VERMONT

DEPARTMENT OF FINANCIAL REGULATION

Act No. 68 (2025) DEPARTMENT OF FINANCIAL REGULATION; DOMESTIC HEALTH INSURER SUSTAINABILITY; REPORT

November 1, 2025

Submitted by:

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Introduction

Section 11d of Act No. 68 of 2025, *An act relating to health care payment and delivery system reform*, requires the Department of Financial Regulation (DFR) to provide to the Health Reform Oversight Committee[1] a plan for preserving the sustainability of domestic health insurers in Vermont, which may include utilizing reinsurance.

Fundamentally, for Vermont's domestic health insurers to be sustainable, they must have adequate resources to pay claims, as well as sufficient reserves ("surplus") to provide for unexpected shortfalls. An insurer without sufficient reserves for projected future claims, or worse yet, an insurer unable to pay current claims, is insolvent and subject to enhanced oversight and even receivership. Given the significant burden that insolvency would pose to Vermonters and the entire health care system, DFR and its counterpart insurance regulators in other states take strong measures to prevent insolvencies well in advance. This includes the use of actuarial modeling to test whether insurers are likely to remain solvent.

It is crucial to recognize the health insurance levers that are within the state's control (including the levers given to DFR and the Green Mountain Care Board), as well as those that the state of Vermont cannot control. DFR's role is to ensure the solvency of insurers. The GMCB's role is to set rates for insurers in the commercial marketplace, and this role has recently expanded to include global hospital budgets and reimbursement rates for services (reference-based pricing). Major cost factors remain outside of the state's control, including the rates paid by Medicare and Medicaid for various services, the level of subsidies offered by the federal government, and the offerings of employer-sponsored health plans under the Employee Retirement Income Security Act of 1974 (ERISA).

It is also essential to acknowledge that insurers have limited tools to influence utilization and cost of care trends that are the primary drivers of insurance rates. The strategy of suppressing health insurance rates in the name of affordability has clearly failed to influence the cost of care, and instead has resulted in obscuring a growing crisis, while seriously threatening the solvency of Vermont's largest health insurer.

Background on Health Insurance in Vermont

As of September 2025, the private health insurance market covers about 52 percent of Vermonters, according to the Department of Vermont Health Access (DVHA).[2] Of the remaining 48 percent, 45 percent are covered by government insurance including Medicare, Medicaid, and military health insurance (Tricare), and roughly three percent of Vermonters are uninsured. Medicare and Medicaid rates are set by the federal government, with price caps on various services and procedures that are typically lower than equivalent services outside of government plans.

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[1] The Health Reform Oversight Committee (2 VSA §691 et seq.) was created by Act 179 of 2013, and consists of four Senators and four Representatives. "When the General Assembly is adjourned, the Committee shall provide legislative oversight and review of revenue collection, expenditures, and planning related to health care reform efforts in Vermont" (2 VSA §692). Vermont Legislative Joint Fiscal Office, "Health Reform Oversight Committee," https://ljfo.vermont.gov/committees-and-studies/health-reform-oversight-committee.

[2] Department of Vermont Health Access, "Health Insurance in Vermont," October 31, 2025, https://dvha.vermont.gov/sites/dvha/files/documents/Health_Coverage_Map_202509.pdf.

About 20 percent of Vermonters have private insurance that is subject to DFR's jurisdiction in some capacity. Roughly 11 percent are in individual and small group plans that are qualified health plans (QHPs, *i.e.* marketplace plans under the Affordable Care Act). Commercial plans, including QHPs, are affected by larger market forces including federal changes to Medicaid and private employers' willingness to provide their own health insurance. Individuals who newly lose their coverage from other sources may turn to QHPs, or may choose to forego health insurance entirely. This makes the QHP segment both vital and potentially volatile.

QHPs and Blue Cross Blue Shield of Vermont (BCBSVT)'s Financial Condition

Ultimately, despite their small share of the market, QHPs are where the greatest risk to insurers is concentrated. People enrolling through the Exchange are largely unable to obtain health insurance through other means. Yet, as premiums increase, they may become increasingly sensitive to price changes. If they opt not to obtain health insurance, that decision has ripple effects through the market as relatively healthier populations are no longer in the risk pool, and costs potentially appear elsewhere such as in hospital emergency departments.

QHP premium rates increased dramatically in recent years, yet remained insufficient to address BCBSVT's financial condition. At the end of 2024, BCBSVT's risk-based capital (RBC) ratio was 214 percent, far below the target range of 590 to 745 percent.[3] This ratio triggered a "company action level" event, at which point an insurer is required to submit an RBC plan including corrective action proposals.[4] Deteriorating RBC levels would trigger increasingly severe responses, including the potential takeover of an insurer.[5] BCBSVT has filed a confidential plan with DFR to improve its RBC ratio, a plan that DFR has approved in accordance with applicable law. DFR has also taken direct steps to provide greater oversight into the cost of care by imposing an order against insurers BCBSVT and MVP on August 14 that requires both companies to demonstrate cost containment in their hospital contracts.[6] The order also enables DFR to appoint a BCBSVT liaison to ensure compliance and improve its solvency position.

BCBSVT's other business activities are also relevant to solvency. About 38 percent of BCBSVT's total underwriting losses between 2020 to 2024 were attributable to QHPs. The decline in the Company reserves over the same period is due to underwriting losses, litigation settlements, and cumulative losses exceeding $50 million in BCBSVT's Medicare Advantage plans, which have since been discontinued.[7]

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[3] Department of Financial Regulation, "Solvency Impact of '2026 Vermont QHP Market - Small Group Rate Filing' of Blue Cross Blue Shield of Vermont,", July 11, 2025, https://ratereview.vermont.gov/sites/dfr/files/documents/BCBSVT%20Solvency%20Opinion%20134524673%20%28Small%20Group%29.pdf.

[4] 8 VSA §8303.

[5] RBC below 150 percent is a "regulatory action level" event in which DFR may order corrective actions. RBC below 100 percent is an "authorized control level" event, and RBC below 70 percent is a "mandatory control level" event, which respectively authorize or require DFR to take any actions necessary to protect policyholders and creditors of the insurer. 8 VSA §8301 et seq.

[6] Department of Financial Regulation, "Order in re: Blue Cross and Blue Shield of Vermont and MVP Health Plan Inc.," Docket No. 25-024-I, August 14, 2025, https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-order-docket-25-025-i-bcbsvt-mvp_1.pdf.

[7] Green Mountain Care Board (GMCB), "Decision and Order in re: Blue Cross and Blue Shield of Vermont 2026 Individual Market Rate Filing," August 22, 2025, pages 15-16. https://ratereview.vermont.gov/sites/dfr/files/documents/2025.08.22_Redacted_2026_Decision_BCBSVT_QHP.pdf.

Strategies for Sustainability of BCBSVT

DFR has identified multiple strategies to help ensure sustainability of BCBSVT. Premium rates must be set at an adequate level to cover costs and provide for contributions to reserve. Insurers such as BCBSVT must also support efficient service delivery to address the costs of care. And as discussed below, reinsurance is also a potential tool, but is not a panacea to resolving affordability and sustainability challenges. Any changes to health insurance need to take place in a dynamic environment where shifts in pricing and service delivery are already underway. As recent laws are fully implemented, many of their provisions will also support sustainability.

The Need for Adequate Premium Rates

For the individual and small group QHP market, BCBSVT's submitted rate filings for 2026 included a proposed 7 percent contribution to reserve (CTR), consistent with its RBC plan and previous rate filings. CTR is essential to provide for a sufficient surplus, given uncertainty about future claims and broader market volatility. Yet, GMCB's final rates for BCBSVT were much smaller than requested: a 9.6 percent increase for the individual market, down from a request of 23.5 percent, and a 4.4 percent increase for the small group market, down from a request of 13.5 percent. Final rates included an overall 4.3 percent CTR: 3.5 percent for the individual market and 5.7 percent for the small group market.[8] These finalized rates do not provide the CTR that DFR and BCBSVT believed were important to restore and stabilize the Company's RBC.

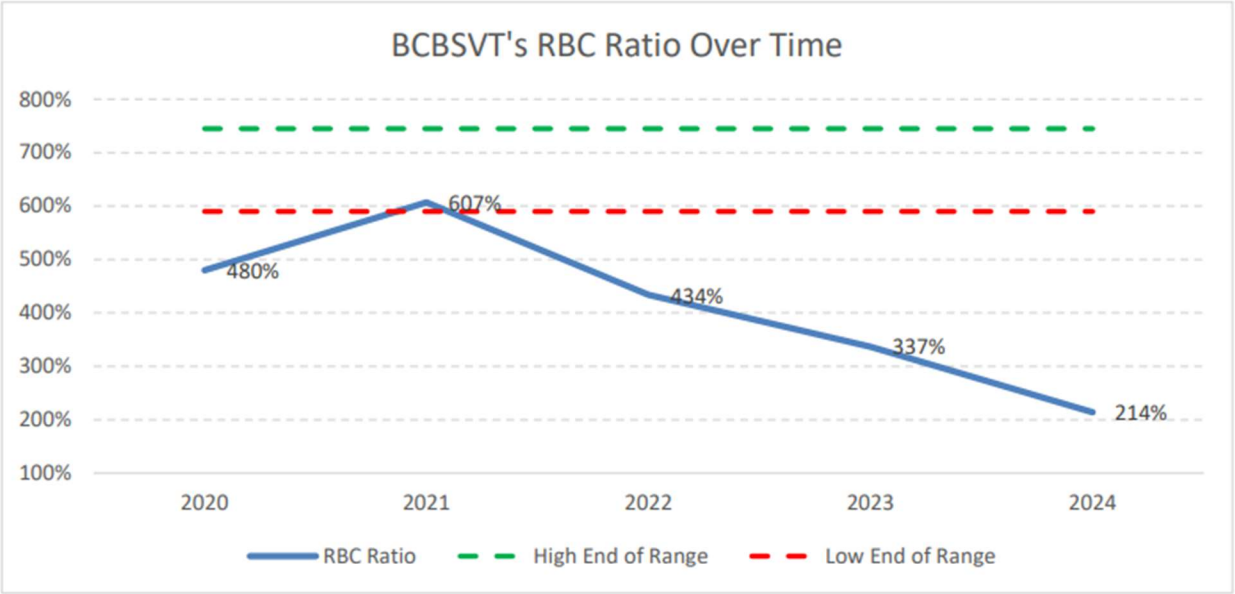
A commitment to affordability is an important part of GMCB's mandate. However, failure to increase rates commensurate with financial obligations only increases long-term risk and uncertainty. Figures 1 and 2 show BCBSVT's historical RBC ratio and annual surplus, clearly demonstrating a downward trend and the cumulative effect of rate decisions over multiple years. If rates do not provide for adequate CTR and surplus, cost reductions alone will not be able to improve BCBSVT's financial position. DFR will continue to stress the need for rates that contribute to solvency during future rate filings.

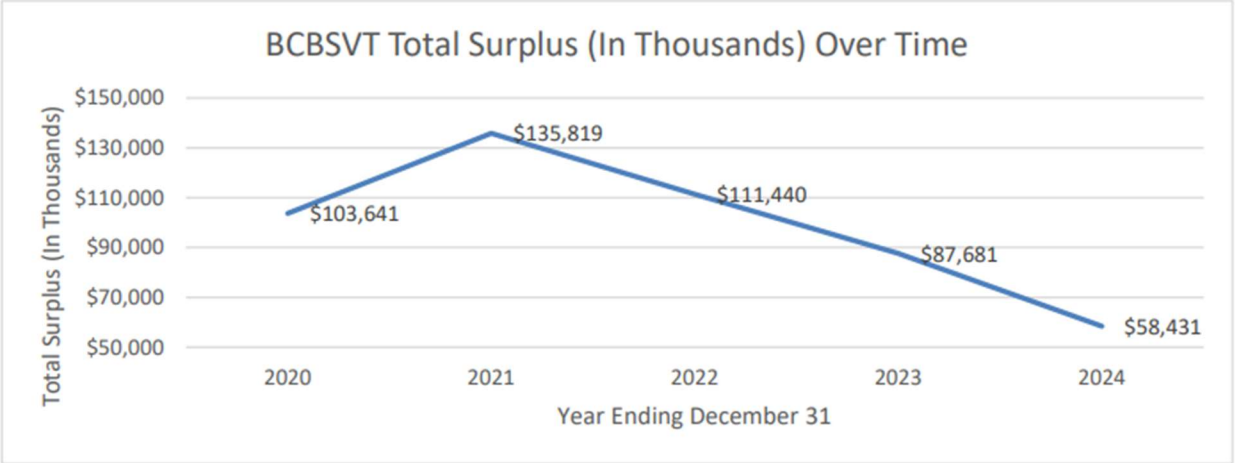
Addressing the Cost of Care

DFR is also exploring multiple legislative options that would further enable insurers to control the costs of care. One option would be to shift payments for certain procedures and services toward site-neutral billing. This is a practice in which the amount paid by the insurer would not vary depending on whether the service was delivered inside or outside of a hospital, which has the benefit of encouraging independent medical practices and providing care in the most convenient and affordable setting possible. Additional options include expanding insurers' ability to audit potentially excessive claims or require prior authorization in limited circumstances. Any proposals would ultimately build upon legislative steps already taken to address the cost of care, including the adoption of reference-based pricing, global hospital budgets, and the development of a Statewide Health Care Delivery Strategic Plan.

[8] GMCB, "Decision and Order in re: Blue Cross and Blue Shield of Vermont 2026 Individual Market Rate Filing," page 34.

Figures 1-2: BCBSVT Risk-Based Capital Ratio and Contributions to Reserve, 2020-2024





Source: Vermont DFR solvency opinion to GMCB, July 2025.

Exploring Reinsurance Options

Reinsurance is a form of sharing risks across insurance companies—essentially providing insurance for insurers. By removing some aspects of risk, reinsurance enables an insurer to better manage other risks and increase its capacity. There are multiple varieties of reinsurance that could be applicable to Vermont. The most significant distinction among these is whether the reinsurance program is pursued under Section 1332 of the Affordable Care Act (ACA), which provides for state innovation waivers. It is unclear whether Vermont's risk pool, which is already older and higher-risk than the national average, would be viable for the reinsurance market given its relatively small number of enrollees and insurers. Additionally, the cost of reinsurance will potentially increase if the risk pool deteriorates further.

Section 1332 Reinsurance

Section 1332 reinsurance programs require a federal waiver from the Centers for Medicare and Medicaid Services (CMS) but are state-administered, with the state reimbursing insurers for a

portion of their higher-cost claims. As of March 2023, 19 states had received approval from CMS for a waiver to provide a reinsurance program for their Exchange plans.[9] Once approved, states are eligible to receive federal funds that reflect the foregone premium tax credit revenue that they would have otherwise received. States fund their own share of a 1332 reinsurance program from sources including insurance premium taxes or assessments, hospital taxes, general fund revenues, and appropriations.[10] Pursuing a waiver in Vermont requires legislative approval.

Section 1332 reinsurance programs have generally shown promising results by sharing the risk of patients with the most costly health care needs. Maryland's program, first passed in 2018, has successfully slowed the rate of premium increases.[11] Similarly, Oregon has estimated that premiums on its Exchange plans are 9 percent lower as a result of its reinsurance program.[12] Virginia's program was established in 2021 with a 15 percent target reduction in premiums, which it exceeded in 2023 and 2024. The reinsurance program also increased the number of carriers offering plans in Virginia localities that were previously underserved.[13] At the same time, 1332 waivers also remain subject to changes in federal policies and funding, most notably the expiration of the Enhanced Premium Tax Credits (EPTCs). Colorado noted recently that the expiration of these credits would cut its reinsurance program budget by 40 percent.[14]

Non-Section 1332 Reinsurance

It is also possible to implement a reinsurance program outside of Section 1332, and some states had implemented such programs prior to receiving waivers. However, seeking a waiver would be preferable as a first step given the potential for federal subsidies to substantially improve the economics of a reinsurance program. Reinsurance is a tool to spread risk, but does not change the characteristics of the underlying risk pool, and a program's success depends on the volatility and magnitude of claims. DFR will continue to explore additional reinsurance options.

Conclusion

Recent actions taken by DFR and the legislature have begun to address the challenges facing domestic health insurers, but additional steps are needed to ensure continued solvency. DFR will continue to work with other agencies, the General Assembly, and outside stakeholders to advance the goal of sustainable and affordable health insurance for all.

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[9] National Conference of State Legislators, "State Roles Using 1332 Health Waivers," Updated August 30, 2023, https://www.ncsl.org/health/state-roles-using-1332-health-waivers.

[10] Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services, "Data Brief on State Innovation Waivers: Section 1332 Waivers," April 2024, https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

[11] Maryland Health Benefit Exchange, "State Reinsurance Program Annual Public Forum," July 16, 2024, https://www.marylandhbe.com/wp-content/uploads/2024/07/State-Reinsurance-Presentation-7-16-24.pdf.

[12] Oregon Division of Financial Regulation, "Oregon Reinsurance Program" (last accessed October 2025), https://dfr.oregon.gov/business/reg/health/Pages/oregon-reinsurance-program.aspx.

[13] Virginia Bureau of Insurance, State Corporation Commission, "Operation of the Commonwealth Health Reinsurance Program," November 1, 2024, https://www.scc.virginia.gov/media/sccvirginiagov-home/consumer-home/insurance/life-amp-health/affordable-care-act/reinsurance-program/november-1,-2024-report-on-the-operation-of-the-commonwealth-health-reinsurance-program.pdf.

[14] Colorado Department of Regulatory Agencies, "Impacts of Federal Actions on Colorado's Health Insurance Market," July 30, 2025, https://leg.colorado.gov/sites/default/files/images/07.30.25_exec_committee_h.r._1_presentation_-_doi.pdf.