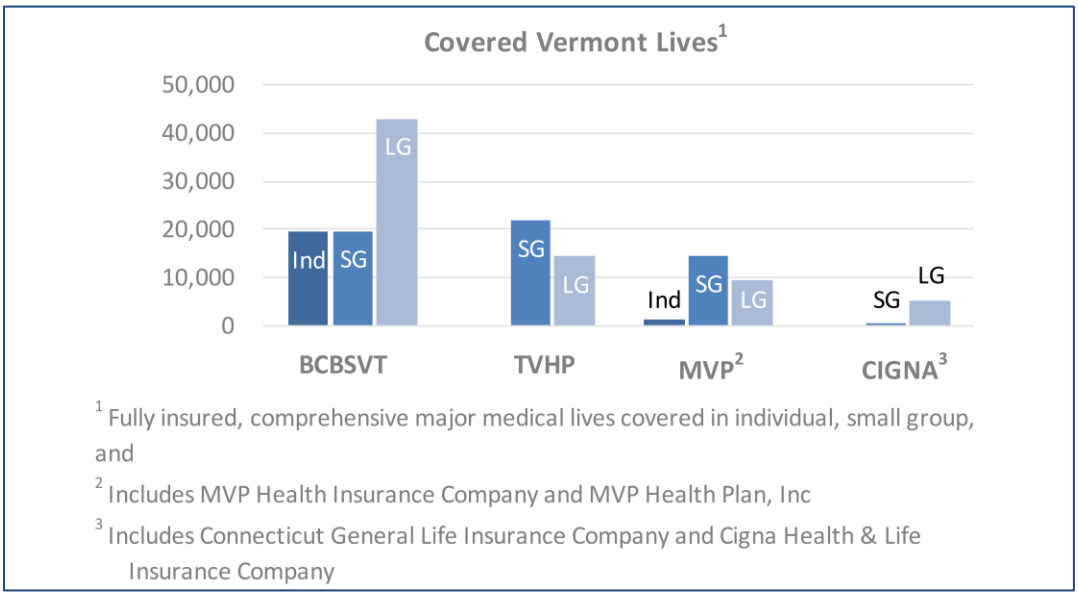
[74] 8 V.S.A. § 3681(4).
[75] 8 V.S.A. § 4512(a).
[76] *See* 11B V.S.A. § 6.03 (Vermont nonprofit corporations may, but are not required to have members). Members are persons who, pursuant to the articles or bylaws, have the right to vote for the election of at least one director. § 1.40(21).
[77] BCBSVT, Bylaws (originally adopted May 26, 1982 and subsequently amended multiple times).
[78] *Id.*
[79] 8 V.S.A. § 4518.
[80] *In re Vt. Health Serv. Corp.*, 144 Vt. 617, 482 A.2d 294 (1984).
[81] *About Blue Cross Blue Shield Association,* Blue Cross and Blue Shield, http://www.bcbs.com/about-the-association/ (last visited June 2, 2014).
[82] Compact Disc: Testimony of Commissioner Susan Donegan, held by the Vermont Senate Committee on Finance, CD 14-76 (Mar. 21, 2014).

BCBSVT controls multiple subsidiaries: it owns 100 percent of Catamount Insurance Services Inc., TVHP, and is the sole member of The Vermont Caring for Children Foundation Inc. (though it holds no ownership interest).[83]



COVERAGE PROVIDED BY BCBSVT

BCBSVT provides major medical coverage to Vermonters in the individual, small group, and large group markets, as well as non-major medical coverage in the form of Medicare supplemental plans and Medicare Part D coverage. Individual and small group plans are offered through VHC, with the exception of plans grandfathered under the ACA. BCBSVT offers coverage to large groups outside of VHC through both fully insured policies and a materially different type of risk-sharing arrangement called "cost-plus" products. Unlike with traditional insurance coverage, an employer offering a cost-plus plan to its employees will be responsible for paying the claims of its employees, and bearing the risk involved in paying those claims. BCBSVT provides administrative services, stop-loss coverage,[84] and a guarantee that in the event the employer cannot or will not pay claims, BCBSVT will pay claims for a limited amount of time, allowing other arrangements to be made. Cost-plus plans must include all state-

[83] Blue Cross and Blue Shield of Vermont, *Annual Statement for the Year Ending December 31, 2013* at 40–41, (Jan. 30, 2014).
[84] Stop-loss insurance generally covers exceedingly large claims, measured either in the aggregate or for a particular claim. This type of coverage would shift the risk from an employer to BCBSVT in the event of an unexpectedly large number of claims (aggregate stop-loss) or any single claim over a certain size.

mandated coverage and be structured such that individuals are subscribers, allowing BCBSVT to meet its mission of being operated "solely for the benefit of subscribers."

Additionally, BCBSVT enters into administrative services only ("ASO") arrangements with some employers. ASO arrangements generally involve BCBSVT providing administrative services such as claims processing to an employer that self-insures its health coverage. Self-insurance means that the employer is solely responsible for paying employee claims and bears all the associated risk. BCBSVT provides administrative services, but does not bear any insurance risk. These plans are similar to cost-plus plans, but differ in important ways, including that self-insured plans cannot be regulated by states. They are not required to include state mandated coverage, are not approved by DFR, and rates are not reviewed by GMCB. [85]

BCBSVT PRESENCE IN VERMONT

As of December 31, 2013, BCBSVT provided major medical health coverage to more than 82,000 Vermonters in the individual, small group, and large group markets,[86] which represented approximately 55 percent of the commercial major medical market.[87] BCBSVT received over $403 million in premium in 2013 for its fully insured major medical plans.[88] More than 50 percent of the lives covered by BCBSVT in 2013 were in the large group market, while the remaining lives were split almost equally between the individual and small group markets.[89] In the past four years, BCBSVT has increased its market share by approximately 11 percent.[90] It is one of only two insurers (MVP being the other) to cover Vermonters in all three of the individual, small group, and large group markets.

[85] The federal Employee Retirement Income Security Act specifically states that employers that self-insure health benefits are not insurance companies, and therefore are not subject to regulation by the states. 29 U.S.C. § 1144(b)(2)(B).
[86] This does not include cost-plus plans or ASO arrangements.
[87] Blue Cross and Blue Shield of Vermont, *Annual Statement For the Year Ending December 31, 2013* at Supplemental Health Care Exhibit 81, (Jan. 30, 2014).
[88] *Id.*
[89] *Id.*
[90] See *supra* text accompanying note 66.

THE VERMONT HEALTH PLAN LLC

TVHP is a wholly-owned subsidiary of BCBSVT. TVHP was formed in 1996 through a partnership of BCBSVT and three local hospitals.[91] It is a Vermont limited liability company. In 2008, TVHP redeemed the ownership interests of the three hospital owners, leaving BCBSVT as the sole owner with a 100 percent membership interest in TVHP.[92]

STATUS OF TVHP UNDER VERMONT LAW

TVHP is licensed as an HMO under Chapter 139 of Title 8. It is also a member of the BCBSVT holding company system. As a limited liability company, all profits and losses of TVHP pass through to the members (here to BCBSVT as the sole member).

As an HMO, TVHP is required to meet all criteria set forth by Chapter 139 of Title 8. These criteria differ from the statutory requirements for BCBSVT under Chapters 123 and 125, but serve the similar purpose of providing authority for DFR to regulate and oversee TVHP's operations. Most insurance requirements under Title 8, including form and rate review, are the same for both BCBSVT and TVHP.[93]

As an insurance company member of the BCBSVT holding company system, TVHP is also subject to significant regulatory oversight in addition to that found in Chapter 139 and elsewhere in Title 8. Comprehensive annual reporting, thorough examinations, and restrictions on transactions within the holding company system are all enforced on TVHP.[94]

COVERAGE PROVIDED BY TVHP

TVHP is licensed as an HMO, and provides HMO products to Vermonters. In 2014, TVHP is not offering individual or small group products through VHC. It provides HMO products only to large groups outside of VHC. Because TVHP charges fixed rates to its members and pays the members' claims, it bears the associated insurance risk.

[91] At the time of formation, Fletcher Allen Health Care Inc. and Comprehensive Health Resources Inc. were also members of TVHP.
[92] Blue Cross and Blue Shield of Vermont, *Annual Statement for the Year Ending December 31, 2013* at 40, (Jan. 30, 2014).
[93] *See* 8 V.S.A. §§ 4515a, 5104 (referring to form and rate review under 8 V.S.A. § 4062).
[94] 8 V.S.A. §§ 3684-3686.

TVHP PRESENCE IN VERMONT

As of December 31, 2013, TVHP provided major medical health coverage to more than 36,000 Vermonters, which represented approximately 24 percent of the commercial major medical market.[95] TVHP and BCBSVT (the other insurer in the same holding company system and owner of 100 percent of TVHP's membership interests) combine to cover approximately 79 percent of Vermonters in the commercial insurance market.[96] TVHP received over $172 million in premium in 2013 for its fully insured major medical plans.[97] In 2013, TVHP covered Vermonters in the small and large group markets, but not the individual market. In the past four years, TVHP has increased its market share by approximately three percent.[98]

MVP

MVP Health Insurance Company and MVP Health Plan Inc. are New York corporations. MVP Health Plan Inc. is a nonprofit company. These entities are part of a holding company system based in New York with 19 different entities.[99] These two MVP entities (together referred to as "MVP")[100] operate in both Vermont and New York. In 2013, the earned premium for MVP attributable to Vermont was approximately 12 percent of its total earned premium.[101]

STATUS OF MVP UNDER VERMONT LAW

MVP does business in Vermont pursuant to certificates of authority awarded under Chapter 101 (MVP Health Insurance Company)[102] and Chapter 139 (MVP Health Plan Inc.)[103] of Title 8.

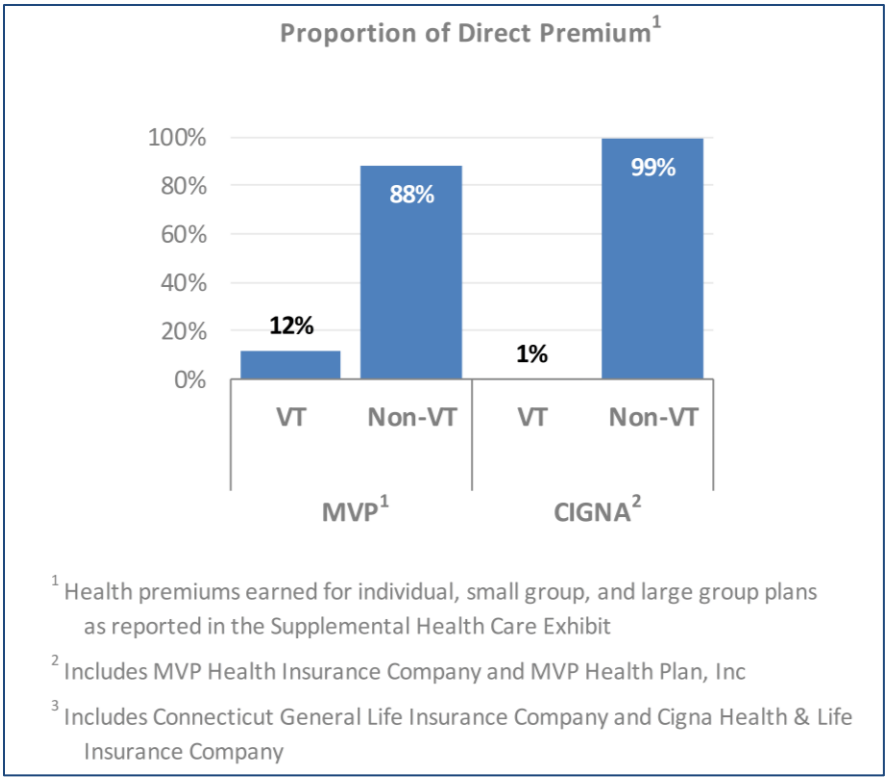
[95] The Vermont Health Plan LLC, *Annual Statement For the Year Ending December 31, 2013* at Supplemental Health Care Exhibit 81, (Jan. 30, 2014).
[96] This does not include BCBSVT's ASO and cost-plus arrangements, which would further increase the combined market share.
[97] See *supra* note 95.
[98] See *supra* text accompanying note 66.
[99] MVP Health Plan Inc., *Annual Statement for the Year Ending December 31, 2013* at 40–41 (Feb. 20, 2014).
[100] All regulatory and financial discussions are equally applicable to each entity. Where appropriate, the report differentiates between the entities for clarity.
[101] See *supra* text accompanying note 66.
[102] 8 V.S.A. §§ 3361-3371.
[103] 8 V.S.A. §§ 5101-5115.

MVP Health Insurance Company is licensed to do business as an out-of-state company[104] and MVP Health Plan Inc. is licensed as an HMO, similar to TVHP.

Though neither of these entities are domiciled in Vermont, they are still subject to the same laws and rules as Vermont companies with respect to health insurance operations. As an out-of-state insurer, MVP Health Insurance Company has specific additional rules with which it must comply regarding licensure, license revocation, assets, and retaliatory provisions.[105] Because both MVP entities operating in Vermont are part of a holding company system, they are also subject to the laws regarding holding companies in MVP's home state of New York.[106]

With respect to other areas outside of insurance operations, Vermont has significantly less oversight responsibility for MVP and significantly fewer regulatory tools to apply than MVP's home state of New York. For example, Vermont requires Vermont insurance companies to abide by very specific investment requirements.[107] MVP, by contrast, is subject to the investment requirements of New York, provided New York's requirements are of a quality that is "substantially as high" as that required by Vermont.[108] The lack of direct authority over out-of-state insurance companies is most acute with respect to financial health. If a Vermont insurance company has liquidity or solvency issues, the Commissioner has broad authority to take many and varied actions to supervise and rehabilitate that Vermont insurer.[109] If MVP has the same issue, the Commissioner may suspend or revoke MVP's authority to do business in Vermont, but otherwise has limited tools to address the underlying problems. As a result, Vermont places significant reliance on New York to actively engage in assuring MVP's solvency.

[104] Generally, insurance companies domiciled in Vermont are "domestic" companies, and insurance companies domiciled in a state other than Vermont are "foreign" companies. For purposes of this report, insurers domiciled in Vermont will be referred to simply as Vermont companies, while those domiciled outside of Vermont will be referred to as "out-of-state" companies.
[105] *See, e.g.*, 8 V.S.A. §§ 3361-3371 (pertaining to licensing and regulation).
[106] N.Y. Ins. Law § 1501 *et seq.* (McKinney 2013).
[107] 8 V.S.A. § 3461 *et seq.*
[108] 8 V.S.A. § 3462.
[109] 8 V.S.A. § 7041 *et seq.*



COVERAGE PROVIDED BY MVP

MVP provides individual, small-group and large group coverage to Vermonters through a variety of products. MVP Health Plan Inc. is one of two health insurance companies to offer products to individuals and small groups through VHC (BCBSVT being the other). MVP offers HMO products through VHC, and to large groups outside of VHC. MVP Health Insurance Company provides coverage to large groups and to small groups with grandfathered health plans under the ACA. Neither MVP entity operating in Vermont provides ASO services.[110] Thus, any products offered by MVP are those in which a premium is paid to MVP in exchange for coverage with all risk associated with that coverage is borne by MVP.

MVP PRESENCE IN VERMONT

As of December 31, 2013, MVP provided major medical health coverage to more than 25,000 Vermonters in the individual, small group, and large group markets, which represented approximately 17 percent of the commercial major medical market.[111] MVP received more than

[110] MVP Health Insurance Company, *Annual Statement for Year Ending December 31, 2013*, at 26.6.
[111] See *supra* text accompanying note 66.

$117 million in premium in 2013 for its fully insured major medical plans.[112] In 2013, MVP was the third largest private health insurer in Vermont, and largest out-of-state insurer.[113] In the past five years MVP's market share has decreased by five percent.[114]

CIGNA

Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company are two Connecticut-based companies that provide health insurance to Vermonters. These two companies are subsidiaries within Cigna Corporation. Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (together referred to as "CIGNA") have health operations in Vermont as well as most other states.[115] Together, they were the fourth largest health insurance company in Vermont in 2013.[116] The earned premium from health insurance attributable to Vermont represented less than one percent of the total earned premiums for CIGNA.

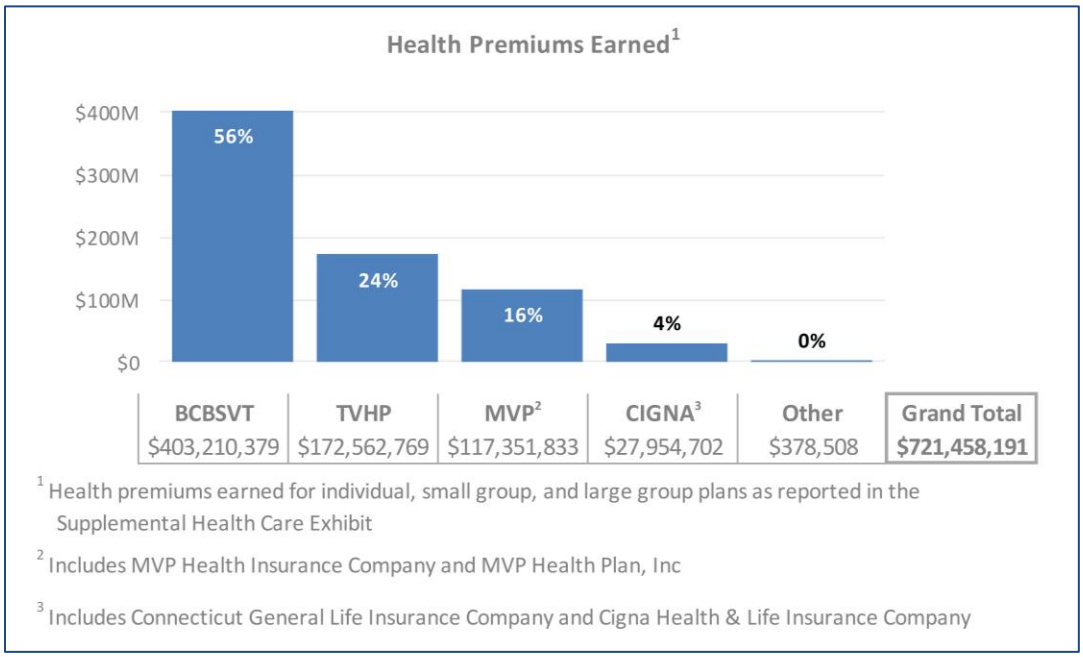
STATUS OF CIGNA UNDER VERMONT LAW

Both CIGNA entities in Vermont are authorized to do business as out-of-state insurance companies pursuant to Chapter 101 of Title 8.[117] Like MVP, CIGNA is subject to Vermont's laws and rules regarding insurance operations, including specific requirements for out-of-state companies. CIGNA is also a holding company, which subjects it to increased reporting requirements under Connecticut's holding company statutes.[118]

Because CIGNA is an out-of-state insurer, Vermont is not its primary regulator. However, if CIGNA violates any of Vermont's laws or rules regarding insurance operations, it will be subject to the same repercussions as a Vermont insurer. By contrast, for purposes of areas such as solvency, investments, and mergers and consolidations, Vermont has limited regulatory

[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] Connecticut General Life Insurance Company, *Annual Statement for the Year Ending December 31, 2013*, at 216-1.AL to 216-6.MP; Cigna Health and Life Insurance Company, *Annual Statement for the Year Ending December 31, 2013* at 216-1.AL to 216-6.MP.
[116] See *supra* text accompanying note 66.
[117] 8 V.S.A. §§ 3361 *et seq.*
[118] Conn. Gen. Stat. § 38a-129 to 140 (2014).

authority. When one of these areas is implicated, Vermont's main tool to protect consumers is its ability to revoke CIGNA's authority to do business in this state.[119]



COVERAGE PROVIDED BY CIGNA

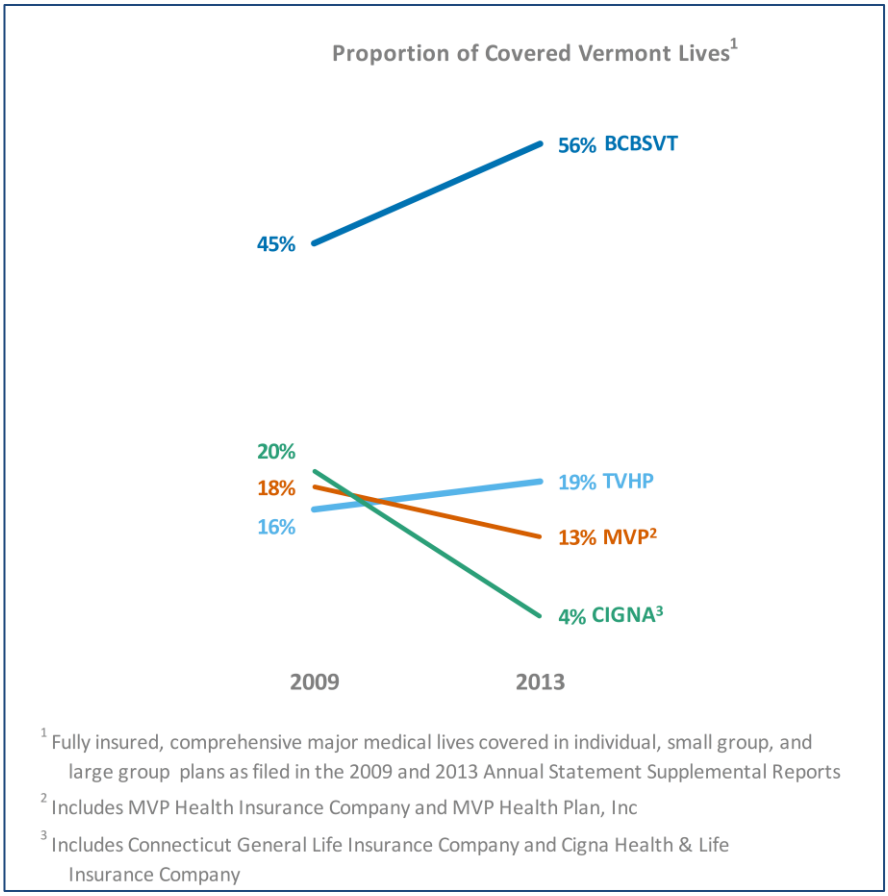
In 2013, CIGNA provided major medical coverage to Vermonters predominantly in the large group market with a very small number of Vermonters covered in the individual and small group markets between the two entities.[120] CIGNA is not providing coverage to individual or small groups through VHC in 2014, meaning its only current presence in the major medical market outside of Vermont's large group market is through grandfathered health plans.

CIGNA also provided ASO arrangements to Vermont employers in 2013, and continues to do so in 2014.[121] These ASO arrangements covered significantly more Vermonters than CIGNA's fully insured individual, small, and large group plans, but are not relevant to this report.

[119] 8 V.S.A. § 3363.
[120] CIGNA, *supra* note 115, at 216-1.VT; CGLIC, *supra* note 115, at 216-1.VT.
[121] CIGNA, *supra* note 115, at 216-1.VT to 216-2.VT; CGLIC, *supra* note 115, at 216-1.VT to 216-2.VT.

CIGNA PRESENCE IN VERMONT

As of December 31, 2013, CIGNA provided major medical health coverage to approximately 5,000 Vermonters, which represented approximately three percent of the commercial major medical market.[122] CIGNA received nearly $28 million in premium in 2013 for its fully insured major medical plans.[123] CIGNA has seen its market share for fully insured plans decline by 16 percent in the past five years, significantly more than any of the other major carriers.[124] In addition to CIGNA's declining market share in the fully insured market, in 2014 the state of Vermont replaced its ASO arrangement with CIGNA for all state employees, causing a decline in CIGNA's ASO business in Vermont.[125]



[122] CIGNA, *supra* note 115, at 216-2.VT; CGLIC, *supra* note 115, at 216-2.VT.
[123] CIGNA, *supra* note 115, at 216-1.VT; CGLIC, *supra* note 115, at 216-1.VT.
[124] See *supra* text accompanying note 66.
[125] *Gov. Peter Shumlin Announces $10 million Savings with Health Care Changes*, State of Vermont, http://governor.vermont.gov/newsroom-gov-shumlin-announced-hc-savings-bcbsvt (Aug. 21, 2013). Analysis of ASO arrangements are not included in this report, but CIGNA's loss of the state employees' plan is an important development affecting its overall presence in Vermont.

VERMONT EDUCATION HEALTH INITIATIVE

The Vermont Education Health Initiative ("VEHI") has operated in Vermont since 1984. In 2014, VEHI completed its transition to an Intermunicipal Insurance Association ("IIA") under Vermont law.[126] An IIA allows municipalities to band together as members of the IIA for the purpose of obtaining or effecting insurance.[127] VEHI has a cost-plus arrangement with BCBSVT, which in 2013 covered more than 42,000 Vermonters.[128] VEHI has a unique structure in that the members pay into a trust and then VEHI purchases coverage for members using funds from that trust.

Though VEHI is not an insurance company, it is discussed here because it is a unique entity bearing many of the characteristics of an insurance company, including reserves and surplus from which it pays claims. VEHI is comprised of school districts, supervisory unions, and private schools. It purchases administrative services from BCBSVT, but is not subject to federal regulatory authority. Generally, self-insured health plans are exclusively regulated by the federal government through the Employee Retirement Income Security Act of 1974 ("ERISA"). However, ERISA exempts governmental plans, and VEHI has the same characteristics as the Vermont School Boards Insurance Trust, which has been ruled by the IRS to be a governmental organization due to the public nature of its membership.[129] VEHI contracts with BCBSVT for services on behalf of its members and also operates a trust for the benefit of its members. All these qualities make VEHI distinctive in Vermont's landscape.

VEHI controls a surplus. As of March 31, 2013, its surplus was approximately $33 million[130] derived from many years of member contributions.[131] The surplus is to be used

[126] *See* 24 V.S.A. §§ 4941 *et seq.* (regulating IIAs); *see also VEHI Intermunicipal Association Member Agreements*, Vermont Education Health Initiative, http://www.vehi.org/health_care_reform.html (last visited Jun. 4, 2014) (announcing that DFR granted a certificate of authority to transact business as an IIA).
[127] 24 V.S.A. § 4942.
[128] BCBSVT 2013 Vermont Education Health Initiative Rate Filing, GMCB-001-13-rr (Green Mountain Care Board Feb. 4, 2013) (decision & order), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/001_13rr_VEHI_dec.pdf.
[129] Letter from Cindy Thomas, Manager, Exempt Organization Determinations, Internal Revenue Service, to Vermont School Boards Insurance Trust Inc. (July 31, 2012).
[130] VEHI Application to Become an Intermunicipal Insurance Association, Amended Financial Plan 2 (May 31, 2013).

exclusively for the benefit of members. Consistent with DFR's rules regarding IIAs, VEHI has a specific and detailed plan for disposition of its surplus in the event it dissolves. In the event any surplus remains after payment of all liabilities and expenses, VEHI will provide those assets to members in accordance with a plan and a formula approved by DFR.[132] The return of surplus to members is part of the contractual arrangement VEHI enters into with each of its member schools.

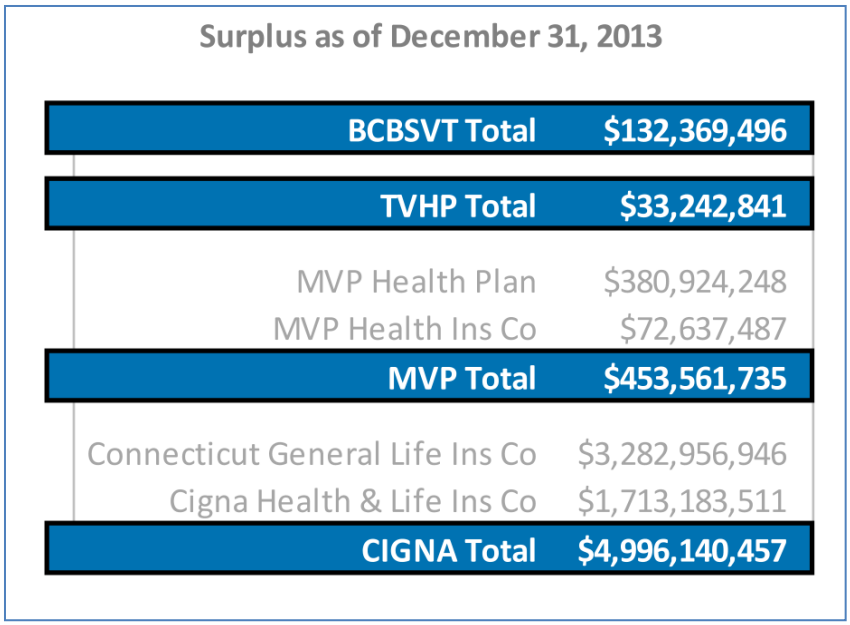
[131] VEHI's surplus is mentioned here because VEHI is alone among the surplus-bearing entities discussed in this report in that it has a well-settled path to disposition of its surplus on dissolution not shared by any other entity. VEHI, and its surplus, are not discussed in any other section of the report.

[132] VEHI Application to Become an Intermunicipal Insurance Association, Amended Operational Plan 3–4 (May 30, 2013) (approved June 7, 2013).

SECTION 4:

CONSIDERATIONS WHEN A HEALTH INSURER CEASES BUSINESS

A health insurer can cease business either voluntarily or involuntarily. The implications and considerations surrounding each are different. Considerations further diverge based on whether the insurer ceasing business is a Vermont company or an out-of-state company. This section discusses the legal and financial considerations for both voluntary and involuntary market exits for both Vermont and out-of-state health insurers, including the potential disposition of surplus funds. Generally, these considerations are broadly characterized as: (1) whether the appropriate legal process is followed when ceasing business; (2) that the exiting insurer retains sufficient surplus to protect Vermonters during the wind-down of operations; and (3) whether and how surplus funds are distributed.



The variations due to voluntary vs. involuntary exits and Vermont vs. out-of-state insurers arise mainly when considering appropriate legal process. The requirement that an insurer ceasing business has sufficient surplus to wind-down operations is necessary and consistently administered through all iterations, and thus is only discussed once in this report. The disposition of an insurer's surplus, like appropriate legal process, varies significantly. In most instances, an insurer ceasing to do business in Vermont only results in surplus being distributed if the insurer is liquidating or otherwise dissolving. As Commissioner Susan L. Donegan stated during testimony before the Vermont Senate Committee on Finance in response to a direct question on this topic, there has not in the past been an instance of surplus flowing back into the state upon an insurer ceasing business.[133] While it has not happened in Vermont, there are circumstances that would result in the distribution of surplus from a private health insurance company. The recipient(s) of surplus depends on many factors related to the

[133] See *supra* note 82.

insurer's domicile, corporate form, and articles of incorporation and bylaws. The circumstances most likely to apply to Vermont and Vermont health insurers are discussed below.

OUT-OF-STATE INSURER VOLUNTARY EXIT

The choice by an out-of-state health insurer to cease business in Vermont's major medical market would most likely reflect one of two scenarios: either the company was going to cease business in Vermont entirely (whether because the company was dissolving or chose to leave Vermont for economic reasons), or it was going to shift its business to sell a different line of insurance in Vermont. In either case, the company would be required to follow appropriate legal process associated with exiting the market, and retain sufficient surplus to protect Vermonters when winding down operations. At the end of the process there would not be any disposition of surplus.

APPROPRIATE LEGAL PROCESS

Even in a highly regulated industry such as insurance, private health insurers may freely exit a state, including Vermont, provided that all contractual and financial obligations are accounted for. Currently, Vermont does not have any formal structure or requirements for out-of-state health insurers that choose to leave Vermont. Under Vermont's existing regulatory structure, insurers providing coverage outside of VHC may stop filing forms and rates for approval in the state, notify individuals and groups of the inability to renew policies, and provide administration to handle claims and other contractual obligations for as long as necessary, including beyond the policy term. An insurer providing coverage through VHC would simply not respond to the next request for proposals from the Department of Vermont Health Access to offer such coverage, and then provide the same notice, administration and claims run-out services as insurer's ceasing coverage outside of VHC. If additional protections were needed, the Commissioner has broad authority over Vermont's insurance market that would likely permit special orders and rules to help ease a potential transition.[134]

[134] *See* 8 V.S.A. § 10 (requiring that the Commissioner supervise insurance carriers in a manner that assures the stability and efficiency of all such organizations and in a way that protects consumers from unconscionable
(footnote continued)

Nearly 25 years ago, legislation requiring community rating of health insurance plans included specific requirements in connection with health insurers leaving Vermont. Additionally, Community Health Plan ("CHP"), a health insurer with a large market share, ceased doing business in Vermont less than 15 years ago. Both community rating requirements and CHP's practical example can be instructive for the future.

In 1991, the Vermont Legislature passed a statute requiring guaranteed issue and community rating of health insurance policies for the small group market,[135] and followed that with a similar statute regarding the individual market in 1992.[136] Community rating is a method of setting premiums that spreads risk evenly across the entire insured population, regardless of age, health status or claims history. At the time, community rating was not a widely utilized tool for rating health insurance policies. Leading up to the passage of the community rating legislation, a number of insurance carriers doing business in Vermont made clear their intentions to cease business in Vermont. The new law required that any registered carrier must provide written notice to the Commissioner at least six months before withdrawing registration to offer policies in the small group and individual markets. This six-month notice requirement was found in 8 V.S.A. §§ 4080a and 4080b until their repeal on January 1, 2014.[137] A "safety net" was also put in place to help ease the transition to community rating for policyholders.[138] Similarly, health insurers that voluntarily ceased providing coverage to Vermonters through the recently repealed Catamount Health program were required by statute to provide six months prior written notice to DFR of the intention to discontinue participation.[139]

The most recent instance of an out-of-state insurance company with a large share of Vermont's private health insurance market ceasing to do business occurred in 2003. CHP was a nonprofit corporation that had been doing business in Vermont since 1981.[140] As of December

practices); s*ee also* 8 V.S.A. § 15 (permitting the Commissioner to adopt rules and issue orders as necessary to the administration of Title 8).

[135] 8 V.S.A. § 4080a, *repealed by* Act No. 171, § 41 (2014).

[136] § 4080b, *repealed by* Act No. 171, § 41 (2014).

[137] §§ 4080a, 4080b, *repealed by* Act No. 171, § 41 (2014).

[138] § 4080c, *repealed by* Act No. 171, § 41 (2014).

[139] § 4080f, *repealed by* Act No. 79, § 52 (2014).

[140] Superseding Stipulation and Order 1 (Vt. Dep't of Banking, Ins., Sec. and Health Care Admin.) (Dec. 23, 2003). As of 2003, Kaiser Foundation Health Plan Inc. was CHP's sole member, and Kaiser Foundation Hospitals had guaranteed the debts, liabilities and obligations of CHP in Vermont.

31, 1998, CHP covered approximately 109,000 Vermonters.[141] On August 31, 1999, CHP provided written notice to the Commissioner of its intent to withdraw from all Vermont markets.[142] On April 9, 2001, the Commissioner signed a Stipulation and Consent Order approving CHP's withdrawal from Vermont, subject to certain conditions agreed to by all parties.[143] The conditions included agreements by CHP to maintain adequate capital and comply with all claims handling requirements during the wind-down, approval by the Commissioner of notices and communications, adequate storage of claims and medical information, and continued reporting during the wind-down.[144] CHP complied with these conditions, and surrendered its certificate of authority when the wind-down of CHP's Vermont business was completed in 2003.[145] In 2006, a letter of credit guaranteeing CHP's obligations was returned.[146] No surplus or other funds were retained by Vermont or Vermont policyholders as a result of the withdrawal or as part of the wind-down.

If an out-of-state health insurer was to shift its business in Vermont so that it was no longer in the major medical health insurance market, the legal process would be different. In the case of a traditional insurer licensed in Vermont to engage in the business of health insurance, no specific process would be required to shift from major medical to some other line within the health insurance umbrella. An out-of-state insurer licensed as an HMO, however, would no longer meet the requirements that an HMO provide "comprehensive health care services."[147] It would be required to apply for a new certificate of authority pursuant to the licensing regime for traditional insurers.

RETENTION OF SUFFICIENT ASSETS

In the event a health insurer ceases business in Vermont, whether an out-of-state or Vermont company, it would not do so all at once. Health insurers are contractually obligated to policyholders while a policy is in force. For practical purposes, reliance on contractual language

[141] CHP's Vermont Information (Vt. Dep't of Banking, Ins., Sec. and Health Care Admin.), prepared by Vt. Ins. Dep't (June 10, 1999).
[142] *Id.*
[143] Stipulation and Order (Vt. Dep't of Banking, Ins., Sec. and Health Care Admin.) (Apr. 9, 2001).
[144] *Id.*
[145] See *supra* note 140.
[146] Letter from Philip H. White, Law Offices of Wilson & White, to John P. Crowley, Commissioner of Vt. Dep't of Banking, Ins., Sec. and Health Care Admin. (June 7, 2006).
[147] 8 V.S.A. § 5101(2).

is coupled with communication and guidance from DFR that enables a smooth transition for policyholders and the exiting company. During any transition period the primary financial consideration for DFR is ensuring that the insurer has, or has access to, sufficient assets to meet all obligations until the company has completed its exit from Vermont's major medical insurance market. A health insurer ceasing to do business in Vermont would likely need sufficient assets for claims and services already incurred, for claims during the period between notice to policyholders and the end of the policy period, for all contractual liabilities extending beyond the end of a policy period, and for applicable administrative costs until all obligations are paid.

Most directly, the health insurer ceasing business in Vermont is contractually obligated to pay claims. Policyholders aggrieved by the insurance company's decision to not pay for a claim under a current policy may seek recourse through the courts.[148] DFR also has the authority to bring an administrative action against an insurer if it refuses to pay claims in accordance with the policy.[149] Vermont law requires that insurers have a minimum level of unimpaired surplus, which the Commissioner may increase as needed.[150] To enforce this requirement, the Commissioner may require that some or all of the company's minimum unimpaired surplus be placed on deposit with the state treasurer.[151] This would give control over the statutory deposit to DFR and the treasurer, ensuring that sufficient assets are available to pay claims, expenses, and obligations until the insurer completes its exit from the market.

Health insurance is a line of insurance with a "short-tail" meaning claims under a health insurance policy will become known and settled quickly, often within a few months. In contrast, under "long-tail" lines such as life insurance claims could arise under a policy for many years. The short-tail nature of health insurance eases the burden of determining the assets that must be available to run out existing policies, and ensuring those assets remain available. However, in addition to claims already incurred, and those potential claims that could be incurred during the duration of the policies, there are certain instances in which health insurance companies will remain obligated to pay for treatment after the policy expires. Vermont law requires group coverage to provide a reasonable extension of benefits up to 12 months beyond the contract

[148] 8 V.S.A. § 4065(11).
[149] § 4724.
[150] §§ 3304, 3309, 3366, 5102b.
[151] *Id.*

expiration and provides for priority between prior and succeeding carriers with respect to the extension of benefits.[152] This extension generally is not utilized but could factor into the surplus a health insurer must have available and the amount of time the insurer must maintain a presence in Vermont before entirely ceasing to do business.

DISPOSITION OF SURPLUS FUNDS

Two of Vermont's four largest insurers, MVP and CIGNA, are out-of-state companies. CIGNA is domiciled in Connecticut and MVP in New York. CIGNA operates throughout the United States and its territories; Vermont represents less than one percent of its total business. MVP operates in Vermont and New York with Vermont representing approximately 12 percent of its total business. In the event that one of these out-of-state health insurers voluntarily ceased business in Vermont, the insurer would continue as a going concern in other states, including the state where the insurer is domiciled. Other than the amounts required to administer policies and pay claims while operations are wound down (as well as any other amounts required to settle contractual debts and obligations in the state), no distribution of surplus would be made other than in the normal course.[153] Specifically, there would be neither a legal basis nor a precedent (in Vermont or elsewhere) for such a distribution in the event that either CIGNA or MVP ceases business in Vermont while continuing insurance operations in other states.

Vermont's insurance laws create a highly regulated market designed to ensure protection of consumers and the stability and efficiency of the market. DFR scrutinizes companies before authorizing them to do business in Vermont. It requires that insurance products meet certain requirements, both for coverage and administration. Also, DFR closely monitors the operations of a company, the financial health of the company, and the corporate governance of the company. Vermont law explicitly requires insurers to maintain sufficient surplus to protect against insolvency.[154] Surplus is built primarily through receipt of premiums from consumers. Vermont law, however, does not authorize the Commissioner to take control of assets held by a

[152] §§ 4091e, 4091f.
[153] Distributions in the form of dividends can be made to shareholders or members at any time, subject to limitations and approvals required by the insurance company's state of domicile.
[154] 8 V.S.A. §§ 3304, 3309, 3366, 5102b.

private company outside of the rehabilitation and liquidation context and even then the Commissioner may only take such control of a Vermont company's assets.[155]

Members of both the House Committee on Health Care and the Senate Committee on Finance asked during hearings about the rights of individuals and of the state of Vermont to recapture surplus in the event an insurer ceases business because of individuals' contribution to surplus through the payment of premiums.[156] Under Vermont law, the surplus of an insurance company is treated similarly to retained earnings of a business corporation not involved in insurance. Just as the law does not contemplate that individuals or the state have a right to a corporation's retained earnings because the product purchased from the corporation is priced to include a contribution to retained earnings, neither does the law contemplate a right to an out-of-state insurance company's surplus.

Further, in the case of MVP, the majority of its operations being in (and surplus coming from) New York allow it to operate in Vermont despite the premiums collected in Vermont accounting for very little, if any, of MVP's surplus.[157] With respect to premiums proposed by MVP in the past, DFR has stated, "[w]hile [the consulting actuary] believes the rates to be deficient, the standard established by Section 4080f(g)(2) is not whether the rates are sufficient to cover anticipated losses and expenses, but rather whether the proposed rates 'threaten the financial safety and soundness of the insurer.' As noted in other recommendations, the Department has no solvency concerns about MVP [Health Insurance Company] and the company has a track record of enjoying strong capital support from other entities in the MVP corporate group."[158] Thus, even if a mechanism existed allowing the Commissioner to take control of a

[155] §§ 7051, 7056.
[156] Compact Disc: Testimony of Commissioner Susan Donegan, held by the Vermont House Committee on Health Care, CD 14-162 (Apr. 4, 2014); Compact Disc: Testimony of Commissioner Susan Donegan, held by the Vermont Senate Committee on Finance, CD 14-76 (Mar. 21, 2014).
[157] MVP, again, is a New York company; its primary regulator is the New York Department of Financial Services.
[158] Memorandum from Stephen W. Kimbell to Green Mountain Care Board, Recommendation for Approval of Third Quarter 2012 MVP Health Insurance Company Catamount Rate Filing (SERFF Tracking Number MVPH-128129148), Jun. 11, 2012 (http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB012_ComRec.pdf). *See also* Memorandum from Stephen W. Kimbell to Green Mountain Care Board, Recommendation for Modification and Approval of MVP Health Plan Inc. First Quarter 2013 and Second Quarter 2013 Small Group HMO Rate Filing (SERFF Tracking Number MVPH-128644483), Oct. 22, 2012 (http://gmcboard.vermont.gov/sites/gmcboard/files/035_ComRec.pdf) ("[T]he Department has no solvency concerns about MVPHP as the company's Vermont business accounts for only about one-quarter of one percent of its total premium revenue.").

private company's assets, MVP's surplus likely does not include significant dollars attributable to its Vermont business.

A recent example in a neighboring state is instructive: on October 15, 2013, MVP Health Care announced that it would be withdrawing from the New Hampshire marketplace.[159] MVP Health Insurance Company of New Hampshire Inc. ("MVPNH") is a New Hampshire-based company that operates only in New Hampshire. It is part of the same holding company system as the two MVP entities that operate in Vermont. For a number of years MVPNH had declining enrollment reaching a low of approximately one percent of the total private health insurance market in New Hampshire,[160] and approximately one percent of MVP's total insured individuals across all its operating entities in New York, Vermont and New Hampshire.[161]

Withdrawing insurers are required by New Hampshire law to provide at least 180 days notice to the insurance commissioner and covered individuals.[162] Due to its small footprint at the time notice was provided no other steps were required by MVP to effect the withdrawal. During the notice period, individuals and groups may renew for one 12-month period, but no new coverage will be provided. To ensure MVPNH continues to have sufficient assets to administer its existing plans and pay claims during the wind-down period (which could last as long as 18 months), the New Hampshire Department of Insurance has received assurances from MVPNH's parent company in New York. After all existing policies (including those renewed during the notice period) have expired and all obligations to policyholders have been met, MVPNH will not have any further responsibilities in New Hampshire. The wind-down and withdrawal will result in MVPNH's surplus being distributed back to the parent company that provided the capital to meet minimum surplus requirements.[163]

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[159] *MVP Announces Intention to Concentrate Resources in Vermont and New York*, MVP Health Care, (Oct. 15, 2013), https://swp.mvphealthcare.com/wps/portal/mvp/shared/aboutus (follow "Press Releases" hyperlink).
[160] *Id*.
[161] Eric Anderson, *MVP Health Care Plans to Withdraw from New Hampshire*, timesunion.com, (Oct. 15, 2013), http://blog.timesunion.com/business/mvp-health-care-plans-to-withdraw-from-new-hampshire/57587/.
[162] Guaranteed Issue and Renewability, N.H. Rev. Stat. Ann. § 420-G:6 (2009).
[163] Information and details in this report regarding MVPNH's exit from the New Hampshire marketplace were helpfully provided through telephone conversations with Barbara Richardson, Director of Operations of the New Hampshire Insurance Department.

MVPNH's withdrawal from New Hampshire can provide some lessons in the event a similar withdrawal occurs in Vermont. However, the similarities are limited. MVPNH is a New Hampshire company. The only Vermont health insurers are BCBSVT and TVHP (a hospital service corporation and HMO, respectively), and neither has affiliates in any other states. The differences between MVPNH and Vermont health insurers results in a more useful comparison between MVPNH and Vermont's out-of-state carriers. New Hampshire's situation is an important example of a private health insurer ceasing business in a state and the remaining surplus after withdrawal from the market being returned to the out-of-state parent company.

Not only do CIGNA and MVP have parent companies to which surplus could be returned, the entities themselves would continue to operate outside of Vermont, further removing the possibility of any disposition of surplus. There is no mechanism for or contemplation of any other disposition of surplus funds in New Hampshire for an entity that will no longer be issuing any health insurance policies. Similarly, there is no mechanism in Vermont that would facilitate the disposition of surplus from an entity that is based in, and remains in operation, in another state. Therefore, MVP or CIGNA would likely continue to utilize its surplus for operations outside of Vermont.

OUT-OF-STATE INSURER INVOLUNTARY EXIT

An out-of-state health insurer might involuntarily exit Vermont as a result of financial trouble or a statute requiring the exit. There are other possible reasons, such as a license suspension or revocation due to violation of insurance laws or rules, but this section focuses on the two more probable scenarios of financial trouble and a statutorily required exit. The considerations for Vermont in either case are that the company both follows appropriate legal process associated with exiting the market and retains sufficient surplus to protect Vermonters during the wind-down of operations. At the end of the process, there would not be any disposition of surplus.

APPROPRIATE LEGAL PROCESS

When an out-of-state health insurer's financial health is in question Vermont can force that insurer to leave the market involuntarily by suspending, revoking or not renewing its license.

DFR has limited authority to intervene in the financial and solvency aspects of out-of-state insurers. Rather, the domestic regulator for those companies has significant authority while Vermont's most powerful tool is to stop the out-of-state insurer from doing business in Vermont. In the context of a health insurer that is part of a holding company system:

> Whenever it appears to the commissioner that any person has committed a violation [Vermont laws relating to holding companies] which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or authority to do business in this state for such period as he or she finds is required for the protection of policyholders or the public.[164]

More generally, whenever a license or other property right is taken by the state, appropriate due process must be provided.[165] Vermont's Administrative Procedure Act ("VT APA") and DFR's rules passed in accordance with the VT APA provide the requirements for notice and hearings that result in license revocation.[166] Any party aggrieved by an act, determination, rule, regulation, order, or other action by the Commissioner pursuant to the holding company laws, including an adverse determination in a license suspension or revocation hearing, may appeal to the Vermont Superior Court for a trial *de novo*.[167] CIGNA and MVP are part of holding company systems subject to these rules.

Nonrenewal of a license is also a powerful tool resulting in a market exit. Because DFR does not have control over the financial health of out-of-state insurers, its best tool to stop an out-of-state insurer with questionable financial health from doing business in Vermont is often to either negotiate with the insurer and sign a mutually-agreeable consent order or to simply refuse to renew the out-of-state insurer's certificate of authority, which must be renewed annually. When determining whether to renew an out-of-state insurer's certificate of authority, the Commissioner must look to the criteria established for licensure of Vermont insurance companies.[168] A Vermont insurance company only receives a license after the Commissioner determines, after broad inquiry into the insurer, its leadership, and its financing, that it is in the public good to do

[164] § 3692.
[165] *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 538 (1985).
[166] 3 V.S.A. §§ 800-849; Vt. Code R. § 1, regulation no. 82-1 (2014).
[167] 8 V.S.A. § 3693.
[168] § 3361(c).

so.[169] Consideration of these criteria would likely justify a decision to not renew the license of an out-of-state insurance company.

If the involuntary exit by an out-of-state health insurer was the result of a statutory change in Vermont rather than a solvency-driven decision, the appropriate process is unclear. A statute requiring an out-of-state company to cease business in Vermont involuntarily could include a specific process by which that company must cease business. It could involve revocation of a license and administrative hearings or it could fundamentally change the Vermont insurance market, effectively eliminating the market for an out-of-state company's services.

RETENTION OF SUFFICIENT ASSETS AND DISPOSITION OF SURPLUS FUNDS

Retention of sufficient surplus by an out-of-state insurer is just as necessary during an involuntary market exit as one that is voluntary and it is handled the same way. See the discussion on "Retention of Sufficient Assets" in the section on "Out-of-State Insurer Voluntary Exit" above for a discussion of why and how DFR ensures sufficient assets are available to pay claims and administrative expenses as an out-of-state insurer winds down operations. Similarly, the above discussion of "Disposition of Surplus Funds" in the same "Out-of-State Insurer Voluntary Exit" section is also applicable to an involuntary exit. There is no mechanism in Vermont law that would result in an out-of-state insurer's surplus being distributed upon an involuntary exit from Vermont.

VERMONT INSURER VOLUNTARY EXIT

It is possible that a Vermont health insurer could voluntarily cease business in Vermont's major medical market by either dissolving the company, or by shifting to other non-major medical lines of business. As with out-of-state health insurers, the considerations in either scenario would include: (1) following appropriate legal process; (2) maintaining sufficient assets during wind-down; and (3) whether and how surplus funds would be disposed. The analysis regarding maintenance of sufficient surplus is consistent with that for out-of-state health insurers, though the appropriate legal process and disposition of surplus discussions are very different.

[169] § 3305.

APPROPRIATE LEGAL PROCESS

If a Vermont health insurer sought to dissolve (when financially healthy), due to the potential harm to Vermonters the Commissioner would likely find that the decision to dissolve could subject the insurer to delinquency proceedings, and place the insurer under supervision.[170] After notice and opportunity for a hearing under the VT APA, the Commissioner could issue a list of requirements to the insurer to abate the determination,[171] and could prohibit the insurer from taking a number of actions without approval from the Commissioner.[172] The determination that would subject a Vermont health insurer to supervision and/or rehabilitation would permit the Commissioner to exercise control over a Vermont insurer as it dissolves, thereby protecting Vermonters. With respect to BCBSVT, the decision to dissolve would likely be a "material transaction" and would require the Commissioner's approval after a determination of whether the transaction meets the general good of the state. [173]

A shift by a Vermont insurer to other lines of insurance business would also require the Commissioner's approval. For example, BCBSVT could shift its business to Medicare supplemental plans, supplemental health coverage generally, or focus primarily on its role as a third party administrator to self-insured plans.[174] The primary question then is whether the new business model would allow BCBSVT to remain a nonprofit hospital service corporation, or whether it would be something else entirely. Assuming BCBSVT's new business was similar enough that it would still be considered a nonprofit hospital medical service corporation (also licensed as a medical service corporation), it would still be required to seek approval from the Commissioner for a change in the "services to be furnished and rendered by it."[175] If BCBSVT could not remain a nonprofit hospital service corporation, it would have to seek a new license to engage in business through the traditional company licensing regime.

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[170] 8 V.S.A. § 7031 *et seq*.
[171] 8 V.S.A. § 7041(a).
[172] 8 V.S.A. § 7041(c).
[173] § 4523(b).
[174] TVHP could not similarly shift its business model. It is licensed as an HMO, which is defined in 8 V.S.A. § 5101(2) as "any person who furnishes, either directly or through arrangements with others, comprehensive health care services." Ceasing to do business in the major medical market would preclude TVHP from providing comprehensive health care services, requiring it to receive a new certificate of authority under another statute to continue operating.
[175] 8 V.S.A. §§ 4513(b), 4584(a).

DISPOSITION OF SURPLUS FUNDS ON DISSOLUTION

The two largest private health insurance companies in Vermont, BCBSVT and TVHP, are Vermont companies. Both are also single-state companies, meaning they operate only in Vermont. If BCBSVT ceased doing business in Vermont due to dissolution that was not the result of insolvency, there would likely be additional surplus remaining after all debts and obligations are paid.[176] If BCBSVT were organized as a mutual company, its member owners would be entitled to distributions. If BCBSVT were organized as a nonprofit with members, or a cooperative, the same outcome would arise. Shareholders would receive distributions if it were a stock company. However, BCBSVT has none of those structures, leaving two important legal considerations necessary for the Commissioner to determine the disposition of any surplus.

The first consideration would be to determine what type of nonprofit corporation BCBSVT is—a mutual benefit corporation or a public benefit corporation. The type of nonprofit corporation dictates the universe of potential recipients of a distribution of assets. The second consideration is how BCBSVT plans to dispose of assets, as articulated in its articles and bylaws, and whether such disposal is permitted by law.

NONPROFIT CLASSIFICATION

BCBSVT is, by statute, a nonprofit corporation.[177] Vermont law requires that all nonprofit corporations be classified as either public benefit corporations or mutual benefit corporations.[178] Public benefit corporations are those designated as such by statute or recognized as exempt under section 501(c)(3) of the Internal Revenue Code. Alternatively, a corporation is a public benefit corporation if it is both organized for a public or charitable purpose, and must distribute its assets to the United States, a state, or a person recognized as exempt under 501(c)(3) of the Internal Revenue Code.[179] Summarized by the Vermont Secretary of State, a public benefit corporation is any nonprofit corporation organized for a public or charitable purpose.[180] A mutual benefit

[176] TVHP is a limited liability company. Pursuant to its operating agreement, any assets remaining after payment to creditors and other obligors would be paid to its sole member, BCBSVT.
[177] 8 V.S.A. § 4512(a).
[178] 11B V.S.A. § 17.05.
[179] *Id.*
[180] *Nonprofit Corporation*, Vermont Secretary of State, https://www.sec.state.vt.us/corporations/start-or-register-a-business/nonprofit-corporation.aspx (last visited June 5, 2014).

corporation is simply any nonprofit corporation that is not a public benefit corporation, or that is designated by statute as a mutual benefit corporation.[181]

BCBSVT was incorporated prior to Vermont's law requiring all nonprofit corporations to be classified as either public benefit or mutual benefit corporations. There has not been any formal determination for BCBSVT in this regard and there is evidence supporting a classification as either a public or mutual benefit corporation. On one hand, BCBSVT has opined in the past that it is a mutual benefit corporation.[182] At least one court has opined that a nonprofit Blue Cross and Blue Shield entity in Wisconsin had not been operated exclusively for charitable purposes, including because it sold policies to people who paid premiums to become policyholders.[183] However, there is also evidence that BCBSVT is a public benefit corporation: it must operate "exclusively for the promotion of social welfare,"[184] the Vermont Supreme Court has labeled it a "quasi-public" company,[185] and a Blue Cross and Blue Shield entity in Missouri was found to be a public benefit corporation.[186]

The significance of the nonprofit classification for BCBSVT is the limitations such a classification places on distribution of surplus in the event of dissolution. The Vermont Secretary of State describes a nonprofit corporation as having the purpose of "some greater good, either for the society as a whole or for a defined community of interest, and not for the individual profit of those involved."[187] This represents the traditional understanding of nonprofit corporations and would prohibit distribution of surplus upon dissolution to officers, directors, or others involved in the running of the corporation. In addition to these distribution limits applied to all nonprofit corporations, Vermont's classification system (mutual benefit and public benefit corporations) further limits potential distributions. If a public benefit corporation's articles of

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[181] 11B V.S.A. § 17.05.
[182] Report of Blue Cross and Blue Shield of Vermont to the Department of Banking, Insurance, Securities and Health Care Administration Concerning the Milnes SERP Payment 2 n.3 (Jan. 20, 2010), http://www.dfr.vermont.gov/sites/default/files/ExhibitsOrder-09-131-H.pdf.
[183] *ABC for Health, Inc. v. Comm'r of Ins.*, 250 Wis.2d 56, 640 N.W.2d 510 (2011).
[184] BCBSVT Articles of Incorporation, (1980).
[185] *In re Vt. Health Serv. Corp.*, 144 Vt. 617, (1984).
[186] *Blue Cross and Blue Shield of Missouri v. Nixon*, 81 S.W.3d 546, (Mo. Ct. App. 2002). *See also* Mo. Rev. Stat. § 355.881 (codifying definitions of "public benefit corporation" and "mutual benefit corporation" similar to those under Vermont law).
[187] *Nonprofit Corporation*, Vermont Secretary of State, https://www.sec.state.vt.us/corporations/start-or-register-a-business/nonprofit-corporation.aspx (last visited June 9, 2014).

incorporation or bylaws do not address distribution of assets on dissolution, those assets may only be distributed to a 501(c)(3) charity or another public benefit corporation.[188] Conversely, a mutual benefit corporation in the same scenario would distribute assets to its members, if any, or otherwise to the persons to whom the corporation holds itself out as benefiting or serving.[189]

INSURER PROVISIONS FOR DISTRIBUTION

Vermont law only restricts distributions based on the classification of the nonprofit if provision for distribution is not otherwise made in the articles of incorporation or bylaws.[190] Distribution will generally be made in accordance with the articles or bylaws, subject to any contractual or legal requirements.[191] BCBSVT's bylaws are silent on distribution of assets, but its articles state that assets,

> shall be distributed in such equitable manner as may be determined by the board of directors, subject to the approval of the Commissioner of Insurance and/or a court of competent jurisdiction, consistent with Vermont law; provided however that in no event shall distribution be made in a manner inconsistent with the requirements of tax exemption of the corporation under the applicable [federal tax code provisions]."[192]

BCBSVT's articles state that assets will be distributed equitably in accordance with a plan to be determined in the future. Vermont law permits assets to be distributed as provided in a nonprofit corporation's articles, but restricts such distributions if no provision has been made for distribution. It is unclear whether BCBSVT's articles contain a sufficient provision for distribution of assets on dissolution could determine the limits on how assets are distributed. If its general statement is insufficient, distribution will be limited to the options articulated by Vermont law, consistent with the type of nonprofit corporation BCBSVT represents. If its general statement is sufficient, BCBSVT (with approval by the Commissioner and/or a court) may have wider latitude in determining how to distribute its assets in dissolution, provided the distribution is consistent with applicable law.

[188] 11B V.S.A. § 14.05(a)(6).
[189] 11B V.S.A. § 14.05(a)(7).
[190] 11B V.S.A. § 14.05(a)(6) and (7).
[191] 11B V.S.A. § 14.05(a)(5).
[192] BCBSVT Articles of Incorporation, (1980).

If BCBSVT sufficiently addresses distribution of assets on dissolution, it is unclear under Vermont law whether the distribution would be further limited beyond the basic prohibition against distributions to officers and directors. To the extent BCBSVT was designated a public benefit corporation and it was found to have charitable assets, distribution options may be limited to other charitable organizations even if BCBSVT attempted to direct distribution elsewhere. In Vermont, trust law requires that when a charitable purpose for which a charitable trust was formed can no longer be completed or no longer exists, the trustee or court select one or more charitable purposes consistent with the settlor's intention.[193] Further, if a particular charitable purpose becomes impossible to achieve or unlawful, the trust property may be distributed in a manner consistent with the settlor's charitable purposes.[194]

In addition to the nonprofit classification and insurer provisions for distribution, insurance law governing BCBSVT requires that it be "maintained and operated solely for the benefit of the subscribers thereof."[195] Whether this provision further restricts distributions, or conflicts with the other considerations must be determined. This intersection between trust law, corporate law, and insurance law has not yet been explored in Vermont courts.

DISPOSITION OF SURPLUS FUNDS IF NO DISSOLUTION

A shift away from the major medical health insurance market to something less comprehensive would likely entail a different set of risks, and thus would likely not require the same level of surplus for BCBSVT to remain healthy. DFR has the authority to approve or deny a change in the services furnished by BCBSVT[196] and in so doing would likely determine whether existing law permits the disposition of any unnecessary surplus. Because BCBSVT is involved in several lines of business beyond major medical insurance and could explore new opportunities, such a determination would itself likely be complex and nuanced.

Vermont corporate law is clear that nonprofit corporations may only distribute assets in very limited circumstances. Unless a nonprofit corporation is dissolving, or purchasing memberships

[193] 14A V.S.A. § 405(b).
[194] *See* 14A V.S.A. § 413 (authorizing the Office of the Attorney General, a trustee, or any interested person to bring a motion to the superior court to enforce this doctrine, generally referred to as *cy pres.*)
[195] 8 V.S.A. § 4512(a).
[196] 8 V.S.A. §§ 4513(b), 4584(a).

back from members, no distributions are permitted.[197] However, "distributions" are generally defined as the "payment of a dividend or any part of the income or profit of a corporation to its members, directors or officers."[198] A distribution of surplus ordered by DFR as part of a change in services may not be a prohibited distribution under corporate law, especially given BCBSVT's requirement to operate for the social welfare.[199] While insurance law would control in the event of a conflict, it is not clear that insurance law would directly conflict with the corporate law restriction on distributions. Should BCBSVT cease business in the major medical market, but continues as a going concern, any conflicts between corporate law and insurance law must be resolved before determining whether a distribution is made.

VERMONT INSURER INVOLUNTARY EXIT

An involuntary exit from Vermont's major medical insurance market would most likely be caused by either the insurer's financial trouble or by a change in statute requiring the insurer to cease business in Vermont. With respect to financial trouble and solvency concerns, the considerations involved would consist of following appropriate legal process and maintaining sufficient assets during the wind-down. If the insurer's solvency is in question, whether sufficient assets exist to pay claims and administrative expenses is an important consideration, but that issue is handled through the legal process described below. Disposition of excess surplus funds is not a consideration during an insolvency-driven involuntary market exit, because all assets would be distributed to meet existing debts and obligations, likely with no additional surplus remaining. In the case of a statute causing a Vermont health insurer to involuntarily cease business, it is impossible to predict what process or disposition of surplus might be required, though recent history can be instructive.

APPROPRIATE LEGAL PROCESS FOR INSOLVENCY

A Vermont insurer would involuntarily cease business if it were ordered to liquidate by the Commissioner. The Commissioner has broad authority to supervise and rehabilitate a Vermont

[197] 11B V.S.A. § 13.02.
[198] 11B V.S.A. § 1.40.
[199] BCBSVT Articles of Incorporation, (1980).

health insurer if it is in hazardous financial condition or is otherwise in distress.[200] Liquidation is ordered where rehabilitation either has not worked or would be futile and the company is insolvent. Liquidation is the process of converting an entity's assets to cash or other assets and settling its obligations with creditors and investors in anticipation of the entity ceasing all activities.[201] Where grounds exist for rehabilitation or liquidation, the Commissioner must petition the Superior Court of Washington County for a corresponding order.[202]

All assets are converted to pay as many of the insurer's liabilities as possible. Usually liabilities are paid in cents on the dollar. Generally, all policy claims are referred to the Guaranty Association,[203] however, neither BCBSVT nor TVHP are members of the Guaranty Association. Thus, there is less assurance that consumer claims will be paid despite insufficient capital and surplus in the insurer to pay those claims, making DFR's regulation of Vermont insurer solvency that much more important. Liquidation is often a long process requiring multiple accountings of the value of assets and liabilities and the seeking and ordering of claims on assets and creditors, with much of the process playing out in the courts.

Insolvency, by definition, means the insurer does not have sufficient capital or surplus to cover all liabilities, except in rare cases. Thus, when a company involuntarily ceases to do business as a result of liquidation, no surplus remains to be distributed.

INVOLUNTARY EXIT RESULTING FROM STATUTE

Vermont law does not provide a mechanism for requiring a health insurer to cease business unless that insurer's financial health is in question or it has violated an insurance law or rule. However, it is the purview of the Legislature to make and change laws.[204] The Legislature has

[200] 8 V.S.A. § 7031 *et seq.*; Department of Financial Regulation Rule I-93-2, Defining Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition.
[201] Financial Accounting Standards Board 3, Accounting Standards Update No. 2013-07 p. 3 (Apr. 2013), http://www.fasb.org/jsp/FASB/Page/SectionPage&cid=1218220137102 (scroll down to download Updated No. 2013-07).
[202] §§ 7051, 7056.
[203] § 4152.
[204] Vt. Const. ch. II, § 6.

provided recent examples of how its decisions can alter markets and how those alterations can have the effect of causing insurers to cease business in Vermont.[205]

In 2011, the Legislature repealed portions of Vermont law regarding health insurance sold to small groups and individuals, thereby eliminating a portion of the health insurance market.[206] The intent of the repeal was to narrow the market for small group and individual insurance to products offered by private insurers through VHC. The repeal itself is an example of the Legislature's ability to shape the health insurance market. If the Legislature was to take similar but broader steps in the future, it could in effect eliminate the private health insurance market (rather than limiting it to VHC). This could be effectuated by health insurer type (repealing the enabling statute for hospital service corporations, or the controlling statute for HMOs, etc.), or, as was done in 2011, by market segment (large group, individual, small group, etc.). Because of the Legislature's freedom to enact, amend, and repeal statutes, there are certainly other ways for the Legislature to produce similar results.

While passing new laws can provide certainty related to a private health insurer ceasing business in Vermont, those laws can also invite legal and constitutional challenges, especially if related to the disposition of surplus. For example, in the 1990s many states passed laws permitting Blue Cross and Blue Shield entities to convert from nonprofit to for-profit corporations, and the laws included provisions articulating how nonprofit assets would be disposed of upon conversion.[207] Many of these laws, and the conversions that resulted, faced challenges in court. The challenges ranged from constitutional claims that the conversion laws represented a taking without just compensation and violated due process,[208] to common law

[205] See *supra* p. 39 for a discussion of community rating legislation and its effects on Vermont's health insurance market.
[206] Act 171, An act relating to health care reform implementation, 2011 VT Acts & Resolves 154, § 41.
[207] *See, e.g.*, 1996 Virginia Laws Ch. 801 (H.B. 1471) and 1996 Virginia Laws Ch. 831 (S.B. 590) (Virginia laws requiring shares of stock or cash equal to the value of the converting entity's surplus to be distributed to the state Treasurer upon conversion); 2002 N.Y. Sess. Laws Ch. 1 (McKinney) (New York law requiring 95 percent of the fair market value of the entity upon conversion to be placed in a fund to be used as a public asset).
[208] *See Consumers Union of U.S., Inc. v. State*, 5 N.Y.3d 327, 840 N.E.2d 68 (2005) (challenging that the relevant New York statute provided for an unconstitutional taking, deprived the insurer of its property without due process of law, violated the Contract Clause, and granted an exclusive privilege to a corporation in violation of the New York Constitution)

claims that the converting entity's assets must be distributed to a charitable cause.[209] New laws have not been proposed in Vermont, so it would be difficult to predict the challenges a potential new law might face or the merits of such a challenge, other than that some sort of challenge is likely.[210] As the Office of the Attorney General notes, "a legal analysis of the consequences of an insurer's departure from the Vermont health insurance market is difficult to do absent a specific factual basis."[211]

[209] *ABC For Health, Inc. v. Commissioner of Insurance*, 250 Wis.2d 56 (2011) (challenging that the Blue Cross entity at issue was a charitable organization, and thus under the *cy pres* doctrine the assets from the charitable trust should have gone to another charitable organization).

[210] For example, the U.S. Supreme Court has acknowledged the right of quasi-public entities to assert Takings Clause challenges even though their assets are employed for quasi-public purposes. *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989).

[211] Letter from William Griffin, Chief Assistant Attorney General, State of Vermont Office of the Attorney General to Commissioner Susan L. Donegan, Commissioner, Vermont Department of Financial Regulation (June 26, 2014) (attached hereto).

CONCLUSION

Health insurance companies in Vermont are regulated by DFR either as their primary solvency regulator or under an out-of-state license to conduct the business of insurance in Vermont. DFR's authority extends to insurance companies ceasing business in Vermont for both Vermont and out-of-state insurers. The process and outcome of any market exit, including the disposition of surplus funds, would depend on many factors discussed in this report and could vary greatly.

Generally, no disposition of surplus would result from an out-of-state health insurer ceasing business in Vermont. It is possible that disposition of surplus funds could occur if a Vermont nonprofit hospital service corporation ceases business, but not in all circumstances. Any statutory changes that direct how surplus funds are to be distributed by insurers ceasing to do business in Vermont must take all regulatory and other legal and constitutional challenges into account.

ATTACHMENT:

LETTER FROM THE OFFICE OF THE ATTORNEY GENERAL

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June 26, 2014

Commissioner Susan Donegan
Department of Financial Regulation
89 Main St.
Montpelier, VT 05620-3101

Re: Consultation Pursuant to Act 144

Dear Commissioner Donegan,

As you know, the Legislature directed the Department of Financial Regulation to consult with the Attorney General's Office on a report relating to the departure of a health insurer from the Vermont market. The Department was asked to "identify the legal and financial considerations involved in the event that a private health insurer offering major medical insurance plans, whether for-profit or nonprofit, ceases doing business in this State, including appropriate disposition of the insurer's surplus funds." 2013, No. 144 (Adj. Sess.) § 18. The Department provided the Attorney General's Office with a draft of its report and Department staff consulted with the Office on the legal considerations.

The Attorney General's Office concurs with the broad conclusion of the draft report. We agree that a legal analysis of the consequences of an insurer's departure from the Vermont health insurance market is difficult to do absent a specific factual basis. The report identifies several general legal concerns – both constitutional and statutory – that might arise in a variety of circumstances. However, an assessment of the actual legal result in a particular case would be very fact-dependent.

The report makes clear that there are a variety of insurers in the Vermont market. The differences among these insurers – corporate structure, domicile, insurance products offered – would affect how a possible termination of business operations in Vermont could proceed. They would affect the degree of control or oversight the Department or another State agency might have.

The reason an insurer ceases doing business in Vermont would add another level of complexity to the legal analysis. Different statutory schemes and legal principles would come into play depending on whether the market exit is voluntary or involuntary. A market exit prompted by the financial circumstances of the insurer would implicate specific statutes. These

statutes might not apply – or might not apply in the same way – to an exit prompted by a change in legislation or other external factors.

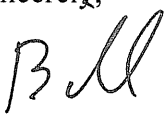
The Attorney General's Office has some oversight of nonprofit entities, including significant authority when a nonprofit hospital converts to a for-profit entity. However, it is not clear that this oversight would apply when a nonprofit insurer leaves the market. The insurance market is unique and the Legislature has enacted detailed laws providing for oversight by the DFR Commissioner. The draft report recognizes the lack of bright lines between insurance and corporate law and between DFR and AGO oversight.

Finally, as the draft report notes, there are a number of scenarios under which there is no clear legal authority for the State to act, beyond broad regulatory oversight. The AGO has not undertaken a sweeping review of all potential areas of constitutional, statutory and common law that might apply in this context. Without further clarity on the specifics of the insurer's market exit, such a review would not be meaningful. However, the draft report does provide a fair, general assessment of the legal and financial considerations that would apply in the event that a health insurer ceases doing business in Vermont.

Please feel free to contact me if you have additional questions or concerns.

Thank you.

Sincerely,



William Griffin
Chief Assistant Attorney General