STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Blue Cross and Blue Shield of Vermont Third Quarter 2021 Large Group Rating Program Filing	))))	GMCB-001-21rr SERFF No.: BCVT-132713612
In re:	The Vermont Health Plan Third Quarter 2021 Large Group Rating Program Filing	)))	GMCB-002-21rr SERFF No.: BCVT-132713919

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board (GMCB or "the Board"), which must approve, modify, or disapprove each filing within 90 calendar days. 8 V.S.A. §§ 4062(a), 4515a, 4587, 5104. On review, the Board must determine whether a proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to Vermont law. 8 V.S.A. § 4062(a)(3).

This decision pertains to the large group rating program filings of Blue Cross and Blue Shield of Vermont (BCBSVT), a non-profit hospital and medical service corporation, and The Vermont Health Plan (TVHP), a licensed health maintenance organization and for-profit subsidiary of BCBSVT. The approved rates will be used by BCBSVT and TVHP to determine the premiums of experience-rated fully insured large groups with over 100 employees.

Procedural History

On February 10, 2021, BCBSVT and TVHP (hereinafter referred to collectively as either BCBSVT or "the carrier," except when specified) submitted their Large Group Rating Program rate filings to the Board via the System for Electronic Rate and Form Filing (SERFF). Because the filings incorporate the factor and rate development from combined BCBSVT and TVHP experience, we review both filings concurrently.

On February 12, 2021, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid representing the interests of Vermont health insurance consumers, entered an appearance as a party to the filings. On April 9, 2021, the Department of Financial Regulation (DFR) filed its analysis and opinion regarding the filings' impact on the carrier's solvency. On April 12, 2021, the Board's contract actuary, Lewis & Ellis (L&E) submitted an

actuarial memorandum evaluating the filings ("L&E Memo"). Each of these documents was subsequently posted on the Board's rate review website.[1]

The Board solicited written public comments on the filings through April 27, 2021; no member of the public provided comment. Pursuant to GMCB Rule 2.000, § 2.309(a)(3), the Board elected to render a decision based on the record, without a hearing, and invited the HCA and BCBSVT to submit memorandums in lieu of hearing.

Findings of Fact

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides coverage to individuals, small and large group employers, and Medicare enrollees in Vermont. TVHP is a licensed health maintenance organization and a for-profit subsidiary of BCBSVT. TVHP provides large group coverage to employers in Vermont. L&E Memo at 1.

2. These filings apply to the carrier's large group products, including Cost Plus products, and establish the formula, manual rate, and accompanying factors the carrier will use to establish premiums for large group renewals. *Id.*

3. The filings are projected to affect 5,828 members (3,423 subscribers) in 36 groups. BCBSVT Actuarial Memorandum (BCBSVT Memo), 2.

4. As originally submitted, the filing would have resulted in an expected average premium change of -0.6% or roughly -$4.05 per member per month (PMPM). *Id.* at 4; L&E Memo at 1.

5. In responding to questions from L&E, the carrier discovered an error in the calculation of its administrative charge. After correcting the error, the carrier expects the filings, if approved, will result in an average premium change of -1.7% or approximately -$11.48 PMPM. The projected change results from a 0.6% increase to projected claims (premium impact of +0.6%), a 63.7% increase in projected pharmacy rebates (premium impact of -2.4%), and a 1.7% increase in administrative charges (premium impact of +0.1%). L&E Memo at 2; BCBSVT Memo at 4.

6. BCBSVT calculated the expected average premium change of -1.7% for a hypothetical group that is renewing with zero experience credibility, exactly average demographics and industry, and no underwriting judgment or management discretion applied to the proposed or in-force rates. BCBSVT Memo at 4.

7. The actual rate change for any particular group, or even averaged across all groups, may differ from the -1.7% average premium change because the filed rating formula incorporates experience which has not yet occurred. Each group's rate increase or decrease will account for its recent claims experience, changes in the distribution of members enrolled, and changes in benefit. L&E Memo at 2.

[1] The SERFF filings, as well as all documents referenced in this Decision and Order, can be found in the rate review section of the Board's website at http://ratereview.vermont.gov/BCBSVT-LG-BCVT-132713612 (BCBSVT) and http://ratereview.vermont.gov/tvhp-rate-review-open-for-review (TVHP).

8. BCBSVT had better than expected claims experience. Projected claims are expected to increase only 0.6% over what was assumed in the prior filing despite an annual paid trend of 7.7%, which implies that paid claims in the experience period were approximately 7.0% lower than what had been expected in the most recent large group filing. Claims used were incurred from July 2019 through September 2020, with March through May 2020 removed because these months were significantly impacted by disruptions to utilization patterns caused by the COVID-19 pandemic. *Id.* at 2-3.

9. To develop medical trend, the carrier used claims incurred between March 2016 and February 2020, a period which excludes any meaningful impact from COVID-19. The data include claims from BCBSVT Cost Plus groups; BCBSVT Administrative Services Only groups with fewer than 1,001 members; BCBSVT Insured Small and Large Groups including small groups enrolled in Qualified Health Plans; BCBSVT insured Association Health Plans (AHPs), and TVHP insured Small and Large Groups. Adjustments were made to the data to reflect network differences between BCBSVT and TVHP. *Id.*

10. For all products combined, the carrier is requesting a total allowed medical trend of 5.9% per year, broken down into 5.6% for hospital claims, 3.6% for professional claims, and 13.8% for outpatient drugs. *Id.* at 3. Medical trend is composed of unit cost trends and utilization and intensity trends. BCBSVT Memo at 10; *see* L&E Memo at 3-5.

11. The unit cost trend for medical costs is projected to be 4.2%. This figure reflects an assumption that commercial rate increases approved for hospital budgets in 2021 and 2022 will return to the levels approved in 2019, rather than the slightly elevated levels approved in 2020, which reflected impacts of COVID-19. BCBSVT Memo at 9; L&E Memo at 4. Unit costs for facilities and providers subject to GMCB hospital budget review are projected to increase 4.7% and unit costs for other BCBSVT service area providers are projected to increase 3.7%. Projected unit cost increases for providers outside the BCBSVT service area were derived from the confidential BlueCross BlueShield Association Blue Trend Survey. L&E reviewed confidential material provided by the carrier as support for the medical unit cost trend assumptions and found the assumptions to be reasonable and appropriate. L&E does not recommend any changes to the medical unit cost trend assumptions. L&E Memo at 4.

12. Consistent with last year's filing, BCBSVT isolated claims related to "outpatient drugs," which are pharmaceuticals that are typically dispensed in an outpatient medical facility, not a retail setting, and which are covered by the medical benefit and paid for by medical deductibles and cost sharing. The annual outpatient drug cost increases for the years ending in February 2018, 2019, and 2020 were 5.4%, 15.5%, and 8.4% respectively. The carrier assumed a 13.8% increase in cost per year for outpatient drugs. L&E noted that this increase is on the high end of trends observed in recent years but found it to be reasonable in light of the historical variability and the introduction of new drugs which were not available during the experience period. L&E Memo at 4.

13. The carrier chose a utilization trend of 0.6% per year for facility claims and 1.1% for professional and ancillary claims, averaging to an overall non-drug medical utilization trend assumption of about 0.8% per year. The carrier normalized the allowed costs to remove the impact of unit cost changes and isolate the change in utilization and intensity of services. As in past filings, the carrier relied on historical utilization changes using various regression algorithms to project

future utilization. The different methods produced varied results, indicating uncertainty in the projected utilization trend. Nevertheless, the data suggest that the underlying trend over the last four years has variability such that a 90% confidence interval would be from about 0.0% to 2.9% per year. L&E believes that BCBSVT's medical utilization trend assumption of 0.8% per year is reasonable. L&E Memo at 3.

14. L&E's estimated range for the total allowed medical trend is 3.6% - 7.9%, not considering the clinical input that went into the outpatient drug projection. L&E believes BCBSVT's assumed total allowed medical trend of 5.9% is reasonable in light of the known and likely hospital budget increases and the consistent pattern of increasing utilization in recent years. L&E Memo at 5.

15. BCBSVT requests a total allowed pharmacy trend of 11.0%, which includes the impact of contracting changes with the Pharmacy Benefit Manager. The aggregate assumption is composed of non-specialty utilization trend; generic cost trend, separately for new and established generics; brand cost trend, separately for new and established brands; impact of brands going generic; specialty trend; and vaccines, over the counter medications, and compounds. The carrier modeled the costs for generic and brand drugs separately but combined the data to analyze utilization patterns. BCBSVT Memo at 17; L&E Memo at 5. The utilization trend for non-specialty drugs is projected to be 3.5% per year based on historical utilization rising steadily during 2019 and 2020, even after the one-time effects from COVID-19 are taken into account. L&E Memo at 6. The carrier calculated unit cost trends of 1.1% for generic drugs, 7.1% for brand drugs, and -48.4% for brand drugs going generic during the projection period. *Id.* The carrier modeled specialty drugs separately due to their high cost and low frequency, with an annual trend of all non-specialty drugs of 4.5% and an annual trend of specialty drugs of 19.6%. *Id.* at 6-7. L&E observed that historical costs for specialty drugs have increased at a steady, high rate for several years, with the years ending August 2018, 2019, and 2020 exhibiting cost increases of 21.0%, 20.2%, and 17.6% respectively. L&E found the total pharmacy allowed trend of 11.0% to be reasonable in aggregate, as well as when analyzed by the components described above. *Id.* at 7.

16. Using medical claims experience incurred July 1, 2019 to February 29, 2020 and June 1, 2020 to September 30, 2020, and pharmacy claims incurred November 1, 2019 through October 31, 2020, BCBSVT calculated a total allowed trend of 6.8%. BCBSVT Memo at 18; L&E Memo at 7. L&E took a long-term view of historical claims and estimated a likely range of annual allowed trends between 5.4% and 9.0%. L&E noted that BCBSVT's trend development, which considers other factors and short-term changes, produced an overall trend factor that is slightly below the midpoint of L&E's range, which L&E believes provides additional validation that BCBSVT's trend development is producing a reasonable overall result. L&E Memo at 7.

17. To account for the leveraging effect of deductibles and copays, BCBSVT used its benefit relativity models to convert the allowed trends into paid trends. L&E found the carrier's approach to adjusting allowed trends to paid trends to be reasonable and appropriate. The carrier calculated a 6.8% paid medical trend and an 11.6% paid pharmacy trend. *Id.* at 8.

18. The proposed administrative charge in this filing is $54.71 PMPM, having been reduced from $61.50 PMPM after the carrier discovered an error during L&E's review. The administrative experience for this filing is January 2020 through November 2020, although transitional costs related to one-time events such as enabling full-time remote work were removed. Those costs are

allocated to groups on a per-account, per-member, or per-contract basis. The administrative charge has increased by $0.89 PMPM over last year. The increase is attributable to the interaction of three factors. First, the actual 2020 administrative costs were less than anticipated in the prior filing, which has a -$2.52 PMPM impact. Second, BCBSVT projects a 6.2% decrease in overall membership across all lines of business, resulting in fewer members over which to spread fixed costs. BCBSVT included the full amount of fixed costs in its calculation of the administrative charge but reduced the variable costs in line with the decrease in membership, resulting in a +$2.24 PMPM impact. Third, BCBSVT assumed administrative cost inflation of 2.2% based on its expectation that wages and benefits will rise by 3.0%[2] while other operating costs and membership will remain at current levels. This assumed cost trend has a +$1.17 PMPM impact on the administrative charge. *Id.*; BCBSVT Memo at 31.

19. The administrative charge has increased by 34% since the 2019 Q3 Large Group filing, where it was $40.85 PMPM. The increase is split about evenly between 1) a 15% increase in expenses driven by new operating systems, management software, IT security enhancements, and inflationary increases in vendor costs; and 2) a 16% change from reduced enrollment and a change in the mix of enrolled membership. The premiums also include allowances for state mandates and assessments. L&E found the carrier's methodology appropriate for the components of the administrative charge and noted that an even higher increase to administrative costs would be supportable. L&E Memo at 9.

20. For federal fees, H.R. 1865- Further Consolidated Appropriations Act repealed the ACA's Section 9010 insurer fee for 2021. Therefore, the health insurance providers fee is not included in the proposed rates. The Patient-Centered Outcomes Research Institute Fee of $0.24 PMPM was found reasonable by L&E. *Id.*

21. BCBSVT proposes a 1.5% Contribution to Reserves (CTR) for BCBSVT Insured Large Groups; 0.375% CTR for BCBSVT Cost Plus Groups; and 2.0% CTR for all TVHP groups. Last year the CTR was 1.5% for all insured large groups. The increase for TVHP stems from the different tax treatment of TVHP as a result of the Tax Cuts and Jobs Act of 2017. While BCBSVT is no longer subject to income tax, TVHP is and requires a higher pre-tax amount to result in an equivalent post-tax CTR. L&E believes the proposed CTR is reasonable to maintain Risk Based Capital (RBC) levels. *Id.* at 9-10.

22. L&E recommends the Board approve the filing with the corrected administrative charge, resulting in a revised anticipated average premium change of -1.7%. L&E believes that, with the corrected administrative charge, the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. *Id.* at 9.

23. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR provided the Board with its assessment of the impact of the proposed filings on the carrier's solvency. DFR noted that BCBSVT's surplus and RBC ratio, two important indicia of solvency, have worsened compared to the prior year end. The carrier's RBC ratio remains below its targeted range as of December 31, 2020. DFR noted that the second and final payment of BCBSVT's alternative minimum tax (AMT) refund, worth

[2] BCBSVT states that it applied the administrative trend increase through 2020 and from 2021 to 2022, but that it assumed no trend for 2021 given decisions regarding cost of living increases in 2021. *See* BCBSVT Memo at 31.

approximately $18 million, was not received in 2020 and is expected in the second quarter of 2021. DFR also noted the uncertainty caused by the COVID-19 pandemic, including the costs of treating COVID-19 infected patients in both the short and long term, the ability of individuals and businesses to afford health insurance premiums given current economic conditions, and whether the reduction of medical services during the pandemic reflects medical services deferred or permanently foregone. DFR cautions that any downward adjustments to the rate that are not actuarially supported would likely further erode the carrier's surplus and RBC ratio but does not expect the proposed rate to have a significant impact on its overall solvency assessment of BCBSVT. DFR Solvency Analysis at 1-2.

24. BCBSVT submitted a memorandum in lieu of hearing on April 21, 2021 arguing that the Board should approve the filing as recommended by L&E. The HCA did not submit a memorandum in lieu of hearing.

Standard of Review

The Board reviews rate filings to determine whether a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State" and is not "excessive, inadequate, or unfairly discriminatory." 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b). Although the latter terms - excessive, inadequate, or unfairly discriminatory - are defined actuarial standards, other standards by which the Board reviews rate filings 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 Board additionally takes into considerations changes in health care delivery, changes in payment methods and amounts, and other issues in its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

In arriving at its decision, the Board must consider DFR's analysis and opinion regarding the impact the proposed rate will have on the insurer's solvency and reserves. 8 V.S.A. § 4062(a)(2)(B), (3). The Board must also consider any public comments received on a rate filing. 8 V.S.A. § 4062(c)(2)(B); Rule 2.000, § 2.201. The insurer bears the burden of justifying its requested rate. Rule 2.000, § 2.104(c).

Conclusions of Law

The ongoing pandemic serves to heighten the inherent tension in our standard of review, which we have noted in prior decisions. *See, e.g., In re: Blue Cross and Blue Shield of Vermont Third Quarter 2020 Large Group Rating Program Filing*, GMCB-002-20rr; *In re: The Vermont Health Plan Third Quarter 2020 Large Group Rating Program Rate Filing*, GMCB-003-20rr, Decision and Order (July 17, 2020) (hereinafter "2020 BCBSVT/TVHP LG Order"), 8. On the one hand, we are required, without specific statutory guidance or a standardized definition, to consider whether the proposed rate is affordable to 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 yet another of our review criteria. Our task, then, is to strike an appropriate balance between achieving the most affordable rates possible, while

also safeguarding the financial solvency of our health insurers. With that in mind, we will turn to the specific issues in BCBSVT's large group filing.

First, we accept our actuaries' assessment that, after correcting the administrative charge, the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory. *See* Findings of Fact (Findings), ¶ 22.

L&E analyzed BCBSVT's development of allowed medical and pharmacy trends and found that the trends outlined in the filing are reasonable. *See* Findings, ¶¶ 11 - 15. L&E also noted that BCBSVT's projected total allowed trend of 6.8% is slightly below the midpoint of the range that L&E calculated by taking a long-term view of historical claims – a view that did not account for some of the factors and short-term changes that BCBSVT considered in its trend development. This provides additional validation that BCBSVT's methodology has produced a reasonable result. *See* Findings, ¶ 16. L&E also found that BCBSVT used a reasonable approach to adjusting allowed trends to paid trends. Findings, ¶ 17.

With respect to BCBSVT's development of the administrative charge increase of $0.89 PMPM,[3] we note that BCBSVT made adjustments that prevented the increase from being higher. In particular, BCBSVT developed its proposed administrative charge as if it had reduced its variable costs consistent with a 6.2% decrease in membership. Findings, ¶ 18. Even with this adjustment, the proposed administrative charge has increased 34% since the 2019 Q3 Large Group filing, when it was $40.85 PMPM. Approximately half of this increase is due to enrollment changes (a reduction in membership and a change in the mix of enrolled members) and approximately half is due to an increase in total expenses. *See* Findings, ¶ 19.

Related to the affordability criterion in our standard of review is the expectation that BCBSVT and TVHP provide benefits and services at minimum cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c), 4584(c), 5104(b). We have repeatedly encouraged BCBSVT to find innovative ways to increase efficiencies and limit increases in administrative expenses as the membership over which these costs are spread has decreased. *See* 2020 BCBSVT/TVHP Order at 10. While adjusting cost projections to reflect cost reductions that have not occurred will help limit administrative charge increases for this block of business in the short term, is not a sustainable approach for the carrier. BCBSVT must take steps to realize actual cost savings equivalent to its ongoing, continuing membership declines. *See id.* at 11.

Approving the rates as filed is not expected to have a significant impact on BCBSVT's solvency. Findings, ¶ 23.

Due largely to increased pharmaceutical rebates, the filing is expected to make premiums more affordable, with the overall average premium change expected to be -1.7% or -$11.48 PMPM. Findings, ¶ 5.

[3] The $0.89 PMPM increase assumes that membership will remain at current levels. Given the historical decline in membership for this block of business, we are concerned that the true increase may be higher.

Finally, consistent with our duty to consider changes in health care delivery and changes in payment methods, we strongly encourage BCBSVT to change the way it pays health care providers. We believe such changes have the potential to enhance affordability, promote quality care, promote access to health care, and protect insurer solvency.

In its Plain Language Summary for this filing, BCBSVT describes its mission and vision as "giving our members access to high-value health care while responsibly managing healthcare costs." To that end, BCBSVT states that it "seeks to improve the health of Vermonters by promoting preventive care and healthy lifestyles . . . and work[s] with providers on strategies to improve health care services and reduce health care costs." The GMCB and the State of Vermont share the mission and vision outlined by BCBSVT. *See* 18 V.S.A. § 9372. Central to its achievement is accelerating the transition to fixed prospective payments across all payers in Vermont. With a true fixed prospective payment "there is no reconciliation of the prospective payment to the fee-for-service equivalent. Providers prefer this model because fixed prospective payments provide predictability, stability, and flexibility." Vermont Agency of Human Services, *Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement* (Nov. 19, 2020), 9. "The pandemic has demonstrated that fixed prospective payments can create stability for the health care system and preserve access to care in-light-of changes in health care utilization." *Id.* at 5. "Because population-based payments are fixed and offered prospectively, they provide the strongest incentive for providers to engage in delivery system transformation." *Id.* at 11. Given the above, BCBSVT should substantially increase the percentage of claims paid through fixed prospective payments.

In addition to the specific areas discussed above, we remind the carrier of our expectation, voiced in prior decisions and again today, that the carrier should promote parity in reimbursements between academic medical centers, community hospitals and independent practices and that reimbursements should reflect actual costs of care, rather than site of service.

ORDER

For the reasons discussed above, we approve the BCBSVT and TVHP large group rating program filings with the corrected administrative charge, resulting in an anticipated average premium change of -1.7%.

SO ORDERED.

Dated: May 7, 2021 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes)
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s/ Robin Lunge)
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s/ Tom Pelham)
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s/ Maureen Usifer)

GREEN MOUNTAIN CARE BOARD OF VERMONT

Filed: May 7, 2021

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

NOTICE TO READERS: This document 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, if any, must be filed with the Board within ten days of the date of this decision and order.