STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2022 Individual Market Rate Filing	)	GMCB-005-21rr
	)	SERFF No. BCVT-132829271
In re: Blue Cross and Blue Shield of Vermont 2022 Small Group Market Rate Filing	)	GMCB-006-21rr
	)	SERFF No.: BCVT-132829562

DECISION AND ORDER

Introduction

Until recently, Vermont's individual and small group health insurance markets were merged. This meant that carriers were required to develop premiums for their individual and small group plans based on the combined claims experience of their enrollees in both markets. *See* Exhibit (Ex.) 16 at 20-21; 45 C.F.R. 156.80(c). Because small employers generally have lower claims costs than individual purchasers of insurance, Vermont's merged market resulted in somewhat higher premiums for small groups and lower premiums for individuals compared to what their respective premiums would have been in an unmerged market.

The American Rescue Plan Act (ARPA) expanded the subsidies that will be available from the federal government in 2022 to lower the cost of purchasing a plan in the individual market. Due to these expanded subsidies, Vermont unmerged the individual and small group markets for 2022. This means that carriers developed premiums for their 2022 individual and small group plans using the experience of their enrollees in each market separately. Because of the cost differential described above, this resulted in proposed 2022 premiums for small group plans decreasing relative to proposed 2022 premiums for individual plans.

Blue Cross and Blue Shield of Vermont (BCBSVT or "the company"), one of two carriers offering individual and small group coverage in Vermont, filed its proposed 2022 rates on May 7, 2021. BCBSVT requested an average annual premium increase of 7.9% for its individual plans, with plan-level increases (excluding catastrophic coverage) ranging from 6.6% to 9.8%, and an average annual premium decrease of 7.8% for its small group plans, with plan-level changes ranging from -7.0% to -9.1%. Unmerging the markets had an impact of approximately +8.3% on the proposed individual rates and -7.4% on the proposed small group rates.

Based on a review of the record, including the testimony and evidence presented at a hearing held on July 21, 2021, we modify the proposed individual and small group rates and then approve the filing. We expect that, as modified, the average annual premium increase for BCBSVT's individual plans will fall from approximately 7.9% to 4.7% and the average annual

premium decrease for BCBSVT's small group plans will be adjusted from 7.8% to 6.7%. As a result of the expanded subsidies under ARPA, we also expect that for households that do not receive Premium Tax Credits (PTC), the actual amount paid by BCBSVT members in the individual market will increase by 4.7% on average. Despite this increase for individual plans, we expect that net premiums (after subsidies) will actually decrease on average by an estimated 8.4% for members who will receive PTC.

Procedural History

1. On May 7, 2021, BCBSVT filed its 2022 Individual Rate Filing and its 2022 Small Group Rate Filing with the Board using the System for Electronic Rate and Form Filing (SERFF). The filings outline BCBSVT's development of premiums for individual and small group plans with coverage commencing January 1, 2022, including qualified health plans (QHPs) offered through Vermont Health Connect, the state's health insurance exchange (VHC or "the Exchange"), and reflective silver plans[1] offered outside of the Exchange. Ex 1.

2. On May 14, 2021, the Office of the Healthcare Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health insurance, entered an appearance as an interested party to the proceedings. HCA Notices of Appearance; *see also* 8 V.S.A. § 4062(c)(3); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.202(c), 2.307.

3. Beginning May 13, 2021, the Board and L&E asked BCBSVT to respond to a series of questions, including ones submitted by the HCA. Exs. 8-15, 27, 29.

4. L&E reviewed the filings on behalf of the Board. On July 6, 2021, L&E issued a report in which it summarized its analysis of the filings and recommended that the Board make four modifications to the filings. Ex 16 at 23. That same day, the Vermont Department of Financial Regulation (DFR), BCBSVT's principal solvency regulator, issued opinions and analyses regarding the impact of each filing on the company's solvency. Ex 17; *see also* July 6, 2021 Letter from Commissioner Michael S. Pieciak re: Solvency Impact of 2022 Vermont ACA Market-Small Group Rate Filing of Blue Cross and Blue Shield of Vermont ("DFR Small Group Letter").

5. Prior to the hearing, BCBSVT agreed to make each of L&E's recommended changes. Ex. 21 at 1-2. The changes recommended by L&E, together with BCBSVT's incorporation of projected hospital budget approvals, resulted in a proposed rate change in the individual market of +5.2% and a proposed rate change in the small group market of -6.2%. Ex. 29 at 2.

[1] Since 2019, BCBSVT has offered silver-level nonqualified health benefit plans in the individual and small group market outside of VHC. These plans are similar in their design to the "silver-loaded plans" offered on VHC. However, unlike the VHC plans, these reflective silver plans do not include any funding to offset the loss of the cost-sharing reduction payments. *See* 33 V.S.A. § 1813.

6. The Board held a hearing on BCBSVT's filings on July 21, 2021. 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. Michael Barber, the Board's General Counsel, served as hearing officer by designation of Board Chair Kevin Mullin. BCBSVT was represented by Michael Donofrio and Bridget Asay from the law firm Stris & Maher LLP. The HCA was represented by Jay Angoff, from the law firm Mehtri & Skalet, PLLC, as well as HCA staff attorneys Kaili Kuiper and Eric Schulteis. Testifying on behalf of BCBSVT at the hearing were Paul Schultz, the company's Chief Actuary; Ruth Greene, the company's Treasurer and Chief Financial Officer; and Dr. Kate McIntosh, the company's Senior Medical Director and Director of Quality. Commissioner Michael Pieciak and Zachary Smith, a Senior Consultant at Oliver Wyman Actuarial Consulting, Inc., testified for DFR. Laura Beliveau, a Board Staff Attorney, led the direct testimony of Jacqueline B. Lee, Vice President and Principal at L&E. Michael Fisher, Chief Health Care Advocate, testified for the HCA. Hearing Transcript (Tr.) at 1-6, 19, 131, 152, 183, 303, 337 (July 21, 2021); Confidential Hearing Transcript ("Confidential Tr.").

7. The parties stipulated to 28 exhibits (1-23 and 25-29) which were admitted into evidence at the hearing. Tr. at 8, 347. Exhibit 30 was stipulated to be entered into evidence by the parties and was admitted into evidence on July 27, 2021.

8. The Board opened a special comment period on May 10, 2021, so that members of the public could comment on the two 2022 individual filings and the two small group rate filings—these filings from BCBSVT and filings from MVP Health Plan, Inc. The public comment period closed on July 28, 2021, and the Board received comments from 7 individuals and 6 organizations. The comments expressed primarily two opinions. The first set of opinions opposed the rate increases in the individual market. The second set of opinions supported the unmerging of the markets and the beneficial impact to the small group market. The Board also held a public comment session from 4:00 p.m. to 6:00 p.m. on July 22, 2021, via Microsoft Teams and with a designated location at the Board's offices at 144 State Street in Montpelier. Two members of the public in attendance made comments reflecting frustration with rising health insurance rates and concern about the temporary nature of the ARPA subsidies.

9. On July 22, 2021, the Board asked BCBSVT to provide written responses that arose out of the hearing. BCBSVT Post-Hearing Questions. BCBSVT responded to the Board's questions on July 27, 2021. BCBSVT Responses to Post-Hearing Questions.

10. On July 27, 2021, L&E submitted a Post-Report Addendum (L&E Addendum) addressing the updated information BCBSVT had provided regarding hospital budget submissions.

11. BCBSVT submitted a post-hearing brief (BCBSVT Brief) on July 28, 2021, in which it argued that the Board should approve the proposed rates as modified by L&E's recommendations. BCBSVT asserted that, because of the ARPA subsidies and unmerging of the

market, if the Board approves both carriers' rates, as modified by L&E, then most BCBSVT members would be better off in terms of net, post-subsidy, premiums. BCBSVT Brief at 7. BCBSVT also asserted that there is no evidentiary basis for cutting BCBSVT's proposed 1.5% Contribution to Reserves (CTR). *Id.* at 8.

12. The HCA also submitted a post-hearing brief (HCA Brief) on July 28, 2021, in which it argued that the proposed rates were excessive and that the enhanced subsidies do not excuse unjustified rate increases. HCA Brief at 7-8. It also argued against BCBSVT's proposed 1.5% CTR and recommended the imposition of a negative CTR factor. *Id.* at 7.

Findings of Fact

13. BCBSVT is a non-profit hospital and medical service corporation that offers health insurance products in several markets in Vermont. Ex. 16 at 1; Ex. 15 at 9.

14. These filings affect approximately 34,600 individuals covered by BCBSVT's individual plans and small group plans. BCBSVT's membership in these plans has decreased significantly over the past several years, as shown in the following table:

Coverage Year	Members	Percent Change
2016	70,423	5.0%
2017	70,035	-0.6%
2018	53,664	-23.4%
2019	43,939	-18.1%
2020	39,195	-10.8%
2021	34,633	-11.6%

Ex. 16 at 1.

15. In its May 7, 2021 filing, BCBSVT requested an average premium increase of 7.9% for the individual market. The table below show average rate changes BCBSVT proposed for each type of plan in the individual market on a per member per month (PMPM) and percentage basis, as well as the distribution of BCBSVT's membership across the plan types.

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Catastrophic	$259.79	$250.48	-2.5%	-$6.55	2.0%
Bronze	$523.14	$557.93	6.6%	$34.79	22.2%
Silver Loaded	$716.39	$768.60	7.3%	$52.21	30.1%
Silver Reflective	$566.55	$610.11	7.7%	$43.56	11.9%
Gold	$699.21	$761.38	8.9%	$62.17	22.4%
Platinum	$838.76	$920.83	9.8%	$82.08	11.4%
Overall	***$656.39***	***$708.14***	***7.9%***	***$51.75***	***100.0%***

Ex. 16 at 3.

16. In its May 7, 2021 filing, BCBSVT proposed an average annual decrease of 7.8% for the small group market. The table below shows the average rate changes BCBSVT proposed for each type of plan on a PMPM and percentage basis, as well as the distribution of the company's membership across the plan types.

Plan Type	Average 2021 Premium PMPM	Average 2022 Premium PMPM	Percent Change	PMPM Change	Percent of Membership
Bronze	$498.97	$453.53	-9.1%	-$45.44	15.3%
Silver	$587.59	$538.16	-8.4%	-$49.42	29.7%
Gold	$670.20	$619.96	-7.5%	-$50.25	32.7%
Platinum	$816.99	$760.00	-7.0%	-$56.99	22.3%
Overall	***$652.11***	***$601.34***	***-7.8%***	***-$50.77***	***100.0%***

Ex. 16 at 3.

17. As filed, BCBSVT's expected claims and premiums produce a projected traditional loss ratio of 87.7% for the individual market and 90.4% for the small group market. After adjusting for taxes, fees, and quality initiatives, the 2022 federal medical loss ratio is expected to be 88.6% for individual plans and 91.3% for small group plans, both of which exceed the 80% minimum required by law. Ex. 16 at 4; Ex. 18 at 16; 33 V.S.A. § 1811(j).

18. The federal government provides a premium tax credit (PTC) to certain taxpayers purchasing a plan through a health insurance marketplace such as VHC who are not eligible for coverage through a government program such as Medicare or Medicaid and who do not have access to an affordable[2] employer-sponsored plan that provides minimum value.[3] *See* 26 U.S.C. §

[2] An employer-sponsored plan generally is considered "affordable" if the portion of the annual premium the employee must pay for self-only coverage that satisfies the minimum value requirement does not exceed a certain percentage of the employee's household income. Internal Revenue Service, Questions and Answers on the Premium Tax Credit, Question 11, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#eligibility.

[3] An employer-sponsored plan provides "minimum value" if it covers at least 60 percent of the total allowed costs of covered services and provides substantial coverage of inpatient hospitalization services and physician services.

36B. Prior to the American Rescue Plan Act (ARPA), 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).

19. The PTC covers the difference between the premium for the second-lowest cost Silver plan - the "benchmark plan" - and a specified percentage of household income. For example, in 2021, prior to ARPA, an individual earning 150% FPL would have needed to contribute 4.14% of his or her income[4] towards the premium of the benchmark plan and would have received a PTC to cover the remainder. *See* 26 U.S.C. § 36B(b)(3)(A)(i). The individual could apply the PTC to the cost of a plan at any metal level – Bronze, Silver, Gold, or Platinum. *See* Ex. 16 at 18. The PTC is typically[5] paid directly to the insurance carrier by the federal government.

20. ARPA significantly expands the PTC for 2021 and 2022. First, for those who were already eligible, ARPA increases the amount of the PTC they can receive by reducing the share of income they are 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)(iii). Second, ARPA expands eligibility for the PTC to individuals and households above 400% FPL. *See id.*; *see also*, 26 U.S.C. § 36B(c)(1)(E).

21. ARPA's enhancements to the PTC, while significant, are temporary. Unless extended, they will not be available for plan year 2023. *See* 26 U.S.C. § 36B(b)(3)(iii). They also do not cover everyone. For example, an otherwise eligible individual that enrolls directly with a carrier will not receive the PTC because the PTC is only available for plans purchased through health insurance marketplaces. *See* 26 U.S.C. § 36B(b)(2)(A).

22. To take advantage of ARPA's expansion of the PTC, Vermont unmerged its individual and small group markets for 2022. Act 25 of 2021, § 34.

23. Unmerging the markets caused BCBSVT's proposed rates to increase 8.3% for individuals and decrease 7.4% for small groups compared to what the proposed rates would have been under a merged market structure. The approximately 17% differential was driven primarily by the fact that the claims experience for small group members was substantially lower than it was for individuals. Another factor contributing to the differential is the different distribution of claims within the two populations. The filings use the same trend assumptions for inpatient claims, prescription drugs, etc., but because the distribution of these claims differs between the individual and small group markets, the overall weighted average trend differs slightly between the two populations as well. Other contributing factors are differences in the morbidity of the populations, which impacts risk transfer payments, and differences in benefit packages, which impacts inter-plan subsidies and the impact of induced utilization. Finally, the individual market covers fewer children than the small group market. Because single individuals in Vermont pay higher premiums

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Internal Revenue Service, Questions and Answers on the Premium Tax Credit, Question 12, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit#eligibility.

[4] In Vermont, the Vermont Premium Assistance would lower the individual's required contribution even further.

[5] Most taxpayers choose to have the credit estimated and paid to the carrier in advance to lower monthly premiums (referred to as advanced premium tax credit or APTC).

in exchange for lower premiums for families, unmerging the two markets resulted in the individual rates decreasing relative to the small group premiums. Ex. 16 at 5, 21; *In Re: Vermont Health Benefits Exchange*, Docket No. 13-002-I, Order Establishing Tier Rate Structure and Multipliers.

24. The amount of subsidy available to individual households is based on their income and the marketplace premium for the second-lowest cost Silver plan. As all Silver plans offered in the individual market are projected to have increased premiums next year, the PTC will increase as well. Subsidized households purchasing Bronze coverage will pay lower net premiums in response to rate increases because their subsidy increase will outweigh the Bronze premium increase. Conversely, Gold and Platinum purchasers will see their rates increase relative to the Silver rates because the subsidy does not fully counteract the increases to the Gold and Platinum premiums. Ex. 16 at 22.

25. At the time of the hearing, approximately 500 BCBSVT members had moved from direct enrollment into Vermont Health Connect. As of May 31, there were 4,682 members directly enrolled. Testimony of Paul Schultz, Tr. at 91:21 - 23; Tr. at 92:7.

26. Since the unmerging of the individual and small group markets was connected to the subsidy expansion under ARPA, and since this expansion is currently set to expire for 2023, it is unclear whether the market will remain unmerged in 2023. If the markets are remerged for 2023, it is likely to result in a higher rate change for small groups than individuals. Ex. 16 at 22.

27. L&E reviewed the rate filings to assist the Board in determining whether the proposed rate changes 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. 16 at 3; Testimony of Jackie Lee, Tr. at 154: 23 - 155:3. L&E makes recommendations regarding the actuarial soundness of the rates; it does not make recommendations regarding affordability, which is not an actuarial standard. Testimony of Jackie Lee, Tr. at 155:6 - 13.

28. To simplify comparisons to BCBSVT's 2021 individual and small group rate filing, L&E explained its review of the proposed 2022 rates from a combined or merged market perspective. This decision takes the same approach. The table below describes, on a merged market basis, BCBSVT's original proposed 2022 individual and small group rates using the rating categories of the Unified Rate Review Template (URRT) and an additional category to capture the impact of unmerging the markets.

Proposed Rating Component	Percentage Change	
	Individual	Small Group
1. 2020 Actual/Projected Claims Experience	-8.3%	
2. Difference in Trend from 2020 to 2021	-0.4%	
3. Trend from 2021 to 2022	+7.2%	
4. Changes to Population Morbidity Adjustment	+0.8%	
5. Demographic Shift	-0.8%	
6. Plan Design Changes	+0.2%	
7. Changes to Other Factors	-0.2%	
8. Changes to Risk Adjustment	-0.6%	
9. Changes in Actuarial Value	+1.0%	
10. Changes in Administrative Costs	+0.0%	
11. Changes in Taxes & Fees	+0.1%	
12. Changes in Contribution to Reserves	+1.0%	
13. Changes in Single Contract Conversion Factor	+0.1%	
14. Impact of Unmerging Markets	+8.3%	-7.4%
Total Proposed Rate Change	**+7.9%**	**-7.8%**

Ex. 16 at 5.

29. Based on its review, L&E recommends that the Board make four modifications to proposed rates. Ex. 16 at 23. These recommendations would result in changes to rating components 3, 4, 8, and 9. *Id.* at 23-24. BCBSVT agreed to L&E's recommendations. Ex. 21 at 1-2; Testimony of Paul Schultz, Tr. at 24:11 – 25:4.

30. L&E's first recommendation relates to BCBSVT's proposed 2021 to 2022 medical unit cost trend. L&E recommends that 2022 hospital budget requests be considered in formulating the assumed medical unit cost trend. Ex. 16 at 7.

31. Approximately 53% of medical costs are related to facilities impacted by the Board's hospital budget review process. For these facilities, BCBSVT originally selected a medical unit cost trend of 5.0% based on its assumption that the commercial rate increases approved by the Board later this year (for hospital fiscal year 2022) will mirror those approved in 2020 (for hospital fiscal year 2021). The company selected a trend of 3.6% for providers outside the BCBSVT service area and non-GMCB providers within the broader BCBSVT service area. *See* Ex. 16 at 7; Ex. 1 at 23-24.

32. BCBSVT reviewed the early July hospital budget submissions. It reported that if the hospital budget submissions were incorporated into BCBSVT's rates without any adjustment, the resulting impact on individual and small group rates would be increases of 0.8% and 0.7%, respectively. BCBSVT then assumed that commercial rates for hospitals in The University of Vermont Health Network would be reduced by 1.5% and all other hospitals would face reductions that average 0.5%. Ex. 29 at 1. The company also updated the medical unit cost trend for Dartmouth-Hitchcock and Alice Peck Day Memorial Hospital, both outside the Board's

jurisdiction. *Id.* at 2. The company's updates increased the original allowed medical trend by 0.2%, which led to an increase in the proposed rate of 0.2%. L&E Addendum at 1; Ex. 29 at 2.

33. The medical utilization component of the medical trend captures projected changes in the amount and intensity of medical services used by members. The company looked at inpatient, outpatient and professional categories separate from the medical Rx category. For inpatient/outpatient/professional, BCBSVT utilized a "matched population" method to control for historical changes in population characteristics. It relied primarily on data from 2017 to 2019 to avoid the disruption from the COVID-19 pandemic. The total medical utilization trend, excluding medical Rx, was 1.0%. Ex 16 at 7-8.

34. Medical Rx trend shows the projected change in cost for prescription drugs administered in outpatient medical settings and paid through the medical benefit. While the number of claims for these drugs is relatively low, the cost of each claim is high. The cost trend is assumed to be 5.3% and the utilization trend is assumed to be 6.7%, resulting in an allowed medical Rx trend of 12.4%. Ex 16 at 9.

35. Combining the annual unit cost and the annual utilization for inpatient, outpatient, professional, and medical Rx results in a total allowed medical trend of 6.4%. Ex 16 at 9.

36. Pharmacy trend, the second element of the total allowed trend from 2021 to 2022, is comprised of projected changes in medication costs and utilization. The company is proposing an allowed pharmacy trend of 11.1% per year, net of changes to pharmacy rebates. Unlike the medical trend analysis, 2020 pharmacy claims did not demonstrate COVID-19 disruptions. Of seven tiers of pharmaceuticals (generic, brand-name, vaccines, over-the-counter, devices, compounds, and specialty), the first six tiers comprise 46% of pharmaceutical costs and historical analysis appropriately yielded cost and utilization trends for these tiers. The seventh tier, specialty, includes high-cost drugs that are used by very few people and comprise 54% of pharmaceutical spending. Because of specialty drugs' low usage and high cost, projections are made on a PMPM basis and not analyzed separately for utilization and unit cost trends. Ex. 16 at 10-11; Ex. 1 at 31.

37. The second recommendation from L&E is to reflect the impact of ARPA on claims. The company originally projected an increase of 1.1% for changes to the population morbidity. This figure reflects a projected claims increase because the members who left BCBSVT in 2021 were lower cost in 2020 than the members who maintained coverage. However, the impact of the increased subsidies from ARPA will cause an adjustment to the 2022 population, which BCBSVT did not include in the initial filing. Based on a market-wide analysis performed by L&E, the membership in the individual market is expected to increase and be somewhat healthier than the currently covered population, resulting in a 0.2% decrease to individual rates and a merged market impact of -0.1%. These changes to the population morbidity adjustment are recommended by L&E and agreed to by BCBSVT. Ex. 16 at 12-13; Ex. 21 at 2.

38. The third recommendation L&E made was to reflect updated risk adjustment transfers. While the company originally projected changes to risk adjustment to have a -0.6% impact on rates, it agreed with L&E that it should be -0.9%, based on updated risk adjustment

transfer payment information from Centers for Medicare and Medicaid Services (CMS). Ex. 16 at 15-16; Ex. 21 at 2.

39. The fourth recommendation involves changes in actuarial value (AV). The AV assumption reflects Pricing AV changes, such as changes in Metal AVs, induced utilization, cost sharing changes and changes in projected enrollment among plans. The increase in the AV assumption is 1.0% relative to the 2021 filing. L&E's recommendation is immaterial to overall rates; it suggests that the company to update the rate to reflect IRS-required changes implemented by the Department of Vermont Health Access (DVHA) to the Standard Bronze High Deductible Health Plan (HDHP), which will not have a material impact to the overall rates. Changes in actuarial value are projected to increase rates by 1.0%. Ex. 16 at 17; Ex 21 at 2.

40. As proposed, changes in administrative costs will have a minimal impact on rates. Actual administrative costs of $42.57 PMPM were adjusted for three factors. The first adjustment is an increase of $0.12 PMPM due to the shift toward the individual market. The second adjustment is an increase of $0.94 PMPM to reflect a single year of personnel cost increases; as approximately 74% of BCBSVT's operating costs are for wages and benefits, a 3% increase between 2021 and 2022 corresponds to a 2.2% increase. This is consistent with decision to forego cost of living wage increases in 2021. The third adjustment is the impact of decreasing enrollment; the amount should be approximately a 5.4% PMPM cost increase, but in order to produce more affordable premiums, it was calculated as if variable administrative costs had been immediately reduced in proportion to enrollment changes, with a resulting increase of $1.66 PMPM. Ex. 19 at 18; Ex. 16 at 17-18.

41. In addition to the base administrative costs, BCBSVT had three additional adjustments to its administrative costs. First, outside vendor fees will increase by $0.37 PMPM. Second, credit card fees will amount to an additional $1.90 PMPM. Third, in 2022 BCBSVT will be responsible for billing individual members enrolled through VHC, taking this responsibility over from DVHA. Start-up costs for taking over this billing function were included in last year's filing. The total amount for VHC billing for the individual group only is $3.82 PMPM. Testimony of Paul Schultz, Tr. 91:1 - 13.

42. 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 remain solvent and can meet their obligations and pay member claims. Ex. 19 at 4. The company has proposed an aggregate CTR of 1.6%, which consists of a base CTR of 1.5% and an additional 0.1% for uncollected premiums and bad debt. Ex. 16 at 19.

43. 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 2021 filings. BCBSVT's proposed base CTR of 1.5% was on the low end of submitted CTRs. Ex. 16 at 19.

44. 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. 17 at 3; DFR Small Group Letter at 3. RBC is expressed as a ratio between reserves and a figure that represents an insurance carrier's

risk; it is developed based on a methodology from the National Association of Insurance Commissioners. Ex. 19 at 5.

45. While BCBSVT's RBC was 567% at the end of 2019, it was 480% at the end of 2020. The largest factor contributing to this decline were "catastrophic losses" in pension assets that were invested in funds managed by Allianz Global Investors. These losses, which are currently the subject of litigation against Allianz by the Blue Cross Blue Shield association, reduced BCBSVT's RBC by 163 points. Ex 15 at 6; *see* Ex. 19 at 39-68. It will likely take a number of years until the litigation against Allianz is resolved. Testimony of Michael Pieciak, Tr. at 136:18 – 21.

46. Another 59-point reduction in the company's RBC was caused by changes in the value of pension liabilities due to a decrease in interest rates in 2020. *See* Ex. 15 at 6; BCBSVT Response to Post-Hearing Questions (July 27, 2021), Question 5; Testimony of Ruth Greene, Tr. at 210:22 – 211:8. If interest rates increase in the future, it will lower the company's pension liabilities and have a positive impact on RBC. *See* Testimony of Ruth Greene, Tr. 211:12 – 20.

47. Another major factor contributing to the decline in BCBSVT's RBC between the end of 2019 and the end of 2020 was a $29.8 million deficiency reserve accrual that reduced the company's RBC by 138 points. Ex. 15 at 6; Testimony of Ruth Greene, Tr. at 260:1 - 2. There are two components to this deficiency reserve accrual; expected COVID-19-related costs that are not included in the company's rates, and rate guarantees the company made to retain some of its largest customers in the self-funded market. Testimony of Ruth Greene, Tr. at 208:4 – 21, 259:14 – 260:5.

48. BCBSVT anticipates that its RBC will improve in 2021, with increases to reserves coming from sources including an alternative minimum tax (AMT) credit refund and proceeds from a successful verdict in the lawsuit against the federal government for unpaid Cost Share Reduction (CSR) payments. Ex. 19 at 8, 35.

49. L&E compared BCBSVT's 2020 capital and surplus position based on several metrics compared to other Blue Cross plans nationally. The company's RBC percentage ranked 57th out of 65 insurers with available data; its surplus on a PMPM basis, $46.98, ranked 53rd out of 63 Blues plans with available data; its surplus as a percentage of premium, 21.6%, ranked 51st of 65 Blues plans; and its surplus equated to 3.2 months of claims, which again ranked 51st out of 65 Blues plans. Ex. 16 at 19-20.

50. L&E recommends that the Board take BCBSVT's relative RBC into account when evaluating the company's proposed CTR and recommends that DFR's solvency analysis be strongly considered. L&E believes that BCBSVT's CTR position is reasonable and does not recommend any changes. The impact to rates is a 1.0% premium increase. Ex. 16 at 20.

51. DFR issued its solvency opinion on July 6, 2021. The opinion acknowledges ongoing pandemic-related uncertainties that could affect Vermont's healthcare system. These variables include the impact of delayed, deferred, and forgone care on population health, the ultimate costs of treating COVID-19 infected patients, and potential vaccination costs.

Nevertheless, the opinion observes that Vermont's health insurance marketplace appears to have steadied, at least for the time being. Ex 17. at 1; DFR Small Group Letter at 1.

52. DFR does not expect the proposed rate would have a significant impact on its overall solvency assessment of BCBSVT. It agrees with the company that its targeted RBC range of 590% to 745% is reasonable and necessary for the protection of policyholders. DFR also agrees with BCBSVT that although its RBC is currently below its target range, the company will be slightly above this range at the end of fiscal year 2021 and approximately at the midpoint of the approved range at the end of fiscal year 2022. Ex. 17 at 3; DFR Small Group Letter at 3.

53. DFR's actuaries modeled that a 1.0% reduction in overall rates, assuming there was no offsetting decrease to projected claims or other non-benefit expenses and no changes in legislation or rate filing requirements, would reduce the company's expected year-end 2022 RBC by 6 points, and leave the company above the mid-point of its target range. Ex. 17 at 11; DFR Small Group Letter at 11.

54. One percent of CTR results in raising the overall insurance rate by one percent. Testimony of Jackie Lee, Tr. at 162:2 - 4.

55. Moving to truly fixed prospective payments has the potential to lower premiums. Fixed payments transfer risk to providers and the more risk BCBSVT is able to share with providers, the less capital it needs to support its operations and the less CTR it may need to request in its rates. To the extent fewer claims need to be processed, administrative expenses may also go down. *See* Testimony of Michael Pieciak, Tr. at 146:7 – 147:8.

56. New for this year, the final component of the 2022 proposed rate change is Impact of Unmerging Markets. Since the creation of VHC in 2014, premiums have been equal for individual members and members enrolling through small groups; this approach has generally caused higher premiums in the small group market and lower premiums in the individual market relative to what the premiums would have been in an unmerged market. As originally proposed and calculated for 2022, there is approximately a 17% differential between the two markets, so there would be an 8.3% increase in individual market premiums and a 7.4% decrease in small group premiums. Two adjustments L&E recommended, and BCBSVT accepted, do not impact both markets equally. Those adjustments are the Risk Adjustment Change and ARPA. After these changes, the unmerging impact is a 5.8% increase to individual rates and a 5.7% decrease to the small group rates Ex. 16 at 27. This corresponds to a 12.2% differential between the two markets.

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.*, 203 Vt. 274, 284 (2016).

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

Conclusions of Law

As we have noted in prior decisions, there is a tension inherent in our standard of review. On the one hand, we are required, without specific statutory guidance or a standardized definition to consider whether an insurance rate is affordable for Vermont consumers; on the other hand, we must consider whether the rate protects insurer solvency and is adequate to cover the costs of paying for members' claims and administering the plan. The failure of a rate to meet either criterion could imperil Vermonters' access to care, implicating another one of our review criteria. Our job is to find the most appropriate balance we can amongst the interrelated criteria we must consider.

Based on our review of the record, the testimony, and evidence presented at a hearing that was held on July 21, 2021, we conclude that the rates proposed by BCBSVT are excessive. Accordingly, we require that BCBSVT modify the rates. The required modifications and our reasoning are described below. As modified, we believe the rates are not excessive, inadequate, or unfairly discriminatory, and are more affordable than the rates that were initially proposed while still protecting BCBSVT's solvency and promoting quality care.

I.

First, we adopt three recommendations from our actuaries, as agreed to by BCBSVT: 1) reduce the proposed individual rates by 0.2% to account for improved population morbidity expected to occur as a result of ARPA's expansion of PTC for 2022; Findings, ¶ 37; 2) update risk adjustment transfers by an additional -0.3% based on updated CMS information; Findings, ¶ 38; and 3) direct the company to reflect changes implemented by DVHA to the Standard Bronze HDHP. Findings, ¶ 39.

II.

Second, we require BCBSVT to reduce its 2021 to 2022 medical unit cost trend assumptions for Vermont community hospitals by 1.0% from what hospitals proposed in their fiscal year 2022 budget submissions. In addition, we require BCBSVT to include the updated contract adjustments based on recent negotiations with non-GMCB providers, as demonstrated in Exhibit 29. Based on L&E's historical analysis of submitted and approved hospital budgets, it is reasonable and appropriate to assume a 1.0% reduction from hospitals' submitted budgets and we

require BCBSVT to use this assumption. It should be noted that this result is roughly consistent with BCBSVT's submission in Exhibit 29. *See* Findings, ¶ 32.

III.

Third, we require BCBSVT to reduce its base CTR assumption from 1.5% to 1.0%. We expect this will reduce the proposed rates by 0.5%. *See* Findings, ¶ 54.

The reduced CTR will still be sufficient to protect BCBSVT's solvency. Despite "catastrophic losses" in its pension assets, rate guarantees that it provided to keep certain large customers, and other factors that negatively impacted its surplus in 2020, BCBSVT is expected to be above the RBC target range DFR has set for it by the end of 2021. Findings, ¶¶ 45, 47, 52. Given this fact, a CTR proposal of 1.5% strikes us as excessive during a time when individuals and small businesses are still struggling financially after a year-long economic slowdown. A 1.0% base CTR will reduce rates by 0.5% and have minimal impact on the company's solvency, allowing reserves to sit comfortably within the company's RBC target range. *See* Findings, ¶¶ 52, 53.

IV.

Fourth, we are troubled by BCBSVT's argument that we should not reduce the rates proposed by its competitor beyond what our actuaries have recommended because it will make BCBSVT's plans less affordable than they otherwise would be. *See* Procedural History, ¶ 11. We recognize that the second lowest cost Silver plan, regardless of which carrier offers it, affects the subsidies available to the members of both carriers and that subsidies impact affordability. *See* Findings, ¶¶ 18-19, 24. Nevertheless, decisions about rates for each carrier need to be based on evidence presented in its respective docket, not recommendations from its competitor. *See* 8 V.S.A. § 4062(a), (e); GMCB Rule 2.000, § 2.307, 2.402-2.403. Furthermore, we have an obligation to consider the impact of our decisions, not only on Vermonters receiving subsidies, but also on those who do not receive subsidies, including Vermonters who directly enroll with the carrier, individuals who are ineligible for subsidies, and employees of small employers who are affected by many of the same actuarial assumptions. Findings, ¶¶ 18-21 and 24-25. We note that the vast majority of BCBSVT members who are directly enrolled with the company have not yet moved to VHC; unless they do so they will not receive the PTC subsidy. Findings, ¶¶ 18, 25. We believe our approach strikes the best balance of ordering appropriate adjustments to rates for Vermonters who are not eligible for subsidies, while still allowing significant subsidy benefits for those who can benefit from them.

V.

Fifth, we wish to express frustration with the $3.82 PMPM that is included in the rates to pay for BCBSVT's assumption of billing functions from VHC. Findings, ¶ 41. We typically think of the "cost shift" as burdening commercial ratepayers with care delivery costs that are not covered by public payer reimbursements. However, this transfer of billing functions from VHC to the carriers has the same effect. Costs are being shifted from public payers, where half or more of the costs are borne by the federal government, to a small population of commercial ratepayers,

resulting in an impact on rates that is not insignificant. While the carriers will incur these costs and the rates need to support those increased costs, it is a frustrating dynamic.

VI.

Finally, consistent with our obligation to consider changes in health care delivery and changes in payment methods, we again strongly encourage BCBSVT to offer truly fixed prospective payments to health care providers in its network. The more risk BCBSVT is able to share with providers, the less capital it needs to support its operations and the less CTR it may need to request in its rates. To the extent fewer claims need to be processed, administrative expenses may be reduced as well. Findings, ¶ 55. Providers have also expressed a desire for more truly fixed payments, which they say provide them with greater predictability, stability, and flexibility. We believe that more widespread adoption of fixed prospective payments is likely to enhance affordability, promote quality care, promote access to health care, and protect insurer solvency.

Order

For the reasons discussed above, we modify and then approve BCBSVT's 2022 Individual and Small Group Rate filings. Specifically, we require that BCBSVT: 1) reflect the impact of ARPA on claims, resulting in a change to the population morbidity adjustment of +0.7%, which is a reduction from the +0.8% as filed; 2) reflect updated risk adjustment transfers, resulting in a change to risk adjustment of -0.9%; 3) reflect the IRS-required changes implemented by DVHA to the Standard Bronze HDHP, with no material impact on rates; 4) reflect updates to allowed medical cost trend based on a 1.0% reduction from submitted 2022 rates for facilities and providers affected by the Board's hospital budget review process and reported updates to negotiations with other facilities; resulting in a 0.2% impact on trend from 2021-2022; and 5) lower its base CTR assumption from 1.5% to 1.0%.

We note that many Vermonters will receive federal subsidies to cover the increased costs in 2022, and we encourage Vermonters to use VHC's Plan Comparison Tool[6] (available beginning this Fall) when determining their best plan options.

SO ORDERED.

Dated: August 5, 2021, at Montpelier, Vermont

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

[6] Available at https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

s/ Maureen Usifer)
)
s/ Tom Pelham)

Pelham, concurring.

I concur with the Board's decision to modify and then approve BCBSVT's 2022 Individual and Small Group Rate Filings. I understand the disruptions to the rate review process caused by the pandemic and the opportunities afforded by the recent federal changes attributable to the American Rescue Plan Act (ARPA). The former has severely muddied the actuarial information available to the carriers and the Board and the latter has provided the opportunity to favorably adjust small group premiums while leaving net individual premiums, inclusive of expanded federal subsidies, essentially stable. First addressing these unique pressures and opportunities is the responsible approach.

Rate review and ACO and hospital budget review are the most powerful levers available to the Board to foster Vermont's health care reform goals, but each comes just once a year. During the current individual and small group rate reviews, there are a couple of foundational priorities crucial to Vermont's healthcare reform efforts that did not receive the attention they deserve, though hopefully only postponed. These include pushing insurance carriers to engage in payment reforms more actively, especially reforms such as capitated payments that decouple our current payment systems from fee-for-service, and the Medicaid cost shift that pushes commercial rates higher.

Capitation: From CMS to AHS leadership and on down to presentations to the Board by national experts, fixed prospective payments (FPPs) and capitated payments have been fully embraced. Improvements in health care quality and costs hinge on payment reform. The All-Payer ACO Model Agreement Implementation Plan issued by the Agency of Human Services in November 2020 recommends taking the following regulatory action to support the Model:

> The GMCB and AHS will request that BCBSVT, MVP, and OneCare Vermont identify clear milestones for including fixed prospective payments in contract model design.

In our Fiscal Year 2021 ACO Budget Order, we required OneCare Vermont to work with payers to propose a target for FPPs, as well as a strategy for achieving those goals. OneCare has responded with very aggressive expectations for non-fee-for-service and full capitation-based payment targets by payers.

During this rate review process, we can clearly see that carriers embrace the concept of value-based payment reforms but have yet achieved little relative to capitated and true fixed prospective payments in practice. While BCBSVT notes that it "has supported and participated in the state's all payer model health care reform effort since its inception" and is "currently working to expand fixed prospective payments with willing providers," the company concludes:

> Although measurable progress toward the State's scale goal was achieved by the attribution of several thousand BCBSVT large group members to OneCare, an analysis of 2019 results

> indicates that OneCare's performance did not result in savings relative to the medical expense. Because the performance to date of this arrangement gives no clear basis for projecting savings in the near term, this filing does not include any adjustment to projected expenditures related to the OneCare program.

Ex. 1 at 7 – 8 (emphasis added). Based on the 2019 Experience Period Index Rates profiled at Exhibit 9 pages 4 and 5 for the Individual and Small Group Rate Filings respectively, BCBSVT had just 0.76% and 1.58% in capitated claims payments relative to total claims.

Cost Shift: The VHC billing provisions in carrier filings are clearly a cost shift from the Department of Vermont Health Access (DHVA) onto ratepayers' premiums and an addition to the massive amounts of Medicaid cost shift already imbedded in ratepayer premiums. BCBSVT says this clearly in Exhibit 1, page 8, when it states "Shifting the billing for Vermont Health Connect from DHVA to the carriers is moving the cost for this service from the state to ratepayers…". For BCBSVT this cost shift amounts to about $727,000 or $3.82 PMPM. While it appears that this transition will enhance the overall efficiency of the billing process, all the financial benefit accrues to DHVA as the burden gets shifted to rate payers. I understand how difficult it might be to carve out this particular increase from premiums in the context of unmerging individual and small group premiums, both practically and legally, but hoped we might find a path to that end, which we did not.

While the challenges of COVID-19 and the unmerging of the individual and small group markets have commanded the attention of carriers and the GMCB, we need to stay mindful that payment reform and the mitigation of the cost shift are foundational elements of Vermont's health care reform effort. These efforts need the persistent attention of all stakeholders if Vermonters are to garner the promised benefits of reform in the near future.

Filed: August 5, 2021

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.