STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Blue Cross and Blue Shield of Vermont Third Quarter 2022 Large Group Rating Program Filing	))))	GMCB-001-22rr SERFF No.: BCVT-133154621
In re:	The Vermont Health Plan Third Quarter 2022 Large Group Rating Program Filing	)))	GMCB-002-22rr SERFF No.: BCVT-133154563

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board (GMCB or Board). 8 V.S.A. §§ 4062, 4515a, 4587, 5104. 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 17, 2022, BCBSVT and TVHP (hereinafter referred to collectively as "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 25, 2022, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid that represents the interests of Vermont health insurance consumers, entered an appearance as a party to the filings. On April 15, 2022, the Department of Financial Regulation (DFR) filed its analysis and opinion regarding the impact of the filings on the carrier's solvency (Solvency Opinion). On April 18, 2022, Lewis & Ellis, the Board's contract actuary, 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]

[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 https://ratereview.vermont.gov.

The Board solicited public comments on the filings through May 3, 2022. No member of the public provided comment. The parties waived a hearing and filed memorandums of law on May 3, 2022. *See* GMCB Rule 2.000, § 2.309(a)(1), (c).

Findings of Fact

1. BCBSVT is a non-profit hospital and medical service corporation that 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, 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 that the carrier will use to establish premiums for large group renewals. *See* L&E Memo, 1.

3. The filings are projected to affect 6,396 members (3,563 subscribers) in 38 groups. *See* L&E Memo, 1; BCBSVT and TVHP Actuarial Memorandums (Carrier Memos), 2.

4. The changes to the rating formula and factors proposed in the filings are expected to increase premiums by approximately 7.9%, or roughly $52.41 per member per month (PMPM). This is the increase that could be expected by a hypothetical group renewing with zero experience credibility, exactly average demographics and industry, and no underwriting judgment or management discretion applied to the proposed in-force rates. Carrier Memos, 4. The actual rate change for any group, or even averaged across all groups, may differ from the 7.9% because the filed rating formula incorporates experience which has not yet occurred. *See* L&E Memo, 2.

5. The projected Medical Loss Ratio (MLR) for 2023 is 89.3% for BCBSVT and 88.5% for TVHP. Carrier Memos, 37. The minimum MLR for these plans is 85.0%. 45 CFR § 158.210(a).

6. For the combined BCBSVT and TVHP block that is used for rate development, the projected claims are expected to decrease 4.0% from what was assumed in the prior filing. The claims used were incurred from November 2020 through October 2021, paid through December 2021. While total claims were substantially higher during the experience period than projected, resulting in financial losses on this business, the removal of COVID claims and catastrophic claims estimates lower claims below what was anticipated.[2] L&E Memo, 2 - 3.

7. Medical trend varies by company and plan type due to contracting differences. For all products combined, the carrier is requesting a total allowed medical trend of 7.5% per year, broken down into 7.8% for hospital claims, 14.6% for mental health professional claims, 5.6% for other professional claims, and 7.3% for outpatient drugs. L&E Memo, 3.

[2] COVID claims were considered to be one-time events and were not included in the development of the manual rate. Additionally, catastrophic claims, which fluctuate year-over-year, were replaced by a long-term average pooling charge in order to maintain stability in the premiums. This pooling charge was significantly less than actual catastrophic claims during the base period. L&E Memo, 3.

8. Medical trend is comprised of unit cost trends and utilization and intensity trends. Carrier Memos, 10. The carrier projects a 5.2% unit cost trend for medical costs. L&E Memo, 5. This projection includes a 5.6% unit cost increase for Vermont facilities and providers impacted by the Board's hospital budget review and a 4.9% unit cost trend for other facilities and providers. *Id.*

9. The projected 5.6% increase for facilities and providers impacted by the Board's hospital budget review assumes that fiscal year 2023 hospital budgets will increase from approved fiscal year 2022 levels. L&E Memo, 5. For other providers within the carrier's service area, the carrier works with its contracting team to include expected increases to fee schedules. Carrier Memos, 9. Projected unit cost increases for providers outside the carrier's service area were derived from the confidential BlueCross BlueShield Association Blue Trend Survey. L&E Memo, 5.

10. 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 carrier's medical unit cost trend assumptions. L&E Memo, 5.

11. To develop its medical utilization and intensity trend, the carrier normalized allowed costs to remove the impact of unit cost changes and isolate the changes in utilization and intensity of services. To reduce fluctuation and capture only trend, the carrier also removed outlier claimants. The data was then analyzed using exponential regression and other methods. L&E Memo, 3.

12. The carrier chose a medical utilization trend of 2.4% per year for facility claims and 2.4% for professional and ancillary claims, which average to an overall non-drug medical utilization trend assumption of around 2.4% per year. L&E Memo, 3.

13. L&E notes that, in past filings, the carrier has consistently relied on historical utilization changes to project future utilization changes, using various regression algorithms. However, the disruptions to healthcare provision during the COVID-19 pandemic has resulted in a unique historical situation that is not likely to be indicative of long-term trends. See L&E Memo, 4.

14. The carrier projects that the level of facility utilization will return to pre-pandemic levels observed in the year ending February 2020. The historical and assumed trends are reflected in the following table:

Year Ending	Normalized Facility Claims PMPM	Annualized Trend
February 2019 (Actual)	$306.73	
February 2020 (Actual)	$299.16	- 2.5%
August 2021 (Actual)	$283.18	- 3.6%
December 2022 (Projected)	$292.50	+ 2.5%
December 2023 (Projected)	$299.16	+ 2.3%

L&E Memo, 4.

15. L&E concluded that the carrier's assumption that hospital utilization will return to pre-pandemic level appears reasonable. L&E noted that, given that there was a slight reduction in utilization leading up to the COVID-19 lockdowns, it is possible that there is a more long-term

downward trend in utilization that compounds the observed drops during COVID-19. L&E Memo, 4. However, L&E also concluded that it is reasonable given the uncertainty at this time to assume that facility utilization will return to pre-pandemic levels. L&E Memo, 4.

16. L&E notes that professional services saw even more extreme disruption due to COVID-19 than facility claims; treatment for mental health issues has risen steadily and other professional services have fallen sharply. However, both of these patterns were actually more pronounced in the period leading up to the pandemic than during it. Thus, it is difficult to be certain to what extent utilization should be expected to rebound. The carrier assumes mental health claims will continue to rise at 10% per year while other professional services will rebound to their pre-pandemic levels. The historical trends and the carrier's assumed trends are shown in the table below:

Year Ending	Normalized MH PMPM	MH Annual Trend	Normalized Other PMPM	Other Annual Trend	Normalized Total PMPM	Total Annual Trend
February 2019 (Actual)	$11.55		$127.25		$138.80	
February 2020 (Actual)	**$13.10**	13.4%	**$122.82**	-3.5%	$135.92	-2.1%
August 2021 (Actual)	$15.21	10.5%	$119.08	-2.0%	$134.29	-0.8%
December 2022 (Assumed)	$17.27	10.0%	$121.26	1.4%	$138.53	2.4%
December 2023 (Assumed)	**$19.00**	10.0%	**$122.82**	1.3%	$141.82	2.4%

L&E Memo, 4.

17. L&E notes that there is a tension between the carrier's assumption that non-mental health professional and facility claims will return to pre-pandemic levels and its assumption that mental health claims will continue to rise as they have during the pandemic. Noting that demand for mental health services has increased substantially due to COVID-19, L&E expresses concern that projecting a continuation of recent trends in mental health utilization into the future is likely to overstate future mental health costs. L&E also does not believe it is likely that sustained increases much more than the level assumed would even be possible given realities in the supply of qualified providers. L&E believes a best estimate should probably be less than 10% and recommends changing the assumed mental health professional utilization trend to 5% per year, which would reduce the proposed rates by approximately 0.3%. L&E Memo, 4 - 5.

18. Consistent with last year's filing, the carrier isolated claims related to "outpatient drugs."[3] L&E Memo, 5. To determine utilization trend, the carrier split outpatient drug experience into four categories: injections with biosimilar option; biosimilars; other injections costing at least $1,000; and all other pharmaceuticals. The resulting utilization trend was 1.8%. The carrier applied a unit cost trend of 5.4% to all outpatient drugs, resulting in an overall trend of 7.3% per year. L&E Memo, 5 - 6.

[3] These are pharmaceuticals that are typically dispensed in an outpatient medical facility, not a retail setting, and are covered by the medical benefit and paid for by medical deductibles and cost sharing.

19. The average annual outpatient drug cost increases for the twelve-month periods ending February 2018, 2019, 2020, and 2021 are reflected in the following table:

Year Ended	Annual Cost Increase – Outpatient Drugs
Feb 2021	13.4%
Feb 2020	8.4%
Feb 2019	15.5%
Feb 2018	5.4%

L&E Memo, 6.

20. L&E explained that the carrier's assumed 7.3% per year trend for outpatient drugs is comparable to outpatient Rx trends observed in recent years and concluded that it is reasonable given the historical variability. L&E Memo, 6.

21. The total allowed medical trend in the filing is 7.5%, as reflected in the following tables:

Medical Cost Type	Cost Trend	Utilization Trend	Total Allowed Trend
Facility	5.4%	2.4%	7.8%
Professional	4.2%	2.4%	6.7%
Total without Outpatient Rx	5.1%	2.4%	7.5%

Medical Cost Type	Total Allowed Trend
Total without Outpatient Rx	7.5%
Outpatient Rx	7.3%
Total	**7.5%**

L&E Memo, 6.

22. L&E's estimated range for total allowed medical trend is 4.95% to 9.7%. L&E notes that each of the numbers within its estimated range are not equally likely, and trends on the low and high end are not as likely to occur as trends in the middle of the range. L&E Memo, 6.

23. The carrier requests a total allowed pharmacy trend, including the impact of contracting changes with the Pharmacy Benefits Manager, of 9.9%. This 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 brand drugs going generic; specialty trend; and vaccines, OTC, etc. L&E Memo, 7.

24. The carrier modeled costs for generic and brand drugs separately but combined the data to analyze utilization patterns. A separate adjustment was then made to incorporate the impact of brand drug patent expiration, which results in a decrease in cost as lower-cost generics become available. L&E Memo, 7.

25. The following tables show the results of the carrier's analysis and requested 9.9% overall allowed pharmacy trend:

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend[4]
Generic	2.8%	1.3%	-1.5%
Brand	10.0%	1.3%	11.5%
Brands Going Generic	-30.3%	1.3%	-29.4%
Total Without Specialty	1.7%	1.3%	3.0%

Pharmacy Trends	Total Annual Trend[5]
Total Without Specialty	3.0%
Specialty	16.9%
Total	9.9%[6]

L&E Memo, 7.

26. The carrier's unit cost trend assumptions of 2.8% for generic drugs and 10.0% for brand drugs are consistent with recent observed cost trends for these categories. Unlike past filings, generic drugs were adjusted slightly to reflect the change in mix between established generics and new generics, which tend to have different average costs. A similar adjustment was made to brand drugs. *See* L&E Memo, 7.

27. When the patent expires for a brand drug, lower-cost generic alternatives become available. The carrier assumed a 30.3% reduction in price for these drugs during the projection period. *See* L&E Memo, 7.

28. L&E concludes that the carrier's assumed unit cost trends for generic, brand, and brand-going-generic are reasonable. L&E Memo, 8.

29. The carrier projects that the utilization trend for non-specialty drugs will be 1.3% per year based on historical utilization rising steadily from past levels during 2020 and 2021, even after the

[4] Total trend may not equal the combination of unit cost and utilization trend due to an adjustment for projected mix between new and established generics/brand.
[5] Total trend may not equal the combination of unit cost and utilization trend due to an adjustment for projected mix between new and established generics/brand.
[6] This figure includes the impact of contracting adjustments in addition to the trends by drug tier.

one-time effects of COVID-19 are accounted for. The 12-month increase in the year ending August 2021, adjusted for COVID-19, is 0.5%. The increase in the year ending August 2020 was 3.1%. Due to consistency between the projected utilization trend and historical utilization trend, L&E believes the proposed non-specialty utilization trend is reasonable. L&E Memo, 8.

30. Due to their high cost and low frequency, the carrier projected specialty drugs based on their total allowed costs, without splitting into unit cost and utilization. L&E agrees with the carrier's decision to analyze specialty cost trend this way. Unlike in prior filings, the carrier did not carve out particular high-cost drugs, given what it explained was the limited utility of this additional complexity. Rather, the carrier grouped all specialty claims into a single category for purposes of trend development. L&E believes this methodological change is reasonable. L&E Memo, 8.

31. Specialty drug costs have increased at a steady, high rate for several years. The years ending in August 2019, 2020, and 2021 exhibited cost increases of 16.7%, 24.2%, and 17.0% respectively. The carrier assumed specialty trend of 16.9% based on regression analysis of historical claims. L&E concluded this trend assumption is reasonable in light of historical increases in cost. L&E Memo, 8.

32. L&E concludes the carrier's 9.9% overall pharmacy allowed trend is reasonable in aggregate and when analyzed by its component parts. L&E Memo, 9.

33. The carrier's 7.5% total allowed medical trend and 9.9% total allowed pharmaceutical trend equate to a 7.9% total allowed trend, as reflected in the table below:

Category	Allowed Trend	Approx. Percent of Claims
Medical	7.5%	84%
Rx	9.9%	16%
Total	**7.9%**	**100%**

L&E Memo, 9.

34. L&E calculated a likely range of annual allowed trends between 4.5% and 10.6% and noted that the carrier's projected 7.9% trend and L&E's recommended 7.6% trend (reflecting a reduction to the mental health trend) fall well within L&E's calculated range. L&E Memo, 9.

35. While the carrier used allowed trends to analyze changes in cost and utilization, plan liability increases at the paid trend rate, not the allowed trend rate.[7] 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 9.0% paid medical trend (83% of claims) and a 10.6% paid pharmacy trend (approximately 17% of claims), for a total paid trend of 9.3%. L&E Memo, 9.

[7] Allowed cost trends are based on charges that reflect the total amount paid by the carrier and the policyholder, while paid trends reflect the actual claim payment made by the carrier only. Paid trends are usually higher because the member's share of cost is often limited to fixed copays, which do not increase with cost trend. L&E Memo, 3.

36. The proposed administrative charge in this filing is $54.94 PMPM, an increase of $4.53 PMPM over the approved administrative charge of $50.41 PMPM for 2022. The administrative experience for this filing is January 2020 through December 2020. Transitional costs related to one-time events were removed. The proposed $4.53 PMPM 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 -$1.75 PMPM impact (the decrease flows through to the projected 2022 and 2023 administrative costs). Second, the carrier has experienced a 13.0% decrease in overall membership across all lines of business between 2020 and 2022. Since fixed expenses will be distributed across a smaller pool of members, an increase in administrative charges results. The impact of membership declines on the administrative charge, however, is an increase of about 10.4% or $5.09 PMPM because carrier developed the administrative charge as if it had reduced variable costs (assumed to be 30% of total costs) with declining enrollment. Third, the carrier assumes an increase in wages and benefits of 3.0% per year, which is consistent with the prior filing, resulting in additional administrative costs of approximately $1.19 PMPM. L&E Memo, 10.

37. 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 a 15% increase in expenses and a 16% change from reduced enrollment and a change in the mix of enrolled membership. According to the carrier, the increased expenses are driven by a new operating system for enrollment, billing, and claims processing, which went live in 2019; new customer relationship management software; enhancements to the company's IT security program; and inflationary increases in vendor costs. L&E Memo, 10.

38. L&E concludes that the process for reflecting the most recent information available is actuarially sound and notes that a higher increase to administrative costs would be supportable because the carrier developed its administrative charge as if it had reduced variable costs with declining enrollment. L&E also notes that, by rebasing to 2020 costs, the carrier is fully reflecting all enrollment changes that occurred prior to 2020. In other words, the method the carrier is using to dampen the effect of enrollment changes on premiums has the effect of partially delaying recognition of enrollment changes for two years. L&E Memo, 10.

39. L&E also concludes that the carrier's assumptions regarding mandates and assessments appear to be reasonable and appropriate. L&E Memo, 10.

40. The carrier proposes a CTR of 1.5% for BCBSVT insured large groups, 0.375% for Cost Plus Groups, and 2.0% for TVHP insured large groups. As a result of the Tax Cuts and Jobs Act of 2017, BCBSVT is no longer subject to income tax. Because TVHP is subject to income tax, it requests a higher pre-tax CTR to achieve an equivalent post-tax CTR. L&E Memo, 11.

41. L&E recommends that the Board consider DFR's Solvency Opinion in evaluating the carrier's proposed CTR. L&E Memo, 11.

42. L&E's opinion is that, if the mental health utilization trend is reduced from 10% per year to 5% per year, as L&E recommends, the filing will not produce rates that are excessive, inadequate, or unfairly discriminatory. L&E Memo, 11.

43. 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 Risk Based Capital (RBC) ratio, two important indicia of solvency, have improved compared to the prior year end. The carrier's RBC ratio was within the targeted range as of December 31, 2021. DFR cautions that any downward adjustments to the rate that are not actuarially supported would likely erode the carrier's surplus and RBC ratio, but states that it does not expect the proposed rate to have a significant impact on its overall solvency assessment of BCBSVT. Solvency Opinion, 1.

44. In its Memorandum in Lieu of Hearing, the carrier argues that the filings produce rates that are affordable, promote quality care, promote access to health care, protect insurer solvency, are not unjust, unfair, inequitable, misleading or contrary to law, and are not excessive, inadequate, or unfairly discriminatory. The carrier urges the Board to approve the filings without modification. The carrier disagrees with L&E's recommendation to reduce the utilization trend for mental health services, arguing that the demand for mental health services was higher in the 12-month pre-pandemic period than during the pandemic and that, while COVID-19 has increased demand for mental health services, the mental health crisis is not getting better. With regard to the likelihood that capacity constraints will dampen the mental health utilization trend, the carrier asserts that it is actively engaged in initiatives to improve access to mental health providers, including telehealth. The carrier notes that the projected medical loss ratios (MLR) – 89.3% for BCBSVT and 88.5% for TVHP – exceed the minimum MLR of 85%. The carrier argues that this supports a finding that the rates produced by the filings are affordable. Carrier Memo in Lieu of Hearing.

45. In its Memorandum in Lieu of Hearing, the HCA argues that the carrier only offered evidence on whether the proposed rates are excessive, inadequate, or unfairly discriminatory, and failed to offer any evidence on whether the proposed rates are affordable, promote quality care, or promote access to health care. The HCA also argues that the carrier did not establish that the proposed rates are not excessive, inadequate, or unfairly discriminatory. Finally, the HCA argues that the carrier did not establish that the proposed rates are needed to protect the carrier's solvency, asserting that the carrier will likely receive money in the near future from litigation against the federal government and may also recover money in connection with litigation against Allianz Global Investors related to management of pension assets. HCA Memo 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

As we have noted in prior decisions, there is inherent tension amongst the factors we must consider in reviewing a rate filing and we seek to strike an appropriate balance between achieving the most affordable rates possible while also safeguarding the financial solvency of our health insurers. *See In re Blue Cross and Blue Shield of Vermont Third Quarter 2021 Large Group Rating Program Filing,* GMCB-001-21rr, *In re The Vermont Health Plan Third Quarter 2021 Large Group Rating Program Filing*, GMCB-002-21rr, Decision and Order (May 7, 2021), 6.

First, we accept our actuaries' recommendation to reduce the mental health utilization trend from 10% per year to 5% per year. *See* Findings of Fact (Findings), ¶¶ 17, 42. While the carrier assumes that non-mental health professional and facility claims will return to pre-pandemic levels, it assumes that professional mental health claims will continue to rise as they have during the pandemic. The carrier did not adequately justify the different assumption it made for professional mental health claims, and we agree with L&E that the assumption is likely to overstate future mental health costs. One reason that utilization of professional mental health services may not continue to increase at the high rate of 10% per year is because of capacity constraints. *See* Findings, ¶ 17. The carrier emphasizes in its Memorandum in Lieu of Hearing that the mental health utilization trend was higher in the 12-month pre-pandemic period than it has been during the pandemic. *See* Findings, ¶ 16. However, given that COVID-19 has increased the need and demand for these services, a higher pre-pandemic trend is not inconsistent with the potential that capacity constraints will limit continued utilization growth. Further, we do not find the carrier's response that it is actively engaged in initiatives to improve access to mental health providers specific enough to be convincing.

To be clear, we are ordering the carrier to reduce the rates slightly because we do not think it is likely that utilization of professional mental health services will be as high as the carrier projects. We are not suggesting that the payment levels be reduced for these services, or that the carrier not make efforts to expand access.

With respect to the carrier's proposed administrative charge increase of $4.53 PMPM, the carrier made adjustments that reduce the impact of enrollment declines. However, as L&E notes, these adjustments will only partially delay recognition of enrollment changes for two years. *See* Findings, ¶ 38. 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 and half is due to an increase in total expenses. *See* Findings, ¶ 37. As in past decisions, we strongly encourage the carrier to find innovative ways to increase efficiencies and limit increases in administrative expenses as its membership continues to decline.

Finally, consistent with our duty to consider changes in health care delivery and changes in payment methods, we continue to strongly encourage the carrier to change the way it pays health care providers and, in particular, to implement truly fixed prospective payments that are not subsequently reconciled to the spending that would have occurred under fee-for-service reimbursement. We believe more widespread adoption of fixed prospective payment approaches will enhance affordability, promote quality care, promote access to health care, and protect insurer solvency.

ORDER

For the reasons discussed above, we order the BCBSVT and TVHP to reduce the mental health utilization trend from 10% per year to 5% per year and approve the filings as modified.

SO ORDERED.

Dated: May 18, 2022 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes)
)
s/ Robin Lunge)
)
s/ Tom Pelham)
)
s/ Thom Walsh)

GREEN MOUNTAIN CARE BOARD OF VERMONT

Filed: May 18, 2022
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.