STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2023 Individual Market Rate Filing	)	GMCB-003-22rr
	)	SERFF No. BCVT-133243519
In re: Blue Cross and Blue Shield of Vermont 2023 Small Group Market Rate Filing	)	GMCB-004-22rr
	)	SERFF No.: BCVT-133243509

DECISION AND ORDER

Introduction

Blue Cross and Blue Shield of Vermont (BCBSVT), one of two carriers offering individual and small group health insurance coverage in Vermont, has proposed to increase its premiums in 2023 by an average of approximately 14.9% for its individual plans and an average of approximately 15.4% for its small group plans. Based on our review of the record, including the testimony and evidence presented at a hearing that was held on July 18, 2022, we modify the proposed individual and small group rates and then approve the filings. We expect that, as modified, the average annual premium increase for BCBSVT's individual plans will be approximately 11.4% and the average annual premium increase for BCBSVT's small group plans will be approximately 11.7%.

Procedural History

1. On May 6, 2022, BCBSVT filed its 2023 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). The filings outline BCBSVT's development of premiums for health benefit plans that BCBSVT will offer to individuals and small employers for the 2023 benefit year. The plans covered by these filings include plans available through Vermont Health Connect (VHC), Vermont's health insurance exchange, as well as plans available directly from BCBSVT. *See* Exhibit (Ex.) 1, 3, 11.

2. On May 13, 2022, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as a party to the proceedings. HCA Notices of Appearance; *see also*, 8 V.S.A. § 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.

3. From May 11, 2022, through June 20, 2022, the Board and its contracted actuaries at Lewis & Ellis (L&E) asked BCBSVT to respond to a series of interrogatories, which included questions suggested by the HCA. Exs. 9 – 16.

4. L&E reviewed the filings on behalf of the Board and issued an actuarial report with respect to each filing on July 5, 2022.[1] In its reports, L&E summarized its review and analysis of the filings and recommended adjustments to the filings. Exs. 17 – 18. Also on July 5, 2022, the Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of each filing on BCBSVT's solvency. Exs. 19 – 20.

5. Vermont hospitals began submitting their proposed fiscal year 2023 (FY 2023) budgets to the Board on July 1, 2022. On July 13, 2022, L&E asked BCBSVT to respond to an interrogatory regarding the hospital budget submissions. BCBSVT responded to this interrogatory on July 14, 2022. Ex 29.

6. The Board held a hearing on BCBSVT's individual and small group rate filings on July 18, 2022. The hearing was held via Microsoft Teams. Members of the public were able to attend the hearing using Microsoft Teams, their phone, or by going to the Board's offices at 144 State Street in Montpelier, Vermont. The Board's General Counsel, Michael Barber, served as hearing officer by designation of Board Chair Kevin Mullin. BCBSVT was represented by Benjamin Battles from the law firm of Pollock Cohen LLP. The HCA was represented by Jay Angoff from the law firm Mehri & Skalet, PLLC, as well as HCA staff attorneys Eric Schultheis and Charles Becker. At the hearing, the Board heard testimony from Paul Schultz, Chief Actuary at BCBSVT; Ruth Greene, BCBSVT's Treasurer and Chief Financial Officer; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance Examiner at DFR; and Kevin Ruggeberg, Vice President & Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

7. On July 20, 2022, the Board asked BCBSVT a series of follow-up questions from the hearing. Post-Hearing Questions. BCBSVT responded to the Board's questions on July 27 and 29, 2022. BCBSVT Responses to Post-Hearing Questions; BCBSVT Supplemental Responses to Post-Hearing Questions.

8. On July 21, 2022, the Board held a public comment forum from 4:00 to 6:00 p.m. to hear from the public on the 2023 individual and small group rate filings of BCBSVT and MVP Health Plan, Inc (MVP). The forum was held via Microsoft Teams with a designated physical location at the Board's offices at 144 State Street in Montpelier, Vermont.

9. Just before midnight on July 21, 2022, the Board closed a special public comment period that it had opened on May 9, 2022, regarding the 2023 individual and small group rate filings. The Board received approximately 245 comments during the public comment period.

10. On July 25, 2022, L&E issued an addendum to its July 5, 2022 reports, which it revised on July 26, 2022. Revised Addendum to L&E Reports.

11. On July 27, 2022, the Board asked L&E to provide information on medical trends being proposed by carriers for individual and small group ACA filings nationally. Post-Addendum Information Request. On July 29, 2022, L&E provided the additional information requested by the

[1] A revised report on BCBSVT's small group filing was issued on July 6, 2022.

Board. On August 1, 2022, BCBSVT submitted a letter urging the Board not to use the data to adjust the proposed rates.

Findings of Fact

12. BCBSVT is a non-profit hospital and medical service corporation that offers health insurance products in several markets in Vermont. *See* Ex. 17, 1; Ex. 18, 1.

13. As of March 2022, there were approximately 19,581 members enrolled in BCBSVT's small group plans and 16,556 members enrolled in BCBSVT's individual plans. Ex. 17, 1; Ex. 18, 1. Membership in BCBSVT's individual and small group plans has declined steadily between 2017 and 2021, but increased in 2022, as reflected in the following table:

Individual and Small Group Membership by Coverage Year

Coverage Year	Small Group Members	Small Group % Change	Individual Members	Individual % Change
2017	41,325		28,710	
2018	30,303	-26.7%	23,361	-18.6%
2019	24,508	-19.1%	19,431	-16.8%
2020	21,568	-12.0%	17,627	-9.3%
2021	18,785	-12.9%	15,878	-9.9%
2022	19,581	+4.2%	16,556	+4.3%

See Ex. 17,1; Ex. 18, 1.

14. In its individual filing, BCBSVT initially proposed an average annual rate increase of 12.3%, or approximately $85.47 per member per month (PMPM), with plan-level increases ranging from 9.7% to 16.3%. Ex. 2, 59; Ex. 6, 7; Ex. 17, 3. In its small group filing, BCBSVT initially proposed an average annual rate increase of 12.5%, or approximately $76.32 PMPM, with plan-level increases ranging from 9.9% to 16.1%. Ex. 2, 72; Ex. 7, 7; Ex. 18, 2.

15. Prior to the hearing, BCBSVT adjusted its proposed premium increases to incorporate L&E's recommendations regarding correcting the URRT section in which the ARPA adjustment is applied; reflecting the updated risk adjustment transfer; and reflecting the final plan cost sharing; and to account for Vermont hospitals' fiscal year (FY) 2023 budget proposals. BCBSVT requested an average annual premium increase of 14.9% for its individual plans, with plan level increases ranging from 12.2% to 18.9%, and an average annual premium increase of 15.4% for its small group plans, with plan level increases ranging from 12.7% to 19.1%. Exs. 30 – 31.

16. The federal government provides a premium tax credit (PTC) to certain individuals who purchase a qualified health plan through a health insurance marketplace such as VHC. *See* 26 U.S.C. § 36B. The PTC is typically paid directly to the insurance carrier by the federal government to lower an eligible individual's monthly premium.[2]

[2] Most taxpayers choose to have the credit estimated and paid to the carrier in advance to lower monthly premiums (referred to as an advanced premium tax credit or APTC). However, taxpayers can also pay the fully monthly premium and claim the credit when they file their tax returns.

17. Prior to the passage of the American Rescue Plan Act (ARPA) in 2021, the PTC was only available to those with a household income between 100% and 400% of the federal poverty level (FPL). *See* 26 U.S.C. §36B(c)(1)(A).

18. The PTC covers the difference between the premium for the second-lowest cost Silver plan, referred to as the "benchmark plan" – and a specified percentage of an individual's household income. *See* 26 U.S.C. § 36B(b). For example, prior to ARPA an individual earning 150% FPL could have received a PTC equal to the difference between the benchmark plan's premium and 4.14% of his or her income. *See* 26 U.S.C. § 36B(b)(3)(A)(i). The individual could then apply this PTC to the cost of a plan at any metal level, (e.g., a Bronze or Gold plan).

19. ARPA significantly expanded the PTC. First, for those who were already eligible, ARPA increased the amount of the PTC they could receive by reducing the share of income they were expected to contribute towards the cost of the benchmark plan. For instance, under ARPA, the individual in the example above with an income of 150% FPL could purchase the benchmark plan for $0. *See* 26 U.S.C. § 36B(b)(3)(A)(iii). Second, ARPA expanded eligibility for the PTC to individuals and households above 400% FPL, capping their contributions at 8.5% of household income. *See id.*; *see also* 26 U.S.C. § 36B(c)(1)(E).

20. ARPA's enhancements to the PTC, while significant, were temporary; unless Congress acts to extend them, they will expire at the end of 2022. *See* 26 U.S.C. § 36B(b)(3)(iii). To take advantage of ARPA, Vermont unmerged its individual and small group markets for 2022, which had the effect of reducing premiums for small group plans and increasing premiums for individual plans compared to what they would have otherwise been. *See* Act 25 of 2021, § 34; *In re Blue Cross and Blue Shield of Vermont 2022 Individual Market Rate Filing*, GMCB-005-021rr, *In re Blue Cross and Blue Shield of Vermont 2022 Small Group Market Rate Filing*, GMCB-006-022rr, Decision and Order (Aug. 5, 2021) (noting that unmerging the markets had an impact of approximately +8.3% on the proposed individual rates and -7.4% on the small group rates).

21. The individual and small group markets will continue to be separate for 2023. *See* Act 137 (2022), § 9.

22. If Congress does not extend ARPA's enhancements to the PTC, many purchasers of individual plans who receive a PTC will see a reduction in premium assistance in 2023. In other words, if ARPA's enhancements to the PTC are allowed to expire, *net* premiums for many individuals receiving the PTC would increase even if gross premiums remained unchanged.

23. Individuals between 400% and 700% FPL (who will no longer be eligible for the premium tax credit at all if ARPA's PTC enhancements are not extended) will be most affected. *See* Ex. 15, 8 (assuming both carriers' rates were approved as filed and calculating net premium changes for BCBSVT's standard Gold, Silver, and Bronze plans with and without ARPA's subsidy expansion). For example, BCBSVT calculated that if the Board approves the 2023 rates *initially* proposed by each carrier, the net monthly premium for an individual at an income of $60,000 per year currently receiving premium assistance would rise by $432.95 for its Standard Gold Plan, $406.49 for its Standard Silver plan, and $397.25 for its Standard Bronze plan. *See* Ex. 15, 8.

24. On July 27, 2022, it was reported that a "deal" had been reached between Senator Joe Manchin III and Democratic leaders on a spending bill (the Inflation Reduction Act of 2022) that would extend the ARPA subsidy enhancements for another three years. However, that bill has not yet been passed by Congress. *See, e.g.,* Tony Room, Jeff Stein, Rachel Roubein and Maxine Joselow, *Manchin says he has reached deal with Schumer on economy, climate bill*, Washington Post (July 27, 2022).

25. Individuals are not required to purchase their coverage through VHC; they may purchase a plan directly from a carrier instead. However, individuals enrolled in such plans ("direct enrollees") are not eligible for the PTC. BCBSVT has attempted to contact direct enrollees by mail five times between April 2021 and February 2022 regarding the ARPA subsidies. As of May 31, 2022, BCBSVT had 3,916 direct enrollees, a decrease of approximately 758 from May 2021, when it had 4,674 direct enrollees. *Id.*

26. L&E reviewed the rate filings to assist the Board in determining whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the law; and are not excessive, inadequate, or unfairly discriminatory. Ex. 17, 3.

27. L&E's review focused on whether BCBSVT's proposed rates are "excessive, inadequate, and unfairly discriminatory" from an actuarial perspective. Ex. 24, 4.

28. Based on its review, L&E recommends that the Board make six modifications to the individual filing and five modifications to the small group filing.[3] Ex 17, 26; Ex. 18, 22.

29. *Medical Trend*- L&E recommends making three modifications to each filing related to medical trend. Ex. 17, 26 – 27; Ex. 18, 22 – 23. BCBSVT initially projected in each filing a total allowed medical trend of 9.0%, comprised of 6.9% trend for unit cost changes and 2.0% trend for utilization and intensity changes. Ex. 17, 6; Ex. 18, 5.

30. *Medical Unit Cost Trend*- The medical unit cost trend reflects expected changes in the cost of medical services between the base experience period and the benefit year. *See* Ex. 1, 26. To project medical unit costs forward from 2021 (the base experience period) to 2022, BCBSVT used actual negotiated provider payment changes. Ex. 17, 6; Ex. 18, 5. To project medical unit costs forward from 2022 to 2023 (the benefit year), BCBSVT took several approaches to estimate the provider payment changes.

31. For drugs dispensed in a facility or office, BCBSVT used the average increase for each facility or provider group to calculate an estimated unit cost trend. Ex. 1, 27.

32. Approximately 53% of medical costs are related to Vermont facilities impacted by the Green Mountain Care Board's hospital budget review process. Ex. 1, 26. For these facilities,

[3] One recommendation in each filing was to correct a mistake related to the calculation of cost trend for one facility. Ex. 17, 6; Ex. 18, 6. This would have had a -0.1% impact on rates. BCBSVT agreed to this correction. Ex. 23, 2. However, this adjustment was rendered obsolete by the recommendation and adjustment for hospital budgets, *see infra*, Findings, ¶¶ 35 – 42; Conclusions of Law, § III, and is no longer listed individually.

BCBSVT started by assuming that the Board will approve FY 2023 budgets that support commercial increases identical to the FY 2022 budgets approved by the Board. However, for hospitals that requested a midyear increase in the spring of 2022, BCBSVT assumed that their approved FY 2023 budgets will be higher than their approved FY 2022 budgets by the annualized proportion of the rate that was not granted by the Board. [4]

33. For other providers within the broader BCBSVT service area, BCBSVT assumed 2022 and 2023 budget increases would be identical to those implemented during the 2021 cycle, except for cases where early negotiations have indicated otherwise. Ex. 17, 6; Ex. 18, 5.

34. For providers outside the BCBSVT service area, BCBSVT used the fall 2021 Blue Trend Survey conducted by the Blue Cross Blue Shield Association. Ex. 17, 6; Ex. 18, 5.

35. The table below reflects BCBSVT's medical unit cost trend projections for Vermont facilities and providers impacted by the Board's hospital budget review process and for other facilities and providers:

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in 2021	Cost Trend from 2021 to 2022	Cost Trend from 2022 to 2023	Total Annual Cost Trend
Vermont Facilities and providers impacted by GMCB's Hospital Budget Review	53.2%	6.3%	9.7%	8.0%
Other facilities and providers	46.8%	5.4%	5.8%	5.6%
Total	100.0%	5.9%	7.9%	6.9%

Ex. 1, 27.

36. In its July 5 report, L&E recommended that once FY 2023 hospital budgets are submitted, this new information be considered in evaluating BCBSVT's unit cost assumptions. Ex. 17, 7. Ex. 18, 6.

37. As part of the hospital budget process, the Board establishes a ceiling or cap on the amount each hospital's rates can increase. *See, e.g., In re Central Vermont Medical Center Fiscal Year 2022*, 21-002-H, FY2022 Hospital Budget Decision and Order (Oct. 1, 2022), 12 (approving Central Vermont Medical Center's charge increase "at *not more than* 6.0% over current approved levels.") (emphasis added).

[4] BCBSVT described its approach in its May 27, 2022, interrogatory response. Ex. 10, 5.

38. Hospitals began submitting their FY 2023 budget proposals to the Board on July 1, 2022. The submissions included rate increase requests from University of Vermont Medical Center of 19.9% and Rutland Regional Medical Center of 17.8%. Ex. 29, 1. The weighted average increase requested by all hospitals is 16.3%. *See* Revised Addendum to L&E Reports, 2. BCBSVT reviewed the hospital budget submissions and reported that if the submissions were incorporated into BCBSVT's rates without any adjustment, the resulting impact on individual and small group rates would be increases of 3.6% and 3.5%, respectively. *See* Ex. 29, 2. BCBSVT revised its proposed rates to reflect an expectation that the Board will reduce the hospital budget requests by 1% and to incorporate the final contracts for certain non-Vermont hospitals. Testimony of Paul Schultz, Tr., 44:25 – 45:10; *See* Ex. 30, 1. The company's updates increased the original allowed medical trend to 8.7% in both the individual and small group filings. Ex. 30, 1.

39. Over the past decade, approximately 30% of hospital change in charge (rate) requests have been reduced. The gap between filed and approved increases has not been constant over time. Through 2016, the difference between filed and approved increases was minimal. However, beginning in 2017, more substantial reductions by the Board have been commonplace and the reductions have tended to be larger for larger requests. *See* Revised Addendum to L&E Reports, 2-4.

40. The rate increases requested by hospitals for FY 2023 are substantially higher than rates requested in recent years. *See* Revised Addendum to L&E Reports. Many of the hospital proposals also reflect growth in net patient revenue and fixed prospective payments that exceeds the two-year 8.6% guidance established by the Board. Green Mountain Care Board, Preliminary Review of FY2023 Hospital Budget Submissions (July 27, 2022), 12 – 14, https://gmcboard.vermont.gov/sites/gmcb/files/documents/Preliminary%20Review%20FY2023%20Hospital%20Budgets%20%281%29.pdf; Green Mountain Care Board, FY 2023 Hospital Budget Guidance and Reporting Requirements (eff. March 31, 2022), 5. https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY23%20Hospital%20Budget%20Guidance-%20FINAL.pdf

41. The Board is scheduled to hold hearings on Vermont hospitals' FY 2023 budgets between August 15 and 23, 2022. The Board must establish hospitals' FY 2023 budgets by September 15, 2022, and issue written decisions by October 1, 2022. 18 V.S.A. § 9456(d)(1).

[redacted]

43. *Medical Utilization Trend*- The second component of total medical trend is medical utilization trend. Ex. 17, 6; Ex. 18, 5. BCBSVT made assumptions regarding future changes to the utilization of medical services based on analyzing historical data by category and categorized the medical claims into Facility (Inpatient/Outpatient), Professional, and Outpatient Drug categories. Ex. 17, 7; Ex. 18, 6.

44. BCBSVT adjusted historical trend to remove the impact of statistical fluctuations, assumed 2023 FWA recoveries would remain at 2021 levels, and used the matched population method it had introduced in the 2022 filings to control for historical changes in population characteristics. L&E found that these approaches are reasonable. Ex. 17, 7; Ex. 18, 6. L&E also found the mental health utilization trend assumption of 8.5% and the medical Rx utilization trend of 3.6% to be reasonable. Ex. 17, 12, 14; Ex. 18, 10, 13. However, L&E had concerns with BCBSVT's 2.0% medical utilization trend in aggregate, as well as individual components of the trend, namely facility trend, facility professional trend, and other professional trend. Ex. 17, 8 – 13; Ex. 18, 7 – 12.

45. L&E noted that BCBSVT's trend calculations rely on a COVID adjustment which was based on an assumption that trend is zero percent, and that total 2021 utilization was lower than total 2019 utilization when aggregated across all service categories. Testimony of Kevin Ruggeberg, Tr., 156: 12 – 17. L&E had concerns that there was circularity and internal inconsistency in BCBSVT's support for utilization trend. Testimony of Kevin Ruggeberg, Tr., 156: 18 – 23. L&E relied on BCBSVT's comparison of average 2021 utilization to a benchmark of 2019 through February 2020. *See* Ex. 13, 10. This analysis indicates that total utilization across all medical service categories in 2021 was 2.8 percent lower than the pre-COVID benchmark. Testimony of Kevin Ruggeberg, Tr., 157: 2 – 17; Ex. 13,10.

46. BCBSVT asserts that it expects facility claims to increase slightly from their current level as a reduction in COVID cases will allow for increased availability of non-COVID-related services. Ex. 23, 8. BCBSVT developed a chart setting forth utilization trend from 2017 to 2021 which showed a 2-year trend result of 1.77%, a 3-year trend result of 0.03%, and a 4-year trend result of 2.16%. BCBSVT Responses to GMCB Post-Hearing Questions, 3. (July 26, 2022). BCBSVT asserted that the 3-year trend result of 0.03% was driven by the "high outlier result in 2018" and is "not indicative of likely future trends." BCBSVT Responses to GMCB Post-Hearing Questions, 3. (July 26, 2022). BCBSVT also asserted that the 3-year trend is not indicative of anything useful because of the impact of COVID in 2020. Testimony of Paul Schultz, Tr., 137:23 – 138:8

47. Although BCBSVT refers to 2018 utilization as an outlier, it submitted a positive utilization trend in 2019 for the 2020 plan year. Testimony of Paul Schultz, Tr., 138:12 – 22. *See also, In re: Blue Cross Blue Shield of Vermont 2020 Individual and Small Group Rate Filing*, GMCB-006-19rr, Decision and Order, 6 (Aug. 8, 2019).

48. L&E believes an overall utilization trend of 1.0% or possibly slightly lower is reasonable. Testimony of Kevin Ruggeberg, Tr., 176: 6 – 177: 1.

49. BCBSVT acknowledges that in the face of higher premium rates, it is a realistic possibility that consumers may migrate to different plans and may utilize less health care, particularly members who are in plans with higher cost sharing. Testimony of Paul Schultz, Tr., 125: 16 – 126: 10. BCBSVT has not historically noticed significant plan migration in response to large premium increases. Testimony of Paul Schultz, Tr., 126: 11 – 18. Vermont may see a rise in the uninsured rate, which typically means healthier members leave the market. Testimony of Paul

Schultz, Tr., 126: 23 – 24. A departure of healthier members might drive claims per member per month higher than is shown in the current filing. Testimony of Paul Schultz, Tr., 127: 1 – 3. These potential impacts are not perceived by BCBSVT as definitively moving claims in one direction or the other, so BCBSVT is projecting the claims based on the population it already has. Testimony of Paul Schultz, Tr., 127, 14 – 18.

50. *Facility*- In determining facility trend, BCBSVT adjusted the data for 2021 to reflect its belief that claims for emergency rooms, ambulances, and urgent care centers were artificially low during 2021 due to COVID. Ex. 17, 9; Ex. 18, 7 – 8. The ongoing impact of COVID into 2021 created a dynamic where some care that had been delayed in 2020 was scheduled in 2021 and also some care that would have taken place in 2021 itself was delayed because of the pandemic. Ex. 17, 9; Ex. 18, 8. Because of the competing influences of returning care and suppressed care, it is impossible to determine with certainty which factor had a greater impact on medical utilization in 2021. Ex. 17, 9; Ex. 18, 8. Because emergent care by definition cannot be deferred, BCBSVT has assumed the observed reduction in emergency utilization resulted from this suppression. Ex. 17, 9; Ex. 18, 8.

51. BCBSVT has assumed a 1.5% facility utilization trend. Ex. 1, 29. L&E recommends this assumption be reduced to 1.0%. Ex. 17, 10; Ex. 18, 9. BCBSVT's filed and approved facility trend in 2021 was 1.1% and its regression on 2019 and 2021 claims (excluding 2020 but including its adjustment to 2021 to approximate removing the impact of COVID) resulted in a facility trend estimate of 0.9%. Ex. 17, 10; Ex. 18, 9; Ex. 13, 5.

52. *Professional Facility* - BCBSVT assumed the utilization trend for professional services offered in a facility setting would mirror facility utilization trend and selected the same value of 1.5%. for this component of trend Ex. 17, 12; Ex 18, 11. Since L&E agrees that the two are closely linked, it recommends the utilization trend for professional facility services be reduced to 1.0%. Ex. 17, 12; Ex. 18, 11.

53. *Other Professional* - BCBSVT proposed a +1.0% utilization trend for other professional, an increase from +0.5% in the prior year filing. BCBSVT's rationale for assuming an increase over last year's trend was that the data available were not sufficient to modify last year's assumption. Ex. 1, 30; *see* Testimony of Kevin Ruggeberg, Tr., 156: 4 – 9. BCBSVT references three statistical results in support of its proposal. Ex. 17, 12; Ex. 18, 11. The first is that the year-over-year trend in utilization from 2019 to 2021 is effectively zero and the second and third are regressions that give undue weight to the suppression of care at the onset of the COVID pandemic. Ex. 17, 12; Ex. 18, 11. L&E recommends a utilization trend for other professional of 0.5%. Ex. 17, 13; Ex. 18, 12.

54. The following table compares BCBSVT's proposed medical utilization trends and L&E's recommended trends for each category and overall.

Category	Assumed Util	L&E Recommended
Inpatient	1.50%	1.00%
Outpatient	1.50%	1.00%
Mental Health	8.50%	8.50%
Professional Facility	1.50%	1.00%
Other Professional	1.00%	0.50%
Medical Rx	3.60%	3.60%
Total Medical	**2.00%**	**1.50%**

Ex. 17, 14; Ex. 18, 13.

55. *Pharmacy Trend* - BCBSVT is proposing an allowed pharmacy trend of 13.2% per year, net of changes to pharmacy rebates. Ex. 17, 15; Ex. 18, 14. Unlike the medical trend analysis, pharmacy claims did not demonstrate disruptions because of COVID. Ex. 17, 16; Ex. 18, 15. BCBSVT projected a 3% increase in generic drug costs and a 10% increase in brand drug unit costs. Ex. 1, 36; Ex. 17, 16; Ex. 18, 15. Specialty drugs have increased at a very high rate in recent years and make up the overwhelming majority of remaining pharmacy costs. Ex. 17, 16; Ex. 18, 15. BCBSVT selected a net annual allowed trend of 19.7% for the specialty tier. L&E believes this is a reasonable assumption based on recent trends and volatility. Ex. 17, 16; Ex. 18, 15. L&E also reviewed prescription drug trends in aggregate and found that BCBSVT appears to be reasonably incorporating incoming information in the development of this assumption. Ex. 17, 16; Ex. 18, 15.

56. *Total Allowed Trend* - BCBSVT projects an average total allowed trend of 9.9% after combining medical trend (9%) and net pharmacy trend (13.2%). Ex. 17, 6, 17; Ex. 18, 5, 16.

57. *Risk Adjustment Transfers* - L&E's third recommendation is to reflect updated risk adjustment transfers. While BCBSVT originally projected changes to risk adjustment to have a +1.9% impact on individual rates and a +0.4% impact on small group rates, it agrees with L&E that the effects should be + 1.7% and +0.3%, respectively. Ex. 17, 20-21, 27; Ex. 18, 18-19, 23; Ex. 23, 2. This update is reflected in the revised rate increase. Ex. 30, 1; *see* Findings, ¶ 16, *supra*.

58. *URRT* - L&E's fourth recommendation is specific to the individual filing. BCBSVT assumed that changes in pool morbidity due to ARPA would reduce claims by approximately 0.1%. *See* Ex. 1, 18; Ex. 17, 19. Specifically, BCBSVT assumed that observed membership growth in individual market plans in 2022 was split between the two carriers offering plans in proportion to their overall market share. BCBSVT also assumed that these new members are similar to the average member of the combined individual and small group market. *See* Ex. 1, 18. L&E concluded that the adjustment is reasonable if the ARPA subsidy enhancements are extended but noted that expiration of these subsidy enhancements could justify an increase to the rates since many existing members will see their premiums rise significantly and this could increase the morbidity of the insured population. *See* Ex. 17, 19. L&E recommends that BCBSVT reflect its

0.1% claims adjustment in the "morbidity" category of the URRT, rather than the "other" category. BCBSVT agrees with this recommendation. This has no impact on premiums. Ex. 17, 19 – 20; Ex. 23, 2.

59. *HDHP Benefit Designs* - L&E's fifth recommendation is that rates be updated to reflect IRS-required changes to the HDHP benefit designs. This recommendation has no material impact on overall rates. Ex. 17, 21-22; Ex. 18, 19. BCBSVT agrees with this recommendation. Ex. 23, 2.

60. *Administrative Costs* - As proposed, the 2023 administrative costs are projected to grow by 1.0% less than premiums in the individual market, resulting in a -1.0% projected impact on individual rates. Ex. 17, 22, 27. The 2023 administrative costs for the small group market are projected to be unchanged relative to 2022 on a percentage of revenue basis and will have no impact on premiums. Ex. 18; 19, 23. The base administrative costs of $55.02 PMPM (individual) and $44.97 PMPM (small group) were included in all plans' rates to cover BCBSVT's operating costs. Ex. 17, 22; Ex. 18, 19.

61. To develop the plan year base administrative cost, the actual 2021 administrative cost for each filing was adjusted for two factors. Ex. 17, 22; Ex. 18, 19. First, BCBSVT applied a 4% per year cost trend. Ex. 17, 22; Ex. 18, 19. This increase is attributed in part to approximately a 4% increase in salaries. Testimony of Ruth Greene, Tr., 223: 10 – 12. BCBSVT is having some retention and hiring difficulties; at any given point in time the company has about 20 vacancies on a base of about 400. Testimony of Ruth Greene, Tr., 223:12 – 224:4. Administrative cost increases also include contracts; a lot of BCBSVT's contracts have been single-year contracts, which previously worked to the carrier's favor but is now creating challenges in keeping its vendors' rate increases in check in this inflationary period. Testimony of Ruth Greene, Tr., 225: 3 – 8. The total dollar value of the 4% annual increase from the experience period to the projection period (a two-year period) is $1.8 million, or $920,000 per year, for the individual and small group markets combined. BCBSVT Post Hearing Responses, 5.

62. BCBSVT's second adjustment to the 2021 administrative cost is to include the estimated impact of membership changes. Ex. 17, 22; Ex. 18, 20. BCBSVT estimates that 70% of the allocated base administrative expenses are fixed costs, and therefore changes in enrollment cause changes in administrative costs PMPM. Ex. 17, 22. BCBSVT's actual administrative costs PMPM have increased substantially in recent years, due in part to its losses in enrollment. Testimony of Kevin Ruggeberg, Tr., 186:24 – 187:3. BCBSVT enrollment has experienced a shift towards Medicare Advantage and other lines of business whose administrative costs are distinct from BCBSVT's core business, resulting in spreading core business fixed costs over fewer members in 2023 than 2021. Ex. 17, 22; Ex. 18, 20; *see* Testimony of Ruth Greene, Tr., 225: 20 – 226: 1. This shift results in a 3.3% increase to the projected administrative costs in both individual and small group markets on a per member basis. Ex. 17, 22; Ex. 18, 20. No adjustment was made to administrative costs for the third-party administration of dental and vision benefits. Ex. 17, 22; Ex. 18, 20. As of 2022, BCBSVT assumed responsibility for billing individual market members enrolled through VHC; the difference between projected administrative costs and the preparatory expenses included in the base period equals $3.48 PMPM in the individual market only. Ex. 17,

22. BCBSVT also includes transaction fees for members who pay their premiums with debit and credit cards, which constitutes approximately 0.25% of individual premium and 0.1% of small group premium. Ex. 17, 22; Ex. 18, 20. L&E considers the administrative expense assumptions to be reasonable. Ex. 17, 23; Ex. 18, 20.

63. BCBSVT's administrative costs as a percentage of premium ranked 31st out of 62 national BCBS plans according to L&E's review of the 2021 National Association of Insurance Commissioners (NAIC) Annual Statements. Ex. 17, 23; Ex. 18, 20. L&E's review also indicated BCBSVT had higher PMPM administrative expenses than approximately 85% of Blues plans. Ex. 17, 23; Ex. 18, 20. L&E did not believe BCBSVT's ranking was unreasonable, given that Vermont is a relatively small state and that BCBSVT has fewer members over which to spread its costs. Ex. 17, 23; Ex. 18, 20.

64. BCBSVT has some quality improvement and cost savings initiatives included in its administrative costs that may impact medical trend. Its laboratory benefit program has an ROI of [redacted]. BCBSVT Post Hearing Responses, 2. The utilization management (prior approval) program not including pharmacy has an ROI of [redacted]. BCBSVT Post Hearing Responses, 2. The combined ROI for all retail pharmacy utilization management programs is [redacted] BCBSVT Supplemental Responses, 1. Fraud, Waste, and Abuse for Pharmacy has an ROI of [redacted]. BCBSVT Supplemental Responses, 2.

65. The Blue Distinction Specialty Care Program is a national program administered by the Blue Cross Blue Shield Association for eleven areas of specialty care. BCBSVT Post Hearing Responses, 3-4. The program has two levels of designation: Blue Distinction Centers, recognized for expertise and quality; and Blue Distinction Centers+, which are Blue Distinction Centers that are also recognized for their cost-efficiency. BCBSVT Post Hearing Responses, 5. This classification is a rigorous process. Testimony of Ruth Greene, Tr., 214:22 – 215:10. At hearing Ms. Greene stated that she did not believe BCBSVT "drives" business to the Blue Distinction Centers but does inform members about them. Testimony of Ruth Greene, Tr., 216: 16 – 21. In a post-hearing submission, BCBSVT clarified that does require use of one of the Blue Distinction Centers or Blue Distinction Centers+ for bariatric surgery. BCBSVT Post Hearing Responses, 5.

66. During the pandemic, BCBSVT removed risk from its value-based arrangements with OneCare Vermont because of uncertainty regarding the pandemic's impact. Testimony of Paul Schultz, Tr., 108: 22 – 109: 1. In June 2022, BCBSVT and OneCare agreed to resume a risk sharing arrangement for 2023 so that BCBSVT has some risk sharing over and above just straight fee-for-service. Ex. 14, 4. Testimony of Paul Schultz, Tr., 108: 11 – 109: 14. OneCare and BCBSVT are working to develop a fair and equitable target-setting process that can be shown to deliver value to consumers. Testimony of Paul Schultz, Tr., 108: 15 – 21.

67. In 2021, approximately 47% of BCBSVT's claim costs were paid under an alternative payment arrangement with OneCare Vermont, while 52.5% was paid as fee-for-service, with no link to quality and value. Ex. 14, 3. BCBSVT's alternative payment arrangement with

OneCare Vermont in 2021 (and 2022) lacked any significant risk due to the uncertain impact of the COVID-19 pandemic on claims. *See* Testimony of Paul Schultz, Tr., 108:22 – 109:1.

68. Only a fraction of a percent of BCBSVT's total allowed claims costs in 2021 were paid through capitated payments. *See* Ex. 14, 3. BCBSVT has expressed a desire to implement fixed prospective payments in a way that will benefit its members but has not yet done so. *See* Testimony of Paul Schultz, Tr., 104 – 111.

69. In June 2022, BCBSVT and OneCare agreed that their 2023 agreement will focus on resuming risk. Ex. 14, 4; *see also* Testimony of Paul Schultz, Tr., 109:2 - 9. BCBSVT and OneCare are currently reviewing a proposed methodology for risk sharing in 2023. Ex. 14, 4. BCBSVT believes that agreeing on this methodology is a critical precursor to the transition to unreconciled FPP and states that planning for FPP will resume as soon as an agreement is reached for the return to risk in 2023. Ex. 14, 4.

70. *Contribution to Reserves and Risk Based Capital* - Contribution to Reserves (CTR) is an important source of funding policyholder reserves, or member reserves, which in turn are the funds that ensure that insurance companies can remain solvent and can meet their obligations and pay member claims. *See* Ex. 27, 1. In the individual market, the company has proposed an aggregate CTR of 1.0%, which consists of a base CTR of 1.5%, a reduction of 0.7% to remove projected direct COVID treatment costs from proposed rates, and an additional 0.2% reduction to account for uncollected premiums and bad debt. Ex. 17, 23. In the Small Group market, the company has proposed an aggregate CTR of 0.8%, which similarly consists of a 1.5% base CTR and the 0.7% reduction for COVID treatment costs, but it does not adjust for bad debt. Ex. 18, 21.

71. As a reasonableness check, L&E used publicly available data to compare BCBSVT's proposed CTR to the CTR of other carriers for individual and small group (QHP) plans in their 2022 filings. BCBSVT's proposed base CTR of 1.5% in both markets was on the low end of submitted CTRs. Ex. 17, 24; Ex. 18, 21. L&E believes a reasonable range for the base CTR is 0.7% to 3.7% in both markets. Ex. 17, 24; Ex. 18, 22. The requested base CTR would have a -0.3% impact on rates in the individual market and a -0.2% impact on rates in the small group market. Ex. 17, 27; Ex. 18, 23.

72. Risk Based Capital (RBC), a method of measuring the minimum reserves appropriate to support overall business operations, is an important element of solvency. DFR has approved an RBC target for BCBSVT of 590% to 745%. Ex. 5, 3; Ex. 19, 2; Ex. 20, 2. BCBSVT's RBC as of the end of 2021 was, and currently is, within its targeted range. Ex. 19, 2; Ex. 20, 2. BCBSVT cites multiple factors, including economic volatility, competitive pressures, and uncertainty around hospital budgets, that make it difficult to predict its anticipated CTR at the end of 2023, although the carrier expresses doubt that it will exceed the range at that time. Ex. 5, 3.

73. At the end of 2021, BCBSVT's RBC ratio was 607%. Ex. 10, 4. This year, BCBSVT developed a stochastic model designed to identify the most likely range of RBC results. [redacted]. Ex. 12, 1; Ex. 13, 5.

74. DFR issued its solvency opinions on July 5, 2022. As they did last year, the opinions acknowledge the ongoing pandemic-related uncertainties that have affected, and could continue to affect, Vermont's health care system, while recognizing the positive impact of effective vaccines and treatment guidelines. Ex. 19, 1; Ex. 20, 1.

75. DFR does not expect the proposed rates would have a significant impact on its overall solvency assessment of BCBSVT. Ex. 19, 3; Ex. 20, 3. However, it notes that any downward adjustments to the filing's rate components that are not actuarially supported will reduce BCBSVT's surplus and negatively impact its solvency. Ex. 19, 3; Ex. 20, 3.

76. The comments received by the Board this year reflected dismay and alarm regarding the affordability of health insurance and the accessibility of health care due to member cost sharing requirements. For example, one commenter wrote: "It has come to the point this year that, while I am insured, I pay so much for a premium out of pocket monthly that, even with the subsidy, the high deductible hanging over my insurance has made it so that I am no longer receiving regular care." This year, many Vermonters also expressed their concerns in the context of high inflation. For example, one commenter wrote: "At a time when everything is going up in cost (food, fuel, gas, etc.) an increase in cost for health insurance would be cost prohibitive for many families, including mine." Another commenter wrote: "Now, with purchasing power eroding fast amid inflation, a leap in insurance costs this high would be an absolute gut punch. Costs need to be falling, not rising, as all of us scramble to do more with hard-earned money that is losing its value."

77. Cost inflation in 2023 is expected to be elevated from the levels observed in recent years. *See* Ex. 17, 16; Ex. 18, 15.

78. The impacts of the pandemic are expected to continue through calendar year 2023. *See, e.g.,* Ex. 1, 43; Ex. 6, 12 – 13; Ex. 7, 12 – 13; Ex. 19, 1; Ex. 20, 1; Ex. 23, 26.

79. The Health Care Advocate testified about the decisions Vermonters will have to make regarding health insurance and health care in the context of the overall inflationary challenges on their families and the stagnation of real wages. Testimony of Mike Fisher, Tr., 238:18 – 239:24. He also testified that under the initially proposed rates, a family of four at slightly over 400% FPL would pay over 25% of their income for premiums. Testimony of Mike Fisher, Tr., 240: 4 – 8.

80. BCBSVT filed a post-hearing memorandum pursuant to GMCB Rule 2.000, § 2.307(g) in which it argued that the Board should approve the proposed rates as modified by the L&E recommendations with which it agreed. BCBSVT asserted that while the cost of health care is burdensome to many Vermonters, access to care and the quality of that care are also of primary importance. BCBSVT asserted that its requested rates strike the best balance among those competing concerns and mandatory insurer solvency requirements. It argues that its medical utilization trend assumptions should be adopted and that its requested contribution to reserves (CTR) is reasonable. BCBSVT Post-Hearing Memorandum.

81. The HCA also submitted a post-hearing brief. It argues that the proposed rates do not meet the statutory criteria in that they are excessive, unjust, unfair, inequitable, and misleading; they fail to promote access; and they are not affordable. HCA Post-Hearing Memorandum.

Standard of Review

The Board reviews rate filings to determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State, and is not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). The Board is required to consider changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401. The Board must also consider DFR's analysis and opinion of the impact of the proposed rate on the insurer's solvency and reserves, 8 V.S.A. § 4062(a)(2)(B), (a)(3), and any public comments received on the filing. 8 V.S.A. § 4062(c)(2)(B); GMCB Rule 2.000, § 2.201.

The Board's review is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the Legislature granted the Board review standards that are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16.

The burden falls on the insurer proposing a rate change to justify the requested rate. GMCB Rule 2.000, § 2.104(c).

In addition to our longstanding statutory criteria, the Board has received temporary supplemental authority. Effective through March 31, 2023, the Board may waive or permit variances from State laws, guidance, and standards with respect to health insurance rate review, among other regulatory activities, as necessary to prioritize and maximize direct patient care, safeguard health care provider stability, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic. Act 85, § 5(a)(3) (2022).

Conclusions of Law

As noted above, in reviewing a rate filing, we must consider whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to the laws of Vermont, and is not excessive, inadequate, or unfairly discriminatory. As we have recognized in prior decisions, these factors are interrelated and often in tension with one another. *See, e.g., In re MVP Health Plan, Inc. 2022 Individual and Small Group Market Rate Filings*, GMCB-007-21rr & GMCB-008-21rr, Decision and Order (Aug. 5, 2021), 16. Neither our statue nor our rule specifies how much weight we should give to any one factor, and we seek to find the most appropriate balance we can amongst them based on the facts and circumstances before us.

Balancing the various rate review factors is difficult even in a "normal" year. This year is anything but normal, as evidenced by the flexibilities given to the Board and other agencies in Act 85 of 2022. BCBSVT requested on average double-digit rate increases in the individual and small group markets even before hospital budget submissions were filed. *See* Findings, ¶ 14. During our

review of BCBSVT's filings, Vermont hospitals submitted their FY 2023 budget proposals to the Board. Findings, ¶ 5. These budget proposals are historically high, due in part to the inflationary and workforce pressures hospitals are facing as they emerge from what we hope is the worst of the COVID-19 pandemic. In response to the hospital budget submissions, BCBSVT raised its proposed rates even further. *See* Findings, ¶ 15. Individuals and small businesses who will be purchasing health benefit plans in 2023 are also dealing with high inflation and increased costs. *See* Findings, ¶¶ 76 – 79. Moreover, ARPA's enhancements to the PTC are set to expire at the end of 2022, which would have drastic impacts on certain segments of the individual market. *See* Findings, ¶¶ 22 – 23. It now appears that Congress may extend these PTC enhancements through the Inflation Reduction Act of 2022, but the passage of this bill is still uncertain at this time. *See* Findings, ¶ 24. Affordability and access are therefore top of mind for us this year. At the same time, adequacy of rates and contribution to surplus are necessary for health insurers to maintain strength of capital to keep pace with claims trends. *See* Findings, ¶¶ 70 – 72.

Ultimately, the size of the proposed rate increases, the potential loss or reduction in federal assistance, the impact of inflation, and concerns that people may forego purchasing insurance or fail to seek necessary care compel us to maximize affordability and access this year to the extent that we are able in light of the other factors we must consider. For the reasons below, we accept our actuaries' recommendations and require BCBSVT to further reduce the rates by 2.0% to promote affordability and access this year.

I

First, we require BCBSVT to implement L&E's recommendations to 1) correct the URRT section in which the ARPA adjustment is applied; 2) reflect updated risk adjustment transfer figures; and 3) reflect final plan cost sharing. BCBSVT has agreed to make each of these changes, and we agree they are appropriate. *See* Findings, ¶¶ 57-59.

II

Second, we require BCBSVT to modify its medical utilization trend components such that they match the L&E recommendations, as summarized below.

BCBSVT has taken multiple approaches within medical utilization trend, depending on the category. Findings, ¶¶ 43-49. Many of these approaches are reasonable, such as assuming FWA recoveries would remain at 2021 levels and using the matched population method to control for historical changes in population characteristics. Results in certain categories are also reasonable, such as the mental health utilization trend of 8.5%, and the medical Rx utilization trend of 3.6%. Some of the approaches, however, are inconsistent and resulted in an overstated assumption for medical utilization trend in aggregate. In particular, BCBSVT did not meet its burden to demonstrate that the facility trend, facility professional trend, and other professional trend projections were reasonable. Findings, ¶ 44.

The dynamics of the COVID-19 pandemic imposed competing forces on utilization in 2021. There were both increases in utilization because of returning care (i.e., rescheduling of care

that had been deferred in 2020) and decreases in utilization because of suppressed care (i.e., care deferred or foregone during spikes in state COVID levels). Findings, ¶ 50.

BCBSVT's approach for facility trend was to use its statistics on emergency care utilization to demonstrate suppression of care, given that emergency care inherently cannot be deferred. Findings, ¶ 50. This assumption prompted BCBSVT to adjust its review of all 2021 facility utilization to incorporate a 1.5% facility utilization trend. Findings, ¶ 51. The data, however, provided other indicators that this assumption may be flawed. BCBSVT's own analysis shows a 3-year trend result of 0.03%, although the carrier represents that the result is affected by COVID and was also driven by a high outlier result in 2018. Findings, ¶ 46. Yet, the 2018 utilization level was not treated as an outlier in 2019 for its 2020 plan year filing. Findings, ¶ 47. BCBSVT's analysis also indicated that total utilization in 2021 was lower than 2019 levels, and when adjusted for COVID, resulted in a facility trend estimate of 0.9%. Findings, ¶¶ 45, 51. We find L&E's interpretation of BCBSVT's historical data, already adjusted for COVID, to be more a likely projection in the context of ongoing competing influences on utilization. *See* Findings, ¶ 45, 51. Therefore, we order a reduction in facility utilization trend from 1.5% to 1.0%.

As facility trend and professional services offered in a facility are closely linked, BCBSVT assumed the utilization trend for professional facility services would mirror the facility utilization trend. L&E agreed this assumption was reasonable and recommended the utilization trend for professional facility services be reduced to 1.0%. Findings, ¶ 52. We accept that recommendation and order BCBSVT to reduce its utilization trend for professional services to 1.0%.

We do not find BCBSVT has demonstrated that its proposed 1.0% utilization trend for other professional is warranted. The statistical results in support of its proposal are an analysis that shows that the trend from 2019 to 2021 is effectively zero and two regressions that give undue weight to the suppression of care at the onset of the pandemic. Findings, ¶ 53. As such, we accept L&E's recommendation and order BCBSVT to reduce its utilization trend for other professional to 0.5%.

Following from our decisions on the individual utilization components, we note that BCBSVT's initial overall utilization trend of 2.0% is overstated. L&E's recommendations regarding utilization result in an average medical utilization trend of 1.5%, which appears to be more appropriate, given the evidence. *See* Findings, ¶ 54. L&E's witness testified that an overall utilization trend of 1.0% or slightly lower would be reasonable. Findings, ¶ 48. The pandemic's conflicting influences on utilization of suppressed care and returning care appear likely to continue into 2023. *See* Findings, ¶ 78. Moreover, higher premium rates may affect utilization, with a realistic possibility that consumers may utilize less health care. Findings, ¶ 49.

III

Third, we require BCBSVT to assume that the Board will reduce the rates requested by Vermont hospitals in their FY 2023 budget proposals by 17%.

The timelines for the Board's review of individual and small group rate filings and hospital budgets present a challenge every year. We would prefer to complete our review of the individual

and small group rate filings after having established hospital budgets for the upcoming year. Unfortunately, we have not found a reasonable way to make this work. *See* GMCB Regulatory Alignment White Paper, Part 2: Options for Regulatory Timeline and Logistics (July 2021).[5]

While we cannot know what we will do with hospitals budgets later this year,[6] we must ensure that the assumptions in the filings are reasonable. BCBSVT's assumption that the Board will reduce the rates proposed by the hospitals by only one percent is not reasonable; it is not consistent with what the Board has done in the past, particularly the recent past. *See* Findings, ¶¶ 38 – 39.

A reasonable approach this year is to assume the Board will reduce hospitals' proposed rates by the average *percentage* rate reduction that the Board has imposed over the past five years, which we calculate as approximately 17%. We think this is a reasonable approach because reductions in recent years have tended to be larger for larger budget requests and this year's requests are historically high. *See* Findings, ¶¶ 38 – 39. Furthermore, this year's historically high requests reflect budgeted revenue growth for many hospitals that exceeds the two-year revenue guidance set by the Board. Findings, ¶ 40.

IV

Fourth, we order BCBSVT to reduce its proposed rates by an additional 2.0% in each filing to provide greater affordability and access for Vermonters.

We received 245 comments during the public comment period. Many of the comments were compelling and personal, and nearly all underscored a common theme - the cost of health care is unaffordable for many individuals, families, and businesses in Vermont who are trying to cope with rising inflation and higher costs for other goods and services. *See* Findings, ¶ 9, 77. *See* HCA Brief, 4.

BCBSVT is requesting an average annual premium increase of 14.9% for individual plans and an average annual premium increase of 15.4% for small group plans, which would increase the overall average gross premiums by approximately $104 PMPM for individual plans and $94 PMPM for small group plans. *See* Findings, ¶ 15. Increasing premiums by this much is likely to cause significant hardship for many individuals and small businesses. For example, we heard evidence at hearing that these proposed increases may cause people to seek leaner (lower AV) plans, avoid seeking care, or drop coverage altogether. *See* Findings, ¶ 49. In the individual market, the gross premium increases could be mitigated if ARPA's enhancements to the PTC are extended to 2023. Conversely, the increases could be compounded if ARPA's enhancements to PTC are allowed to expire, particularly for individuals just over 400% FPL. *See* Findings, ¶ 23. Affordability and access are of paramount concern this year and, in light of these concerns, we conclude that a 2.0% reduction to rates is warranted.

[5] https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCBRegulatoryAlignment_Part2_20210730.pdf
[6] The Board is scheduled to hold hearings on hospital budgets between August 15 and August 26, 2022, and will begin deliberating on August 31, 2022.

We note that there is a range of actuarially sound rates, and evidence in the record demonstrates that the adjustments required in sections I – III do not set the lowest actuarially sound rate. For example, L&E concluded that a CTR as low as 0.7% was in the range of reasonableness and that an overall utilization trend of 1.0% or slightly lower was reasonable as well. See Findings, ¶¶ 48, 72.

BCBSVT can also take specific action to constrain costs and manage this reduction. First and foremost, BCBSVT can negotiate for lower unit cost increases than it assumed in the filings. [redacted] The rate *restrictions* or *limitations* we place on hospitals through our hospital budget orders should not stand in the way of these negotiations. *See* Findings, ¶ 40.

Second, BCBSVT can take steps with programs it already has to improve quality care and reduce costs. For example, BCBSVT can increase investments in its quality improvement and cost savings initiatives which generate a positive ROI. *See* Findings, ¶ 64. BCBSVT can also promote the Blue Distinction (high quality designation) and Blue Distinction Plus (high quality and low cost designation) programs. These programs exist, yet there was no evidence that the carrier actively promotes use of these facilities among its members, other than for one procedure. Findings, ¶ 65. Encouraging members to take advantage of these Blue Distinction and Blue Distinction Plus facilities is another way to lower costs and improve quality for BCBSVT and its members. Actively promoting these programs will also provide an incentive for hospitals to provide services at a lower cost and at a higher level of quality. We expect to see more reliance on this program, and we will continue to request data on its impact on cost and quality.

Third, BCBSVT can make a greater effort to contain administrative costs. BCBSVT's worsening rank on this measure in comparison to Blues plans nationally is concerning. The 3.3% increase in administrative costs in this filing reflects the need for BCBSVT to reduce costs in response to events that negatively impact the QHP program such as switching the Medicare Advantage population to an entirely different platform. *See* Findings, ¶ 62 – 63.

Finally, we believe there is great potential for BCBSVT to expand its engagement with OneCare Vermont and to slow health care cost growth and improve quality through fixed prospective payment arrangements. While BCBSVT has expressed a desire to implement such payments, it has not yet done so in a meaningful way. As we emerge from what we hope are the worst days of the pandemic and as BCBSVT and OneCare resume a relatively small "two-sided" risk-sharing arrangement in 2023, BCBSVT must take this opportunity to make meaningful progress towards a more substantial goal in 2023 and beyond, which is so important to the evolution of health care reform in Vermont. *See* Findings, ¶ 66 – 69.

In sum, we do not believe that a 2.0% reduction places an undue burden on BCBSVT because the record shows that there are factors that could justify a lower rate and there is time for the carrier to implement changes that could positively impact its bottom line.

Based on the above, we believe a 2.0% reduction results in rates that strike the best balance available amongst the factors that we must consider. Our approach is also supported by the

discretion provided in Act 85 to take necessary actions to prioritize and maximize direct patient care in response to evolving needs related to the COVID-19 pandemic. Act 85 (2022), § 5(a)(3).

V

Finally, while it does not impact rates, we feel compelled to express our opinion that BCBSVT can and should do more to encourage direct enrollees to purchase a plan through VHC so that they can take advantage of federal and state subsidies that may be available to them. Particularly in this difficult year, carriers need to do everything they can to help consumers make wise choices and enhance affordability. BCBSVT must include in next year's individual rate filing detailed information on the efforts it has taken to encourage enrollment through VHC and the effectiveness of these efforts.

Order

For the reasons discussed above, we modify and then approve BCBSVT's 2023 Individual and Small Group Rate Filings. Specifically, we order BCBSVT to: (1) correct the URRT for the ARPA adjustment in the individual filing; (2) reflect updated risk adjustment transfers as estimated by L&E; (3) update rates to reflect IRS-required changes to the HDHP benefit designs; (4) reduce medical utilization trend assumptions such that they match the L&E recommendations; (5) assume that the Board will reduce the rates requested by Vermont hospitals in their FY 2023 budget proposals by 17%; and (6) reduce the resulting rate increase, after items (1) – (5) are implemented, by 2.0 percentage points.

With the modifications required by this order, we expect that the overall average rate increase for individual plans will be reduced from approximately 14.9% ($104 PMPM) to approximately 11.4% ($79 PMPM) and the overall average rate increase for small group plans will be reduced from approximately 15.4% ($94 PMPM) to approximately 11.7% ($71 PMPM).

Pursuant to 8 V.S.A. § 4062(b)(3)(A), we also require BCBSVT to submit a report to the Board following the conclusion of its negotiations with Vermont hospitals that describes the actual reimbursement increases negotiated with each hospital.

SO ORDERED.

Dated: August 4, 2022, at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT

)
s/ Tom Pelham)
)
/s Thom Walsh)

Walsh, concurring.

I concur with the Board's decision to reduce the requested rates by 2.0% to provide greater affordability and access. I believe this reduction appropriately goes further than prior reductions made by the Board explicitly for affordability.[7] Nevertheless, I write separately to express my opinion that the decision and the process do not adequately consider the affordability of the rate request, which is paramount to our charge under Act 48.

In our review of insurance premium rates, the Board must determine if the rate is "affordable, promotes quality of care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law."

Actuarial calculations help to measure concepts such as adequacy and excessiveness, financial calculations help to measure insurer solvency, and legal analysis ensures that the rates are not misleading or contrary to existing law. The evidence presented during our recent hearings assures that those standards are met. However, affordability, justness, fairness, and equity are concepts that are more challenging to measure and have not been included in the calculations.

There are measurements that speak to the concept of affordability. Under the Affordable Care Act, for example, employer-sponsored coverage is considered "affordable" if the portion of the premiums required to be paid by the employee costs less than 9.12% of household income. *See* 26 CFR § 1.36B-2(c)(3)(v)(A); IRS Rev. Proc. 2022-34. Similarly, according to a Commonwealth Fund definition, someone is "underinsured" if they have insurance coverage but incur annual out-of-pocket expenses equaling 10% or more of their income if their income is at or above 200% FPL or 5% or more of their income if their income is below 200% FPL, or if they have a deductible equal to or greater than 5% of household income. *See* Department of Vermont Health Access, 2021 Vermont Household Health Insurance Survey (March 2022), 43.[8] During the recent hearing, the Health Care Advocate testified that even before the rate increases approved in this order go into effect, a Vermont family of four earning just over 400% FPL would pay over 20% of their income on premiums alone to purchase a standard Silver plan. Findings, ¶ 79. This amount does not include out-of-pocket expenses like deductibles and copayments.

Concepts of equity and fairness could also be better reflected in our process. For example, increased costs may disproportionately impact single-parent households, many of which are

[7] *See In re Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing*, GMCB-009-18rr, Decision and Order (Aug. 14, 2018), 17 – 19 (reducing overall rate by 1.0% to provider greater affordability); *In re MVP Health Plan, Inc. 2019 Individual and Small Group Rate Filing*, GMCB-008-18rr, Decision and Order (Aug. 14, 2018), 14 – 16 (reducing overall rate by 1.0% to provide greater affordability and access).
[8] https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-VHHIS-2021-Report.pdf

headed by women, BIPOC communities, and other historically marginalized groups, and could therefore exacerbate existing disparities in access to care.

For these reasons, I believe we should work with our governmental partners and other stakeholders to develop a framework that includes better measures of affordability, justice, fairness, and equity.

Developing better measures of affordability is crucial because people who cannot afford adequate insurance still get sick, have accidents, and need care. Therefore, the potential for creating more uncompensated care should concern regulators, insurance carriers, and healthcare provider systems because an unaffordable system is not sustainable.

Filed: August 4, 2022

Attest: s/ Jean Stetter, Administrative Services Director
Green Mountain Care Board

NOTICE TO READERS: This decision is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made (email address: Christina.McLaughlin@vermont.gov).

Appeal of this decision to the Supreme Court of Vermont must be filed with the Board within thirty days. Appeal will not stay the effect of this Order, absent further Order by this Board or appropriate action by the Supreme Court of Vermont. Motions for reconsideration or stay, if any, must be filed within ten days of the date of this decision and order.