STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield of Vermont 2025 Individual Market Rate Filing	)))	GMCB-004-24rr SERFF No. BCVT-134091560

In re: Blue Cross Blue Shield of Vermont 2025 Small Group Market Rate Filing	)))	GMCB-003-24rr SERFF No. BCVT-134096633

PREFILED TESTIMONY OF DR. THOMAS WEIGEL

Dated: July 12, 2024

Attachments:

Attachment	Title
A	Dr. Thomas Weigel CV
B	May 13, 2024 Memorandum from Tom Weigel, MD and Ruth Greene to Martine Brisson-Lemieux (Attachment D to the rate filings)

Dr. Thomas Weigel, being duly sworn, deposes and says as follows:

What is your current employment?

I am the Chief Medical Officer at Blue Cross and Blue Shield of Vermont (Blue Cross VT). I have held this position since September 2022, and originally joined Blue Cross VT in December 2021.

Please describe your primary job responsibilities.

As Chief Medical Officer, I serve as the principal clinical spokesperson and executive responsible for the programs, budget, and resources of the Healthcare Informatics, Reimbursement and Management Division, which includes Pharmacy, Quality, Utilization Management, Case Management, and Medical Director Departments. I recommend and monitor clinical aspects of benefit administration, monitor the quality of health-care services, conduct quality improvement programs and participate in provider reimbursement development and value-based care initiatives.

Is your current CV attached to this pre-filed testimony as Attachment A?

Yes.

Have you given sworn testimony about past rate filings?

Yes. I testified at the July 19, 2023, hearing regarding our 2024 individual and small group rates.

As part of your employment responsibilities at Blue Cross VT, how do you stay informed?

As the Chief Medical Officer at Blue Cross VT, I stay informed through active participation in board meetings, executive staff meetings, and various committee and staff meetings. These interactions provide critical insights into the strategic direction and operational priorities of the company. I also collaborate closely with other departments, including data analytics, claims, and member services, to stay updated on internal performance metrics and member health trends. Leading and participating in these meetings ensures that I am continuously informed about internal developments and can make well-informed decisions to guide our healthcare policies and initiatives.

What materials did you review and rely on in preparing this pre-filed testimony?

I reviewed and relied on the following materials:

- Blue Cross and Blue Shield Vermont 2025 Vermont QHP Market – Individual Market Rate Filing, SERFF Tracking Number BCVT-134091560 (May 13, 2024)
- Blue Cross and Blue Shield Vermont 2025 Vermont QHP Market – Small Group Market Rate Filing, SERFF Tracking Number BCVT-134096633 (May 13, 2024)
- Blue Cross VT Responses to all questions posed by the Green Mountain Care Board (including those proposed by the HCA)
- Blue Cross VT Responses to all Lewis & Ellis Objection Letters in this matter
- Prices Paid to Hospitals by Private Health Plans (RAND 2024), *available at* https://www.rand.org/pubs/research_reports/RRA1144-2.html.

Are you aware that the Green Mountain Care Board, in evaluating Blue Cross VT's proposed rates, must assess whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency, and are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State?

Yes.

One of the criterion listed above is that the proposed rates "are affordable." Do you believe the proposed rates satisfy that criterion? Please explain your answer.

Yes, I believe the proposed rates satisfy the affordability criterion. Providing our members with access to the high-quality health care they need at the lowest possible cost to them is our core mission and the over-arching goal of everything we do.

We do understand that many of our members struggle to pay the premiums we have to charge in the individual and small group markets, and we understand that the proposed rates currently under review are no exception. That's why we undertake a host of programs aimed at reducing the cost of health care, thus enhancing affordability while also promoting quality and access to necessary care. Those programs are detailed in the May 13, 2024 memo I prepared, along with our CFO Ruth Greene, which was submitted as Attachment D to the rate filings. That memo is also attached to this pre-filed testimony as Exhibit B, and I adopt the contents of that memo as part of my testimony.

Please briefly describe the programs discussed in Exhibit B.

Our programs that enhance access, quality, and affordability span the following three categories: value-based payment models, Exh. B at 2-3; payment integrity, *id.* at 3-4; and integrated health management, *id.* at 4-7. Beyond those programs, we achieve additional savings for our members by managing our administrative costs aggressively and keeping them low,

especially for a plan of our size. *Id.* at 7. Our comprehensive network and world class member support further promote ready access to high-quality care for our customers. *Id.* at 7-8.

Why do you conclude that Blue Cross VT's proposed rates are affordable even though they outstrip economic indicators that reflect Vermonters' ability to pay, like household income and wage growth?

Blue Cross VT is aware of general economic indicators regarding wage growth, inflation, and household income. We also, of course, closely track increases in the price and utilization of the health care costs that we pay for. We are keenly aware that the growth of those health care costs outpaces increases in wages and household income. Compounding that challenge, Vermont's healthcare spending is a high outlier compared to the rest of the country. To begin with, according to the RAND 5.0 report cited above,[1] UVMMC operates at a staggering 317% of Medicare rates (Table 6.46), far exceeding the national norm for hospitals. As a reference, Dartmouth-Hitchcock operates at 191% of Medicare rates (Table 3) and the most expensive hospital in Massachusetts, Mass General-Brigham, operates at 231% of Medicare (Table 6.20).

The impact of those high UVMMC rates ripples across Vermont's entire healthcare system, because UVMMC absorbs about half (52%) of the total hospital spend for Blue Cross of Vermont. *See* Fiscal Year 2023 Vermont Hospital Reporting: Year-End Actuals at 7 (GMCB March 13, 2024) (showing UVMMC's FY23 year-end actual net patient revenue/fixed prospective payment of 1.739B against a systemwide total of 3.344B), *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY23%20Actuals%20Report%20Presentation-%20FINAL.pdf. That financial strain is exacerbated because here in Vermont, 47% of our total healthcare expenditure flows into hospitals, *see* 2020 Vermont Health Care Expenditure Analysis

[1] Prices Paid to Hospitals by Private Health Plans (RAND 2024), *available at* https://www.rand.org/pubs/research_reports/RRA1144-2.html.

https://gmcboard.vermont.gov/sites/gmcb/files/documents/2020_VT_Health_Care_Expenditure_Analysis_Final_May_9_2022.pdf, far above the national average of 30%. *See* Peterson-KFF Health System Tracker, *available at* https://www.healthsystemtracker.org/indicator/spending/drivers-health-spending-growth.

In the face of these hard realities, Blue Cross VT cannot develop rates based on individual member and small group employee income or small business finances. Even if we had perfect information about our members' incomes and small business finances, we would have no choice but to propose rates adequate to cover our projected claims costs regardless of how those rates compare to those data points.

That leaves us two levers we can control to propose rates that are as affordable as possible: The programs outlined above and described in Exhibit B that aim to reduce underlying health care costs, and the tight control we exert over our administrative costs. Because I believe we are doing everything we can on those two fronts, I conclude that the proposed rates are affordable in the context of this proceeding.

Does this conclude your Prefiled Testimony?

Yes.

Dated: July 12, 2024

Dr. Thomas Weigel, MD

State of Vermont, County of Washington.

Signed and sworn to (or affirmed) before me on July 12, 2024 by Dr. Thomas Weigel.

Signature of notary public: Angelina L Buzzi.

Printed name of notary public: Angelina L. Buzzi.

Commission number: 157.0000593.

Commission expiration date: January 31, 2025.

Title of office is Notary Public.

CERTIFICATE OF SERVICE

I certify that I served the above Prefiled Testimony of Dr. Thomas Weigel (dated July 12, 2024) on Michael Barber, Laura Beliveau, and Tara Bredice of the Green Mountain Care Board and on Charles Becker and Eric Schultheis of the Office of the Health Care Advocate, by electronic mail, on July 12, 2024.

/s/ Michael Donofrio

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EXHIBIT A
TO THE PREFILED TESTIMONY OF DR. THOMAS WEIGEL

Tom Weigel, MD, MBA

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(802) 458-2657

Innovative Physician Executive with outstanding track record of championing transformations that drive improvement in efficiency, productivity, clinical quality and treatment outcomes. Known for data-driven decision-making, expert clinical knowledge, and an innovative, creative approach to problem solving. Inclusive leader skilled in fostering collaborations, building consensus, and embracing change.

Experience

BLUE CROSS BLUE SHIELD OF VERMONT; BERLIN, VT 2021–Present

Vice President and Chief Medical Officer 2022-Present

- Oversee Pharmacy, Quality, Utilization Management, Case Management, Provider Relations and Medical Directors Departments, managing 80 FTEs and a $7M budget
- Shape clinical aspects of benefit administration and monitor healthcare service quality
- Drive quality improvement and value-based care initiatives

Senior Medical Director 2021-2022

- Serve as an integral contributor to the development of clinical strategy for business units throughout the organization in the context of regulatory guidelines and quality requirements
- Supply clinical validation of existing utilization management programs and develop new programs based on market research and competitive differentiation

DEPARTMENT OF MENTAL HEALTH (DMH), STATE OF VERMONT 2019–Present

Medical Director

- Serve as the Department's senior clinical leader by providing counsel to the Commissioner of Mental Health regarding a broad range of clinical, policy, programmatic, political and strategic issues.
- Led DMH team to assess and improve clinical quality and patient care experiences at the Brattleboro Retreat through a legislative mandate, Act 140.
- Improved DMH quality assessments of Vermont's Designated Hospitals, adding measures of patient care experience, readmission rates, length of stay, grievances, and data from the Behavioral Healthcare Performance Measurement System (BHPMS).
- COVID-19 Response: Served as DMH conduit to the Health and Safety Guidance and Restart Team, Health Operations Committee and State Emergency Operations Committees.
- Assess quality of care at Vermont's Designated Agencies and Hospitals for adherence to DMH's standards. Identify best practices and need for corrective actions.

ANXIETY INSTITUTE; GREENWICH, CT 2018–2019

Director of Integrative Psychiatry, Outpatient and Partial Hospital Programs

- Consult with Anxiety Institute clinicians and other referring professionals regarding client mental health care, case management and psychopharmacology. Provide diagnostic evaluations and ongoing clinical psychiatric care for clients in the outpatient and partial hospital programs.

MCLEAN HOSPITAL (AN AFFILIATE OF MASSACHUSETTS GENERAL HOSPITAL); Belmont, MA 2004–2017

Assistant Director of Clinical Measurement (Patient Reported Outcome Measures - PROMS) 2009–2017

- Created transparent view into medical team performance by working with clinical and system leaders including CIO and CMIO to design and implement electronic system for measuring patient symptoms and treatment outcomes in over 20 programs and 11 clinical subpopulations at all levels of care. This system provides individual patient and aggregate data reports and is a repository for research purposes with over 13,000 unique patient entries. Resulted in increased number of research publications and improved clinical care as rated by patients and staff.

Clinical eCare Director, McLean Residential and Partial Hospital Programs 2015–2017

- Leveraged role to analyze clinical workflow, documentation, regulatory requirements and gap analysis to plan for a standardized future state to launch into Epic (EMR). Service areas comprise 221 beds in 18 programs, including 7 satellite sites, utilizing both inpatient and outpatient Epic modules.

Chair, Medical Records Committee 2015–2017

- Eliminated inessential and redundant record requirements including over 20 forms and 16 patient signatures in child programs and 11 forms and 10 patient signatures in adult programs.

Associate Medical Director – Klarman Eating Disorders Center 2009–2017

- Led administrative and clinical oversight of a profitable insurance-based 20-bed residential treatment program. Doubled capacity by partnering in efforts to hire additional professional staff and spearheading redesign of patient/office space. Reduced medication errors and order rewrites by 75%.
- ***Quality Improvement****:* Active on multiple committees to improve quality and develop a culture of safety including Care Experience, Infection Control, Clinical Support Services, and Falls Prevention.
- ***EMR Creation/Development:*** Initiated funding, design, development, and implementation of first-generation electronic medical record (EMR) used for medical charting. Laid foundation for next generation highly functional, secure, and HIPAA-compliant EMR database. Current EMR database improved productivity, quality, and efficiency of medical charting, billing and scheduling. Processed over 300,000 patient-specific transactions in 2016 in 10 separate treatment programs.
- *Additional Committees:* Women's Mental Health Division Steering Committee; Adult Psychiatry Residency Subcommittee.
- Recognized for outstanding performance and commitment to excellence with 2 Partners in Excellence Awards.

HARVARD MEDICAL SCHOOL; Boston, MA 2004–2017

Instructor in Psychiatry

Instruct medical students, residents and peers.

Key Achievements:

- Expanded and enhanced MGH/McLean/Harvard medical residency program to design and implement clinical rotations on eating disorders for psychiatry residents and medical students.
- Orchestrated Clinical Practicum on Eating Disorders for both American Academy of Child and Adolescent Psychiatry and New England Council of Child and Adolescent Psychiatry.

ADDITIONAL EXPERIENCE:

Private Practice, Child and Adult Patients; Boston MA – Outpatient Psychiatrist 2001-2016
North Shore Medical Center; Salem, MA – Adolescent and Adult Inpatient Psychiatrist 2002-2004
Caritas Health Care Inc.; Lawrence and Methuen, MA – Child and Adolescent Psychiatrist 2001-2002

Education

MIT SLOAN SCHOOL OF MANAGEMENT, **MASTERS OF BUSINESS ADMINISTRATION (MBA)** 2015-2017

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, **DOCTOR OF MEDICINE (MD**) 1991-1995

UNIVERSITY OF WISCONSIN, **BACHELOR OF SCIENCE IN PHILOSOPHY AND MOLECULAR BIOLOGY (BS)** 1987-1991

Medical Training

HARVARD MEDICAL SCHOOL / CHILDREN'S HOSPITAL, **FELLOW IN CHILD PSYCHIATRY** 1999-2001

HARVARD MEDICAL SCHOOL / MASSACHUSETTS GENERAL HOSPITAL, **RESIDENT IN PSYCHIATRY** 1996-1999

ST. LUKE'S MEDICAL CENTER, MILWAUKEE WI, **INTERN IN MEDICINE** 1995-1996

Publications (20)

https://www.researchgate.net/profile/Thomas-Weigel-2

Boards

CARING FOR CHILDREN FOUNDATION, BOARD MEMBER

- Blue Cross Blue Shield Vermont Philanthropy

MAD RIVER RIDERS, BOARD MEMBER

- Mad River Valley Chapter of the Vermont Mountain Bike Association (VMBA)

EXHIBIT B
TO THE PREFILED TESTIMONY OF DR. THOMAS WEIGEL

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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800 247 2583
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TO: Martine Lemieux, Chief Actuary

FROM: Ruth Greene, Vice President, Treasurer, and Chief Financial Officer
Tom Weigel, MD, Vice President and Chief Medical Officer

DATE: May 13, 2024

RE: Blue Cross Blue Shield of Vermont programs that enhance access, quality, and affordability for our members

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Under the Green Mountain Care Board rate review rules, payers must demonstrate that their proposed filings produce rates that are affordable, promote quality care, and promote access to care. GMCB Rule 2.401 (See also 8 V.S.A. § 4062(a)(3)).

Affordability and the other non-actuarial "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 Ins. Co.*, 2016 VT 111, ¶ 16. As the Board has noted, it must assess affordability "without specific statutory guidance or a standardized definition." *In re Blue Cross 2021 Filing*, GMCB-005-20rr, at 17 (Aug. 14, 2020).[1] But any approach to affordability cannot overlook the reality that rates "are driven by claims costs." *In re MVP Health*, 2016 VT 111, ¶ 23. Economic factors like household income or wage data that are unrelated to the cost of health care grow more slowly than the health care goods and services that Blue Cross VT's proposed rates are intended to finance. Therefore, rates pegged to indicators like personal income or wage growth, will leave the system perilously underfunded – unless paired with substantial, counter-balancing reductions in the underlying costs.

Blue Cross VT is aware of general economic indicators regarding wage growth, inflation, and household income. We also, of course, closely track increases in the price and utilization of the health care costs that we pay for. We are keenly aware that the growth in those health care costs outpaces increases in wages and household income, and, in turn, the importance of doing what we can to slow the growth of health care costs. Blue Cross VT does not have the information to track individual member and small group employee income, or have knowledge about small business finances. Further, even assuming that we had this information, it is not clear how we could use it. Our rate development process is, and must be, "driven by claims costs." *In re MVP Health*, 2016 VT 111, ¶ 23. As a result, even if we had perfect information about our members' incomes and small business finances, we would have to propose rates adequate to cover our projected claims costs regardless of how those rates compare to those data points. That leaves us two levers we can actually control to propose rates that are as affordable as possible: The programs outlined below that aim to reduce underlying health care costs, and the tight control we exert over our administrative costs are the primary way we can affect affordability from a consumer perspective.

[1] In its Large Group decision dated Friday, May 10, 2024, the Board noted (at p.10) that "BCBSVT failed to provide us with the information we requested regarding the affordability of the rates" after reviewing a document similar to this memo. Given that this filing is due May 13 – the Monday following the Board's Large Group decision, Blue Cross VT welcomes the chance to continue discussing affordability in the QHP rate review process and to addressing, to the best of its ability in this context, the Board's ongoing questions and concerns, and reserves its rights to modify or supplement this document throughout the QHP review process.

With those considerations in mind, this memo provides "better evidence regarding the affordability of rates": A description of our numerous programs aimed at reducing the cost of health care, thus enhancing affordability, while also promoting quality and access to necessary care. With these efforts, Blue Cross VT is able to offer competitive offering to individual and small groups in the state of Vermont. These efforts flow naturally from our mission as a not-for-profit organization, and advance our vision that together we can build a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care.

By working towards and achieving savings from programs identified in this memo, we've made our rates more affordable, because the savings allow us to reduce the rates we would otherwise have to charge to cover the expected health care costs of our members and employer groups. We implement and monitor programs for all our lines of business, including the QHP markets.

Programs that enhance access, quality, and affordability usually fall under one of three categories: 1) value-based payment models, 2) payment integrity, and 3) integrated health management. As explained below, our savings programs work across all three, and we also realized savings through our provider network, administrative costs management, and services for members and groups.

Value Based Payment Models

Value-based payment, where providers are rewarded for improving outcomes instead of increasing utilization, is widely accepted as a foundational element of a more sustainable and affordable health care system. In a value-based payment system, providers have the incentive to improve outcomes without the disincentive of losing income by reducing unnecessary care. Likewise, because they are rewarded for outcomes, as opposed to volume, they can shift to lower cost treatments and retain margin. For example, value-based payment generally rewards primary care practices for the savings achieved through reduced need for specialty care associated with better health. Blue Cross VT has invested in the programs below because we are committed to doing what we can to make Vermont's health care system more sustainable and affordable. We cannot sustain that investment over the time if our premium revenue is insufficient to cover our costs and to maintain our reserves.

Vermont Blue Integrated Care

Blue Cross VT is in its second year of an advanced primary care model, Vermont Blue Integrated Care (VBIC), in collaboration with four primary care practices, encompassing 7,500 attributed lives across our whole book of business. Recognizing the value of the primary care system and the importance of not overburdening such providers, VBIC's overarching goal is to keep the program as simple as possible and align with other existing programs wherever possible. VBIC focuses on implementing quality metrics for disease management, particularly for diabetes, hypertension, wellness (prevention), and colorectal screening, and targets large member cohorts that can benefit from interventions to reduce claims costs over time. The program also incorporates existing resources which have already been successfully piloted, such as case management to improve quality and reduce gaps in care. Providers are financially rewarded for participating, and then again for reaching quality and utilization metrics that improve outcomes and reduce costs.

VBIC is in its early stages and active refinements are being made in response to provider and member feedback. It is too soon to say what the return on investment will be, but Blue Cross VT believes programs such as VBIC will serve as the backbone of long-term health care affordability, access, and quality.

Enhanced Community Primary Care
New in 2024, Blue Cross VT implemented the Enhanced Community Primary Care (ECPC) program. This program utilizes existing data – meaning no additional work for providers – to pay independent community primary care practices for delivering high quality care while encouraging low-cost referral patterns. This allows providers to focus on the provision of appropriate care. The maximum a practice can earn is $6.30 per member per month (PMPM). Based on preliminary data, practices will earn an average payment of $2.54 PMPM. Practices will receive annual score cards tracking performance on the program metrics and comparing them to the threshold and their peers. This is a new program, so it is too early to quantify any results. Blue Cross VT will be closely monitoring whether it is an effective means to advance affordability, quality, and access to care.

Blueprint
At Blue Cross VT, our payment reform objectives are aligned with the Blueprint for Health and the statewide All Payer Model, simplifying the landscape for providers. Our aims encompass enhancing health outcomes, broadening care coordination and preventive services, overseeing chronic condition management, facilitating cancer screening, and curbing overall healthcare expenses. In fiscal year 2023, payments from Blue Cross VT to the Blueprint totaled $5.6 million, underscoring our dedication to bolstering and engaging in Vermont's healthcare endeavors.

Payment Integrity

Through its payment integrity programs, Blue Cross VT ensures that the submitted claims are accurate and appropriate with automated claims reviews and payment audits. However, H.766 – which recently passed both houses of the Vermont Legislature – will limit Blue Cross VT's ability to contain health care costs and improve affordability by limiting key tools such as coding validation reviews and claims edits, of the payment integrity programs listed below.

Automated Claims Review
Automated claims reviews are a widely used method to review claims, ensuring accuracy and consistency in provider billing. Claims reviews examine how a claim is coded and adjust claims when a coding error has been made, rather than simply denying the claim. Claims reviews thus reduce overpayment for improperly billed claims, such as duplicate claims for the same service. We use our claims review systems to ensure that claims are accurately coded, properly represent the services provided, and are consistent across providers.

Blue Cross VT uses an industry-leading vendor to ensure claims filed are appropriately coded and paid. This technology ensures the precision and consistency of coding in accordance with established business standards and Vermont state law. Through this technology, Blue Cross VT can methodically assess claims based on current payment policies, encompassing aspects like global payment rates, multiple daily visits, pre/post-operative appointments, new patient consultations, frequency regulations, as well as reviews for incidental, mutually exclusive, and re-bundled services.

To enhance payment policy compliance and coding validation, to minimize fraud, waste, and abuse, and to comply with the Blue Cross and Blue Shield Association (BCBSA) requirements, Blue Cross VT implemented a secondary claims editor in 2023. This technology analyzes large volumes of claims data to identify patterns suggestive of fraudulent billing activities, in addition to capturing a larger array of coding errors than other vendors. This technology greatly expands Blue Cross VT's ability to find and correct instances of fraud, waste and abuse. These enhanced capabilities align with state and federal transparency goals and ensure that a member is only charged for the care they receive.

Coordination of Benefits and Internal Audits
Blue Cross VT works with other insurance carriers, including other health insurers, automobile insurance companies, and workers' compensation insurance companies to ensure that the right coverage is applied, and the correct insurance companies provide coverage. Blue Cross VT also has an internal team that reviews claims for fraud, waste, and abuse through data mining, review of outlier claims, review of claims against payment policies, and other internal audit investigations.

Integrated Health Management

Once again, H.766 will limit Blue Cross VT's ability to contain health care costs and improve affordability by removing pieces, such as some prior authorization and step therapy, of the integrated health management programs.

Better Beginnings
Better Beginnings is an established care management program for pregnant persons, to support maternal health through and after pregnancy and reduce the risk of pregnancy complications. In addition to saving money, member satisfaction scores tend to increase for members participating in the Better Beginnings program. Better Beginnings offers specialized services during and after pregnancy, supported by experienced nurses who act as a resource and assist with system navigation. These nurses are the primary contacts, aiding in decision-making and care coordination.

Retrospective Utilization Review
Blue Cross VT's Retrospective Medical and Drug Utilization Review program integrates medical and pharmacy claims data to identify possible health and safety issues that would not be noticeable by looking at only the pharmacy claims. The program identifies gaps in care for heart failure, coronary heart disease, diabetes, osteoporosis, migraines, chronic obstructive pulmonary disease, HIV, and rheumatoid arthritis. It also identifies safety concerns such as drug-disease, drug-drug or drug-age interactions as well as therapeutic duplications and overuse. After identifying these clinical concerns, the program generates a notification to the prescribers involved to make them aware of the concern and providing recommended next steps.

Case Management
Blue Cross VT's integrated health programs provide a comprehensive approach, catering to individuals' diverse health needs regardless of their condition, life stage, or acuity. Each member connects with a single point of contact at Blue Cross VT who can address their needs. Member feedback on using our case management programs is largely positive as members appreciate the assistance in navigating a confusing health care ecosystem. The integrated health clinical staff offer compassionate assistance with expert knowledge on treatment options and resources. The overarching goal is to guide and educate members so they can receive timely, high-quality, and cost-effective care. These strategies are at the core of Blue Cross VT's long-term success in delivering high quality health plans at competitive prices by improving affordability, access and quality.

Poorly planned care after a patient is discharged from the hospital can result in readmissions that are both expensive and unnecessary. Blue Cross VT uses a proprietary program to identify members at the highest risk for re-admission and reaches out to offer discharge and care coordination support through case management.

Recognizing that a significant portion of Blue Cross VT members have both medical and mental health conditions, and understanding the benefits of integrating medical, mental health, and substance use

disorder (MHSUD) care, Blue Cross VT transitioned to an integrated case management approach in 2013 with the creation of Vermont Care Collaborative (VCC), a partnership with the Brattleboro Retreat, Vermont's leading MHSUD provider. VCC established an in-house team of medical and MHSUD professionals, improving support quality, access, and addressing system gaps.

Blue Cross VT's case management efforts have reduced claims costs by 14 percent for members with medical and MHSUD conditions, and 8 percent for those with solely medical conditions.

Rare Disease Management
The Blue Cross VT Specialty Health Support program provides support for members with rare, complex conditions in partnership with a third-party vendor that combines its deep rare condition experience and expertise with real-time electronic health record information to identify risks and gaps in care early and to create personalized care strategies, often including the member's caregiver. Through proactive intervention and the use of online tools, Blue Cross VT Specialty Health encourages healthier member choices and supports self-management, thereby preventing complications and emergencies and minimizing hospitalizations and associated expenses. With this holistic approach, members enjoy improved quality of life and better health outcomes.

Utilization Management
Blue Cross VT's utilization management programs play a crucial role in enhancing affordability by preventing unnecessary or inappropriate medical services. By authorizing only medically necessary and evidence-based treatments, the programs help control expenses for members and the larger healthcare system. The utilization management programs consists primarily of prior authorization and post-service review, which are done both by internal Blue Cross VT teams and third-party vendor partners.

Before certain medical services or procedures are administered, healthcare providers must obtain prior approval by submitting clinical information regarding the patient's condition and proposed treatment plan. Services and procedures that require prior approval are identified based on the likelihood of over-utilization based on market trends, high costs, or safety concerns. Post-service review assesses healthcare resource utilization. For example, such reviews involve the length of hospital stays, frequency of medical visits, and resource usage to align with established guidelines and medical necessity. By conducting thorough clinical reviews, the program ensures that treatments are medically necessary for each patient's condition. Members must also typically obtain prior approval for services from an out of network provider, where prices tend to be higher and quality can be, sometimes significantly, lower.

Advanced Imaging Management
Blue Cross VT has partnered with a third-party vendor to manage advanced imaging solutions for members. Advanced imaging is widely used but poses risks like radiation exposure and high costs. Provider margin on advanced imaging tends to be high, encouraging over-utilization. The advanced imaging management program mitigates these risks by ensuring members only undergo clinically necessary imaging, such as MRIs, CTs and PET scans. In addition, beginning in 2024, Blue Cross VT is waiving prior approval requirements for imaging at Open MRI, an independent provider of imaging services that is significantly less expensive than hospital imaging services but provides high quality services. This program will further reduce costs while promoting access and quality.

Lab Benefit Management
Costs for lab tests can vary widely between labs. Furthermore, the lab industry has struggled with fraud, waste and abuse. Lab testing is an increasing cost in the health system. While it is driven by new and expanding genetic testing, it is also an area of significant waste of routine laboratory tests, such as blood counts. Blue Cross VT partners with a third-party vendor to manage the lab network and ensure that

network laboratories are high quality and cost effective. Blue Cross VT is currently working with the vendor to implement genetic testing oversight, which should ensure that extremely expensive genetic tests are only used when the evidence supports their effectiveness. Additionally, oversight will be expanded to hospital laboratories. This will further help contain health care costs and improve affordability.

Pharmacy Cost Management
Blue Cross VT has been actively pursuing partnerships and initiatives that contribute to cost savings and improve access to care. Our partnership with Vermont Blue Rx for pharmacy benefit management services has been highly successful, providing the company with deeper discounts and rebates. The ongoing partnership with Vermont Blue Rx continues to benefit Blue Cross VT members.

To address the rising costs of drugs provided through the medical benefit (as opposed to the pharmacy benefit), including gene therapies and infusible cancer drugs, Blue Cross VT has joined forces with other Blue Cross and Blue Shield affiliated companies to establish Synergie Medication Collective. The collective's focus on improving affordability and access to these expensive drugs is projected to deliver millions in savings to overall medical drug claims upon full implementation. Synergie is actively working on creative cost-saving solutions and value-based contracting models with pharmaceutical manufacturers, promoting more sustainable drug pricing over time.

In another initiative, Blue Cross VT participates in a joint venture with CivicaRx and 18 other Blues plans to manufacture generic drugs that are currently expensive and bring them to market at a fraction of the cost. This venture has already resulted in the introduction of a generic equivalent of a high-cost cancer medication to the market in 2023, available at a remarkable 95 percent lower cost than the brand name medication.

Blue Cross VT has recently contracted with a vendor who will provide medication therapy management to members. This vendor works on reducing readmissions and medication-related adverse events, which cost the larger healthcare system billions annually and cause significant morbidity and mortality. By connecting patients to appropriate care and helping providers find suitable medications on a patients' formulary, while minimizing unnecessary or harmful medications, this new program aims to decrease delays in care, manage utilization, and control costs.

Integrated Pain Pilot
Entering its fifth year, Blue Cross VT leads the development of pilot programs through comprehensive pain clinic centers of excellence, which provide support for members with pain-related diagnoses. The first partner clinic, the UVMMC Comprehensive Pain Program, opened its doors in January of 2019 for this outcomes-based, bundled payment, currently a 16-week comprehensive and integrative program called Partners Aligned in Transformative Healing (PATH). This program provides non-interventional primary care and mental health-based group medical care, while leveraging integrative therapies using a bundled payment model.

The PATH program has resulted in a 17 percent decrease in medical claims, a 23 percent decrease in pharmacy claims, and a 65 percent decrease in emergency department visits for members participating in the program. Participants also report an improvement in pain, fatigue, anxiety, depression, physical function and activity.

As we strive to broaden the scope of the pain program pilot, Blue Cross VT has collaborated with the Department of Vermont Health Access (DVHA) to offer this program to Medicaid beneficiaries. Although improved outcomes may not directly contribute to savings for Blue Cross VT members, population

improvements in pain management and the costs of untreated or ineffectively treated pain benefit the community at large.

Integrated Health Management programs are proven to improve affordability through better health outcomes and ensuring that our members are receiving high quality and lower cost care when available.

Other Blue Cross VT activities to promote Affordability, Access, and Quality

Network Size
Blue Cross VT's provider network is vast and comprehensive. Our networks offer members access to a nationwide network of providers, including over 97 percent of the providers in Vermont. Our comprehensive network allows our members to access the quality care their need in their local communities and nationally.

Administrative Costs
Serving our customers efficiently and effectively is one of our focuses and we carefully allocate our precious resources. Therefore, we take the management of our administrative costs very seriously. Comprising about 6 percent of the overall premiums, they are the only costs that Blue Cross VT can manage directly, and we do so actively. Despite its small size, Blue Cross VT has consistently posted atypically low administrative costs. This is evidenced by the fact that the administrative charges included in this filing for 2025 are below the median administrative charge of $61.50 PMPM for commercial insured Blues Plans in 2022[2]. In a similar vein, Lewis & Ellis has noted our "atypically low administrative costs" year after year in its analyses of our QHP rates. *See, e.g.,* Lewis & Ellis analysis of 2024 Small Group QHP rates (July 5, 2023) ("Among individual and small group carriers nationwide, these figures are in the 26th percentile on a PMPM basis, and the 4th percentile as a percentage of premium. That is, BCBSVT has atypically low administrative costs, despite not being a very large health plan. It therefore appears that BCBSVT manages and limits administrative costs better than the typical health plan nationally.").[3]

Comparison with Other Payers
Vermont only has two carriers offering QHP coverage for individuals and small employer groups. Both carriers file their 2025 rates on the same day so it is not possible to compare rates at this moment. In recent years, both carriers have had similar rates, rate increases, and financial results, showing that these rates reflect the true risk of the covered population. While data on QHP rates in other states for prior years is available online, the difference in benchmark benefit designs, market rules, specifically age rating, may make comparisons misleading. Other dynamics, such as plan offering and silver loading guidance, also makes comparisons to other states and national average difficult. As of May 8, 2024, no other state has posted 2025 QHP rates online, which makes comparisons to this filing impossible.

Our actuarial team regularly reviews trend surveys from the BlueCross BlueShield Association, Oliver Wyman, Buck, and other sources, as well as reviewing emerging pharmacy news and trends from an external vendor. This allows our actuaries to consider our trends in a regional and national context.

[2] *See* Plan Management Navigator at 11 (Sherlock Co. June 2023), *available at* https://sherlockco.com/docs/navigator/June2023/Blue%20June%20Navigator%202023.pdf
[3] https://ratereview.vermont.gov/sites/dfr/files/documents/BCBSVT%202024%20VISG%20Filing%20-%20SG.pdf

Member and Group support

Blue Cross VT's world class customer service helps members navigate the healthcare system. We also offer members access to the Member Resource Center, which enables members to view their benefits, estimate the cost of their care, compare the cost of a service across multiple providers, review their summary of health plan payments, track their out-of-pocket costs, and communicate with us securely. Our local plan experts assist Vermonters with available plan options, help guide them to select the best health plan for their family, and answer questions related to availability of premium subsidies.

Groups also have access to the Employer Resource Center, which allows groups to manage their group's enrollment needs, including submit and update employee information, review their employee eligibility, request ID cards, and view reports. Blue Cross VT also offers a broad choice of benefit designs to small groups in this market and provides an integrated financial account solution. With the support of our local small business team, Vermont small groups can offer their employees and their family members the best coverage for their organization needs.

Individual and group members (age 21 and over) have access to a wellness portal (Be Well Vermont) to help with their wellness journeys.

Conclusion

Vermont policy requires extensive and high-quality insurance coverage with a strong focus on local access to care. Blue Cross VT is committed to providing the most affordable coverage possible to its members while promoting access to quality care and offering comprehensive coverage. Through the programs discussed above, Blue Cross VT ensures that members only pay for services that are medically necessary, that reflect the services they received, and that do not negatively impact interactions with their prescriptions. Blue Cross VT also supports members through its case management programs and by removing prior authorization for lower costs and high-quality providers. Finally, Blue Cross VT, through its value-based programs, supports local independent primary care providers which will help improve access and quality of care. It is the integration and application of all the programs discussed above that allows Blue Cross VT to offer products in the QHP markets that are affordable, promote quality care, and promote access to care, while meeting the standard applied by the Board. GMCB Rule 2.401 (See also 8 V.S.A. § 4062(a)(3)).