

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont)	GMCB-002-23rr
2024 Individual Market Rate Filing)	
)	SERFF No. BCVT-133654578
)	
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In re: Blue Cross and Blue Shield of Vermont)	GMCB-003-23rr
2024 Small Group Market Rate Filing)	
)	SERFF No.: BCVT-133654592
)	

DECISION AND ORDER

Introduction

Blue Cross and Blue Shield of Vermont (BCBSVT), one of two carriers offering individual and small group health insurance coverage in Vermont, seeks to increase its premiums in 2024 by an average of 18.0% for its individual plans and an average of 17.5% for its small group plans.¹ Based on our review of the record, including the testimony and evidence presented at a hearing on July 19, 2023, we modify the proposed rates and then approve the filings. As modified, we expect premiums to increase, on average, approximately 14.0% for BCBSVT’s individual plans and 13.3% for BCBSVT’s small group plans.

Procedural History

1. On May 9, 2023, BCBSVT filed its 2024 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). *See* Exhibit (Ex.) 1.
2. On May 11, 2023, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as a party to the proceedings. *See* HCA Notices of Appearance; 8 V.S.A. §§ 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.
3. From May 16, 2023, through June 30, 2023, BCBSVT responded to a series of interrogatories issued by the Board and its contracted actuaries at Lewis & Ellis (L&E). Exs. 8 – 13. The interrogatories included questions suggested by the HCA. *See* Ex. 13.
4. L&E reviewed the filings on behalf of the Board and issued actuarial reports on July 5, 2023, summarizing its review and recommending adjustments to the filings. Exs. 14 – 15. That same day, L&E provided the Board with information it had requested regarding historical premium changes for certain plans offered by BCBSVT (BCBSVT VISG Information Request

¹ At the time of the initial filings, the average proposed rate increases were 15.5% for individual plans and 14.5% for small group plans. Ex. 6, 7; Ex. 7, 7. They were adjusted to 18.0% for individual and 17.5% for small group prior to hearing. Ex. 20, 5.

Response). Ex. 24. Also on July 5, 2023, the Vermont Department of Financial Regulation (DFR) issued opinions regarding the impact of the filings on BCBSVT's solvency. Exs. 16 – 17.

5. Vermont hospitals submitted their proposed fiscal year 2024 (FY 2024) budgets to the Board in early July 2023. On July 18, 2023, the Board asked BCBSVT to provide information regarding the hospital budget submissions. BCBSVT responded to this request the same day. Ex. 26.

6. The Board held a hearing on BCBSVT's individual and small group rate filings on July 19, 2023. The hearing was held remotely. Members of the public were able to attend the hearing using Microsoft Teams® or their phone. The Board's General Counsel, Michael Barber, served as hearing officer by designation of Board Chair Owen Foster. BCBSVT was represented by Bridget Asay and Michael Donofrio of the law firm Stris & Maher LLP. The HCA was represented by staff attorneys Eric Schultheis and Charles Becker. At the hearing, the Board heard testimony from Martine Brisson-Lemieux, Actuarial Director of Financial Integrity at BCBSVT; Ruth Greene, BCBSVT's Vice President, Treasurer, and Chief Financial Officer; Tom Weigel, M.D., BCBSVT's Vice President and Chief Medical Officer; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance Examiner at DFR; and Kevin Ruggeberg, Vice President & Consulting Actuary at L&E. *See* Hearing Transcript (Tr.).

7. On July 21, 2023, the Board asked BCBSVT a series of follow-up questions from the hearing. Post-Hearing Questions. BCBSVT responded to the Board's questions on July 27, 2023. BCBSVT Responses to Post-Hearing Board Questions.

8. On July 24, 2023, the Board held a public comment forum from 4:30 to 5:30 p.m. to hear from the public on the 2024 individual and small group rate filings of BCBSVT and MVP Health Plan, Inc. (MVP). The forum was held via Microsoft Teams®.

9. Just before midnight on July 24, 2023, the Board closed a special public comment period that it had opened on May 10, 2023, regarding the 2024 individual and small group rate filings. The Board received approximately 147 comments during the public comment period.

10. On July 26, 2023, L&E asked for additional information regarding the impact of FY2024 hospital budget submissions on rates. BCBSVT responded to this inquiry on July 27, 2023. BCBSVT Response to Objection # 7.

11. On July 28, 2023, the HCA and BCBSVT filed post-hearing memorandums pursuant to GMCB Rule 2.000, § 2.307(g). HCA Post-Hearing Memorandum; BCBSVT Post-Hearing Memorandum.

Findings of Fact

12. BCBSVT is a non-profit hospital and medical service corporation that offers health insurance products in several markets in Vermont. *See* Ex. 14, 1; Ex. 15, 1.

13. The May 9, 2023 filings under consideration in this docket outline the development of premiums or "rates" for health benefit plans BCBSVT will offer to individuals and small

employers for calendar year 2024 coverage. The plans will be available for purchase either through Vermont Health Connect (VHC or the “Exchange”) or directly from BCBSVT. *See* Ex. 1, 3.

14. As of February 2023, there were approximately 21,943 members enrolled in BCBSVT’s small group plans and 18,517 members enrolled in BCBSVT’s individual plans. Membership in BCBSVT’s individual and small group plans declined from 2017 to 2021, but increased in 2022 and 2023, as reflected in the following table:

Coverage Year	Small Group Members	Small Group % Change	Individual Members	Individual % Change
2017	41,325		28,710	
2018	30,303	-26.7%	23,361	-18.6%
2019	24,508	-19.1%	19,431	-16.8%
2020	21,568	-12.0%	17,627	-9.3%
2021	18,785	-12.9%	15,878	-9.9%
2022	19,581	+4.2%	16,556	+4.3%
2023	21,943	+12.1%	18,517	+11.8%

See Ex. 14, 1; Ex. 15, 1.

15. Plans in Vermont’s individual and small group markets are offered in bronze, silver, gold, and platinum metal levels. “Catastrophic” coverage is also available to certain individuals.² Each metal level corresponds to an “actuarial value” (AV), which reflects the percentage of claims for essential health benefits that a health insurer expects to cover, on average. Bronze plans have the lowest AV and the least generous coverage, while platinum plans, with the highest AV, have the most generous coverage. *See* 42 U.S.C. §§ 18022(d) – (e); Ex. 3, 4.

16. In its individual filing, BCBSVT initially proposed an average annual rate increase of 15.5%, or approximately \$118.14 per member per month (PMPM), with plan-level increases ranging from 12.4% to 21.1%. Ex. 2, 50; Ex. 6, 7. In its small group filing, BCBSVT initially proposed an average annual rate increase of 14.5%, or approximately \$97.76 PMPM, with plan-level increases ranging from 13.1% to 15.8%. Ex. 2, 63.

17. Prior to the hearing, BCBSVT adjusted its proposed premium increases to incorporate L&E’s recommendations to reflect updated information on risk adjustment transfers and plan benefits. BCBSVT also updated its proposed premium increases to reflect updated membership movement assumptions and to account for Vermont hospitals’ fiscal year (FY) 2024 budget proposals and New Hampshire hospitals’ updated contract terms. With these changes, BCBSVT is now requesting an average annual premium increase of 18.0% for its individual plans and 17.5% for its small group plans. Ex. 20, 5.

18. The significant rate increases that BCBSVT seeks for 2024 come on the heels of double-digit increases last year. While the Board reduced BCBSVT’s proposed 2023 premiums by approximately 3.5% in the individual market and 3.7% in the small group market, the final approved rates were, on average, 11.4% higher in the individual market and 11.7% higher in the

² Catastrophic coverage is characterized by low premiums and high deductibles. *See* 42 U.S.C. § 18022(e).

small group market than 2022 premiums. Ex. 14, 2; Ex. 15, 2. *In re Blue Cross and Blue Shield of Vermont 2023 Individual and Small Group Market Rate Filings*, GMCB-003-22rr & GMCB-004-22rr, Decision and Order, 1 (Aug. 4, 2022).

19. Each plan covered by these filings has its own cost sharing rules (e.g., deductibles, copays, and coinsurance). Within certain limits, these rules require members to pay out of their own pockets for costs covered by the plan. In general, cost sharing increases every year. This year is no exception. *See* Ex. 3, 4 – 5.

20. Those who purchase one of BCBSVT’s individual plans through VHC may be eligible for subsidies that help lower premiums, cost sharing, or both. Premium subsidies take the form of federally funded premium tax credits (PTC), as well as supplemental state funded premium assistance. *See* 26 U.S.C. § 36B; 33 V.S.A. § 1812(a). Cost sharing subsidies take the form of federally mandated but “unfunded” cost sharing reductions, as well as supplemental state funded cost-sharing assistance. *See* 42 U.S.C. § 18071; 33 V.S.A. § 1812(b). The mechanics of the federal subsidies are described briefly below.

21. Subsidies are not available for most employees of small group employers. Some members of the individual market are ineligible due to income levels. *See* 26 U.S.C. § 36B(b)(3)(A)(i). People who enroll in an individual plan directly with BCBSVT are also not eligible for subsidies. *See* 26 C.F.R. § 1.36B-2(a)(1). In 2023, approximately 1,414 individual plan members were directly enrolled with BCBSVT. *See* Ex. 6, 16.

22. The PTC is typically paid directly to the insurance carrier by the federal government to lower an eligible individual’s monthly premium.³ The PTC covers the difference between the premium for the second-lowest cost silver plan in the market and a specified percentage of an individual’s household income (the “required contribution”). *See* 26 U.S.C. § 36B(b). The required contribution varies with income such that individuals with lower incomes are eligible for a larger credit than individuals with higher incomes. While the PTC is calculated by reference to the second lowest cost silver plan in the market, it can be used to purchase a plan at any metal level. *See generally*, Kaiser Family Foundation, *Explaining Health Care Reform: Questions about Health Insurance Subsidies* (Oct. 27, 2022).⁴

23. In 2021, the American Rescue Plan Act (ARPA) made significant enhancements to the PTC. *See* 26 U.S.C. § 36B(c)(1). For individuals already eligible for the PTC, ARPA increased the size of the credit they could receive by reducing their required contribution. ARPA also expanded eligibility for the PTC to individuals with household incomes above 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(c)(1)(E). ARPA’s enhancements to the PTC were extended through 2025 by the Inflation Reduction Act of 2022. *See* Pub.L. 117-169, Sec. 12001. Unless these enhancements are extended again or made permanent, the “cliff” that existed at 400% FPL prior to ARPA will return in 2026. *See id.*

³ Most taxpayers choose to have the credit estimated and paid to the carrier in advance to lower monthly premiums (referred to as an advanced premium tax credit or APTC). However, taxpayers can also pay the fully monthly premium and claim the credit when they file their tax returns.

⁴ <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/>

24. Federal law requires carriers to offer cost sharing assistance to members with household incomes between 100% and 250% FPL. *See* 45 C.F.R. § 155.305(g)(2)(i) – (iii). These cost-sharing reductions (CSRs) take the form of different plan designs at the silver metal level (CSR variants) – plan designs that have lower member cost-sharing and higher AVs than a base silver plan. *See* 45 C.F.R. § 156.420. The federal government used to reimburse carriers directly for the cost of providing CSRs. In October 2017, however, the Trump Administration announced that it would stop making these payments, notwithstanding carriers’ continued obligation to provide CSRs to eligible individuals. Carriers responded by building the cost of CSRs (CSR loads) into their premiums. In most states, including Vermont, CSR loads were applied to on-Exchange silver plans only, a practice known as “silver loading.” *See* 33 V.S.A. § 1813; Ex. 3, 4. Because the PTC is calculated using the second lowest cost silver plan in the market, silver loading had the effect of increasing PTC for eligible individuals. In connection with silver loading, carriers also began to offer “reflective silver” plans directly to individuals (i.e., “off-Exchange”). These plans are almost identical to “on-Exchange” silver plans, except their premiums are lower because they do not include the additional cost of the CSR benefit. *See* 33 V.S.A. § 1813(a)(1); Ex. 3, 6-7.

25. Earlier this year, after consulting with L&E, MVP, BCBSVT, and the HCA, the Board adopted guidance on an aspect of carriers’ CSR load calculations. *See* Green Mountain Care Board Guidance on Silver Loading (eff. March 15, 2023).⁵ The Board’s policy was intended to ensure compliance with rating rules and prevent insurers from calculating CSR loads based on the characteristics of individuals expected to enroll in CSR plans. *See id.* However, the anticipated impact of the guidance was a larger increase in the premiums of silver plans in relation to other plans and an increase in PTC. *See* Lewis & Ellis Presentation to the Green Mountain Care Board, Cost Sharing Reductions and Silver Loads, 9 (March 8, 2023).⁶ While the guidance only addressed one aspect of carriers’ CSR load calculations, the Board anticipated reviewing other aspects through the rate review process. *See* Recording of Mar. 15, 2023, Green Mountain Care Board Meeting, 3:57 – 5:05.⁷

26. L&E reviewed the rate filings to assist the Board in determining whether to approve, modify, or disapprove the proposed rates. *See* Ex. 14, 3; Ex. 15, 2. L&E’s review focused on whether BCBSVT’s proposed rates are “‘excessive, inadequate, and unfairly discriminatory,’ specifically from an actuarial perspective.” Ex. 21, 4. These terms have definitions that are included in Actuarial Standard of Practice (ASOP) No. 8. L&E bases its evaluation of a filing on these actuarial standards and, if necessary, recommends that the Board adjust the filing to meet the standards. L&E does not review a filing to determine whether the proposed rates are affordable or whether they promote access and quality. *See* Ex. 21, 4; Testimony of Kevin Rugeberg, Hearing Tr. 115:10 – 12.

27. Based on its review, L&E recommends that the Board make three modifications to each filing. Ex 14, 20; Ex. 15, 20.

⁵ <https://ratereview.vermont.gov/sites/dftr/files/documents/Guidance%20on%20Silver%20Loading.pdf>.

⁶ <https://gmcboard.vermont.gov/sites/gmcb/files/documents/CSR%20and%20Silver%20Loads%2020230308.pdf>

⁷ <https://www.youtube.com/watch?v=6FAK85B-nxw>

28. Medical Trend- One of the major drivers of BCBSVT's proposed rate increases is a projected increase to claims costs (referred to as "trend") from 2023 to 2024. BCBSVT initially projected in each filing a 2024/2023 total allowed medical trend of 8.7%, comprised of 7.9% trend for unit cost changes and 0.8% trend for utilization and intensity changes. Ex. 14, 6; Ex. 15, 6.

29. The allowed medical and pharmacy trends reflect projected changes in the utilization of medical services and pharmaceuticals (utilization trends) and the price of those services and pharmaceuticals (unit cost trends). *See* Ex. 14, 6; Ex. 15, 6.

30. Medical Unit Cost Trend- The medical unit cost trend reflects expected changes in the cost of medical services between the base experience period and the benefit year. *See* Ex. 1, 24. To project medical unit costs forward from 2022 (the base experience period) to 2023, BCBSVT used actual negotiated provider payment changes. Ex. 14, 6; Ex. 15, 6. To project medical unit costs forward from 2023 to 2024 (the benefit year), BCBSVT took several approaches to estimate the provider payment changes.

31. For drugs dispensed in a facility or office, BCBSVT used the average increase for each facility or provider group to calculate an estimated unit cost trend. *See* Ex. 1, 25.

32. Approximately 52% of medical costs are related to Vermont facilities and providers impacted by the Board's hospital budget review process, in which the Board has authority to limit the amount that Vermont hospitals can raise their charges or rates. BCBSVT's medical unit cost trends in these filings are significantly impacted by its assumptions about the outcome of this process, which does not conclude until the beginning of October. 18 V.S.A. § 9456(d)(1). In developing a medical unit cost trend for these facilities and providers, BCBSVT started by assuming that the Board will approve FY 2024 budgets that support commercial increases identical to the FY 2022 budgets approved by the Board. Ex. 1, 24.

33. For other providers within the broader BCBSVT service area, BCBSVT assumed 2023 and 2024 budget increases would be the two-year average of past increases, except for cases where early negotiations had indicated otherwise. Ex. 1, 24; Ex. 14, 7; Ex. 15, 7.

34. For providers outside the BCBSVT service area, BCBSVT used the fall 2022 Blue Trend Survey conducted by the Blue Cross Blue Shield Association. Ex. 14, 7; Ex. 15, 7.

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

Annual Reimbursement Changes due to Budget Increases and Contracting Season	Percent of Total Allowed Medical Claims in 2022	Cost Trend from 2022 to 2023	Cost Trend from 2023 to 2024	Total Annual Cost Trend
Vermont Facilities and providers impacted by GMCB's Hospital Budget Review	52.2%	13.5%	5.3%	9.3%
Other facilities and providers	47.8%	5.9%	6.6%	6.2%
Total	100.0%	9.8%	5.9%	7.9%

Ex. 1, 25.

36. L&E's first recommendation in its July 5, 2023 report was that once FY 2024 hospital budgets are submitted, this new information be considered in evaluating BCBSVT's unit cost assumptions. Ex. 14, 7, 20. Ex. 15, 7, 20. BCBSVT also anticipated updating those assumptions upon review of the FY 2024 hospital budget submissions. *See* Ex. 1, 24 n.18.

37. The rate increases proposed by Vermont hospitals for FY2024 significantly exceed the increases BCBSVT had expected for facilities and providers not regulated by the Board. For example, BCBSVT's inpatient unit cost trend for Board-regulated hospitals from 2023 to 2024 would be 11.2% using the hospital budgets as filed. The same trend for hospitals not regulated by the Board is projected to be 6.6%. Similarly, BCBSVT's outpatient unit cost trend for Board-regulated hospitals from 2023 to 2024 would be 10.4% using the hospital budgets as filed. The same trend for hospitals not regulated by the Board is projected to be 6.9%. A similar dynamic exists with respect to BCBSVT's unit cost trend for physician services. BCBSVT Response to Objection #7, 7.

38. Board-regulated hospitals also received significantly higher increases from BCBSVT last year than hospitals not regulated by the Board. BCBSVT's inpatient unit cost trend for Board-regulated hospitals from 2022 to 2023 was 14.6%. The same trend for hospitals not regulated by the Board was 6.4%. BCBSVT's outpatient unit cost trend for Board-regulated hospitals from 2022 to 2023 was 13.3%. The same trend for hospitals not regulated by the Board was approximately 6.7%. A similar dynamic exists with respect to BCBSVT's unit cost trend for physician services. BCBSVT Response to Objection #7, 7.

39. The Board's approach to hospital budget review will be different this year from years past. Earlier this spring, the Board chose to maintain a two-year growth target for net patient revenue and fixed prospective payments (NPR/FPP). The target was set at 8.6% over hospitals' actual FY 2022 NPR/FPP and, because of the size of budget approvals last year, many hospitals' FY 2024 budgets do not meet this target. The Board will be scrutinizing these hospitals' budgets based on a variety of new factors and external benchmarks, many of which were recommended to the Board by economists who frequently work with the State of Vermont. *See* Economic and Policy

Resources, Inc. and Kavet, Rockler & Associates, LLC, Initial Economic Analysis and Summary Consensus Recommendations Associated with Green Mountain Care Board Budgetary Review Process (Aug. 22, 2022).⁸ For example, growth in salary and benefits, a significant component of hospital expenses, will be compared to information from the U.S. Bureau of Labor Statistics' Employment Cost Index; changes in cost inflation will be assessed in light of information from the Producer Price Index for general medical and surgical hospitals; and changes in commercial prices will be analyzed by looking at resources such as reimbursement and cost coverage variation studies. *See* FY24 Hospital Budget Guidance Presentation, 16 (Mar. 29, 2023);⁹ FY 2024 Hospital Budget Guidance and Reporting Requirements (eff. Mar. 31, 2023).¹⁰

40. The Consumer Price Index (CPI) has eight major groups, one of which is the medical care index. The medical care index is divided into two main components, medical care services and medical care commodities, each containing several categories. U.S. Bureau of Labor Statistics, Factsheets, Measuring Price Change in the CPI: Medical Care.¹¹ Growth in CPI for All Urban Consumers for medical care was 0.1% from June 2022 – June 2023. Looking at the individual categories, prices for hospitals and related services grew 4.2%, with prices for inpatient services rising 3.7% and prices for outpatient services rising 5.7%. Prices for physician services grew by 0.5%. Shameek Rakshit et al., Peterson – KFF Health System Tracker, *How does medical inflation compare to inflation in the rest of the economy?* (July 26, 2023).¹²

41. Just recently, the Centers for Medicare & Medicaid Services (CMS) finalized a rule that will increase inpatient reimbursements made under the inpatient prospective payment system (IPPS) by 3.1% beginning October 1, 2023. The final increase is slightly higher than the 2.8% increase reflected in CMS's proposed rule. *See* Dave Muoio, Fierce Healthcare, CMS locks in 3.1% pay bump for hospitals, new equity requirements for fiscal 2024 (Aug. 1, 2023).¹³ This increase will affect the five prospective payment system hospitals in Vermont, which are generally larger than critical access hospitals.

42. Prior to hearing, BCBSVT reported that if the hospital budget submissions were incorporated into BCBSVT's rates without any adjustment, the rates in both markets would increase by an additional 2.1%. BCBSVT calculated that if hospital budgets are reduced by 17%,¹⁴ rates would need to increase an additional 1.4% in both markets. Ex. 20, 2, 3, 5; Testimony of Martine Brisson-Lemieux, Hearing Tr. 42:3 – 4. BCBSVT determined that incorporating the final

⁸ <https://gmcboard.vermont.gov/document/initial-economic-analysis-and-summary-consensus-recommendation-associated-gmcb-budgetary>.

⁹ https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Guidance%202023_03_29.pdf

¹⁰ https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY24%20Hospital%20Budget%20Guidance%20FINAL%20DRAFT_0.pdf

¹¹ <https://www.bls.gov/cpi/factsheets/medical-care.htm>

¹² [https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/#Annual%20percent%20change%20in%20Consumer%20Price%20Index%20for%20All%20Urban%20Consumers%20\(CPI-U\)%20for%20medical%20care,%20by%20category,%20June%202022%20-%20June%202023](https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/#Annual%20percent%20change%20in%20Consumer%20Price%20Index%20for%20All%20Urban%20Consumers%20(CPI-U)%20for%20medical%20care,%20by%20category,%20June%202022%20-%20June%202023).

¹³ [CMS locks in 3.1% pay bump for inpatient hospitals in FY 2024 \(fiercehealthcare.com\)](https://www.fiercehealthcare.com/news/cms-locks-in-3-1-pay-bump-for-inpatient-hospitals-in-fy-2024)

¹⁴ In last year's filings, BCBSVT was ordered to assume that the Board would reduce proposed hospital budgets by 17%, the average percentage rate reduction imposed by the Board over the past five years. *See In re Blue Cross and Blue Shield of Vermont 2023 Individual and Small Group Market Rate Filings*, GMCB-003-22rr & GMCB-004-22rr, Decision and Order (Aug. 4, 2022), 17 – 18.

contracts for New Hampshire hospitals would reduce the rates by 0.5%. Ex. 20, 3, 5. The company’s updates increased the medical unit cost trend to 8.7% in both the individual and small group filings. BCBSVT Response to Objection #7, Q. 1, 5.

43. *Medical Utilization Trend*- The second component of total medical trend is medical utilization trend. See Ex. 14, 6; Ex. 15, 6. BCBSVT made assumptions regarding future changes to the utilization of medical services based on analyzing historical data by category and categorized the medical claims into Facility (Inpatient/Outpatient), Professional, and Outpatient Drug categories. Ex. 14, 7; Ex. 15, 7.

44. BCBSVT adjusted historical trend to remove the impact of certain high-cost therapies and procedures that affect few members, removed the impact of changes to Fraud, Waste, and Abuse (FWA) recoveries, assumed 2024 FWA recoveries would remain at 2022 levels, and used the matched population method introduced in the 2022 filings to control for historical changes in population characteristics. BCBSVT also measured utilization trend as the trend in allowed cost normalized for the trend in unit cost; this approach is standard practice, ensures that total allowed cost projection is consistent with expectations, and incorporates trends in the mix of services into the utilization trend. L&E found that these approaches are reasonable. Ex. 14, 7 – 8; Ex. 15, 7 – 8.

45. Facility claims were assumed to increase by 0.5% per year and professional claims by 1.0% per year between 2022 and 2024, which L&E found to be reasonable. 2022 utilization is measurably higher than 2019 utilization for both categories, with likely increases in underlying trend when disruptions from COVID are removed. Ex. 14, 8 – 9; Ex. 15, 8 – 9.

46. The utilization of drugs processed through the medical benefit is assumed to increase at a rate of 2.0% per year. There was a transition from higher-cost injections to available biosimilar equivalents between 2019 and 2022. When drugs with lower cost biosimilars were available, 6.2% were dispensed as biosimilars in 2019 compared with 39.3% in 2022. BCBSVT assumed a biosimilar rate of 49.3% for 2024. Ex. 14, 9; Ex. 15, 9.

47. L&E found each component of the medical utilization trend development to be reasonable. To confirm that the methodologies were consistent and coherent in aggregate, L&E considered the aggregate utilization data across all medical services. Consistent across all service categories, 2020 claims were low, with a sharp increase in 2021 and a slight decrease in 2022.

Year	Normalized PMPM	Annual Change
2019	\$498.73	
2020	\$454.65	-8.8%
2021	\$532.39	+17.1%
2022	\$529.70	-0.5%
Average		+2.0%

L&E believes this suggests two plausible interpretations. Either the trend prior to 2022 has ended and there is now a zero or slightly negative trend or there is a continuing positive utilization trend. If there is a positive trend, it is masked either by random fluctuation in 2021 and/or 2022, or by artificially inflated 2021 claims resulting from care deferred during 2020's COVID restrictions. BCBSVT has assumed an average utilization trend of approximately 0.8%. BCBSVT's assumption is below the observed average trend since 2019 and L&E believes it strikes a reasonable balance between the recent dip in utilization and longer-term suggestion of increases in utilization since before the pandemic. L&E believes the medical trend assumptions are reasonable in aggregate. Ex. 14, 10; Ex. 15, 10.

48. The table below summarizes the original trend assumptions for medical costs and the overall medical allowed trend from 2022 to 2024.

Cost Category	Annual Unit Cost	Annual Utilization	Annual Allowed Trend
Inpatient	8.7%	0.5%	9.2%
Outpatient	8.5%	0.5%	9.0%
Mental Health Professional	5.7%	1.0%	6.8%
Facility Professional	5.7%	0.5%	6.2%
Other Professional	5.7%	1.0%	6.8%
Medical Rx	9.3%	2.0%	11.5%
Total Medical	7.8%	0.8%	8.7%

Ex. 14, 10; Ex. 15, 10.

49. Pharmacy Trend - BCBSVT is proposing an allowed pharmacy trend of 14.9% per year, net of changes to pharmacy rebates. Ex. 1, 36; Ex. 14, 11; Ex. 15, 11. Unlike the medical trend analysis, pharmacy claims did not demonstrate disruptions because of COVID. Ex. 14, 11; Ex. 15, 11. BCBSVT projected a 3.8% increase in generic drug costs and a 10.5% increase in brand drug unit costs. Ex. 1, 34; Ex. 14, 11; Ex. 15, 11. Specialty drugs have increased at a very high rate in recent years and make up the overwhelming majority (65%) of BCBSVT's pharmacy costs. BCBSVT projected a 19.5% increase in specialty drug costs. Ex. 14, 12; Ex. 15, 12.

50. In July 2021, BCBSVT changed its Pharmacy Benefits Manager (PBM). The contracted rates with the PBM include certain discounts that impact the projected pharmacy allowed charges. BCBSVT characterizes the contract as containing annual discount improvements. Ex. 1, 35.



51. The net annual allowed trend for specialty drugs has varied drastically since 2019, with increases in 2020, 2021, and 2022 of 18.6%, 3.2% and 23.0% respectively. The three-year average was 14.9%. Ex. 14, 12; Ex. 15, 12. BCBSVT says that its acceptable range of assumptions

for allowed specialty was 15.0% to 23.0%, although that range does not go as low as the three-year average. *See* BCBSVT Responses to Post-Hearing Board Questions, 5. BCBSVT used three regression methods which heavily relied upon the 2022 data in its selection of 19.5% for the specialty tier. Ex. 14, 12; Ex. 15, 12; *see* Ex. 1, 35. L&E does not necessarily agree with BCBSVT’s heavy reliance on the most recent single year’s trend increase. Ex. 14, 12; Ex. 15, 12. L&E believes the three-year average of 14.9% would have been reasonable, but notes that a higher utilization trend could have been supported by a longer lookback period consistently across medical and drug spending. Testimony of Kevin Ruggeberg, Hearing Tr. 132:21 – 133:23; Ex. 14, 12; Ex. 15, 12.

52. *Total Allowed Trend* - BCBSVT projects an average total allowed trend of 10.0% after combining medical trend (8.7%) and net pharmacy trend (14.9%). Ex. 14, 13; Ex. 15, 13.

53. *Plan Design Changes* – Changes to membership enrollment in different plan designs can affect claims levels and silver load. The plan design changes factor addresses the impact on rates resulting from the effect of these enrollment changes on claims. In the 2023 plan year filing, BCBSVT had projected that the enrollment shift to leaner plans would result in a 0.4% decrease in utilization. For 2024, BCBSVT anticipates the shift to leaner plans will be slightly less than the prior year, resulting in only a 0.3% decrease in utilization. The net effect of this evolution in assumptions is a 0.1% rate increase in the individual market. In its small group filing, BCBSVT assumed a slight shift to leaner plans for 2024 compared to 2023, causing a small decrease in utilization in 2024 and resulting in a 0.1% decrease in proposed rates. *See* Ex. 14, 13 – 14. Ex. 15, 13 – 14.

54. *Membership Movement/Silver Load* –Beginning in 2020, Vermont was required to maintain continuous health care benefits for Medicaid enrollees as a condition of receiving enhanced federal funding. *See* Families First Coronavirus Response Act, Pub.L. 116-127, Sec. 6008(b) (Mar. 18, 2020). In April 2023, this “continuous coverage” requirement ended, and Vermont started reviewing the eligibility of individuals enrolled in Medicaid once again. People who lose Medicaid eligibility through this “redetermination” process will be able to purchase a plan through VHC. *See* Vermont Agency of Human Services, Department of Vermont Health Access, Unwinding from Medicaid Continuous Coverage (Mar. 2023), 13, 26.¹⁵

55. BCBSVT relied on a study done by NORC at the University of Chicago that estimated the number of members who would enroll in the individual and small group markets due to Medicaid redeterminations. Ex. 14, 14; Ex. 15, 14. For the individual market, BCBSVT assumed that members previously on Medicaid would enroll in On-Exchange Silver plans with the same proportion by plan as current enrollment, adjusted for assumptions regarding the impact of CSR changes on membership movement. *See* Ex. 1, 15-16.

56. In response to the Board’s March 15, 2023 Guidance on Silver Loading, BCBSVT initially developed its 2024 silver load by calculating a paid-to-allowed ratio similar to all other plans for each federal CSR variant on each of the four silver plan designs. Then, BCBSVT used

¹⁵https://dvha.vermont.gov/sites/dvha/files/doc_library/Medicaid%20Unwind%20Operations%20Plan%20March2023.pdf

its projected 2024 membership accounting for the mix of federal CSR variants within each silver plan to calculate the on-exchange silver plans' average paid-to-allowed ratio. *See Ex. 1, 43.*

57. On July 5, 2023, L&E issued an actuarial report with respect to MVP's filing for the individual market, *In re MVP Health Plan, Inc. 2024 Vermont ACA Individual Market Rate Filing*, Docket No. GMCB-004-22rr (L&E MVP Indiv. Market Report). In that report, L&E recommended that MVP be required to assume certain enrollment shifts resulting from Vermont's new CSR guidance, as well as the resumption of Medicaid redeterminations. L&E MVP Indiv. Market Report, 13 – 14, 19.

58. Before the hearing, BCBSVT updated the estimated membership movement from on-Exchange silver plans to align with the recommendations L&E made regarding MVP's filing. BCBSVT believes that it and MVP took reasonable but differing approaches to implementing the Board's Guidance in the filed rates and the resulting asymmetry in silver loads would harm BCBSVT members, who would pay for a larger silver load without an accompanying increase in subsidies. Updating membership movement in this manner would reduce BCBSVT's proposed rate in the individual market by 0.7% and have no impact on the small group rate. Ex. 20, 3 – 5.

59. *Changes to Other Factors-* BCBSVT expects the combined rate effects of changes due to enhanced ARPA subsidies, cyber-attack impact updates, miscellaneous claims adjustments, non-system claims changes, and COVID-19 adjustments to account for a 5.3% increase in the individual market relative to the prior filing and a 3.9% increase in the small group market relative to the prior filing. Updating BCBSVT's assumptions last year about the claims impact of new enrollment related to the extension of enhanced ARPA subsidies in the individual market results in a 0.1% premium increase in the individual market only. Also in last year's rate filing, the base period had been artificially inflated following a cyber-attack on one facility that caused rescheduling of surgical procedures, so BCBSVT had assumed a 0.9% decrease in claims from the base period to remove that artificial bump in utilization. This year, the downward adjustment has been removed, resulting in a premium increase of 0.9% in both the individual and small group markets. In addition, L&E reviewed and found reasonable various other minor adjustments, including smoothing out the impact of catastrophic claimants, non-Essential Health Benefit Claims, and provider network changes, resulting in a 1.5% increase in rates in the individual market and 0.1% decrease in the small group market. Ex. 14, 14 – 15; Ex. 15, 14 – 15.

60. The rate effect of changes to non-system claims, including changes to pharmacy rebates, Blueprint payments, Interplan Teleprocessing System fees, vaccine payments, and the net cost of re-insurance, is 2.5% in the individual market and 1.0% in the small group market. The primary driver of this change is the reduction in pharmacy rebates. The Vermont 340B Drug Pricing Program has reduced the price for some drugs sold in a hospital setting. However, BCBSVT's PBM generally does not include those already-discounted drugs in its rebate programs. The hospital is paying a discounted price for the drugs, but BCBSVT is paying the higher contracted rate, without the ability to receive rebates from the PBM. The impact of losing the pharmacy rebates for those drugs is estimated by BCBSVT to increase individual rates by 1.5% and small group rates by 1.2%. Ex. 14, 14; Ex. 15, 14.

61. BCBSVT assumed that 2024 COVID costs will mirror 2022 costs, increasing projected claims by about 1.6% in the individual market and 1.9% in the small group market. Additionally, last year BCBSVT assumed that the base period claims were suppressed by COVID lockdowns and social distancing, which increased last year's premiums by 1.3% in both markets. Removing that assumption this year reduces rates by 1.3%. The combined effect of these adjustments increases rates by about 0.3% in the individual market and 0.6% in the small group market. Ex. 14, 15; Ex. 15, 15.

62. COVID-19 infection rates spiked in early 2022, resulting in peak claims within Vermont. Ex. 1, 27: Testimony of Martine Brisson-Lemieux, Hearing Tr. 86:9 – 21. BCBSVT's COVID medical and pharmacy claims PMPM for January 2022 through March 2022 show a combined cost of \$12.43 PMPM for the individual market and \$18.36 PMPM for the small group market. The combined cost from January 2023 through March 2023, however, was \$5.21 PMPM for the individual market and \$6.63 PMPM for the small group market. See Ex. 9, 1, 4. Replacing January through March 2022 COVID costs with January through March 2023 COVID costs would decrease individual rates by approximately 0.2% and small group rates by approximately 0.4%.

63. Risk Adjustment Transfers - L&E's second recommendation is to reflect updated risk adjustment transfers. Under the Affordable Care Act's risk adjustment program, premiums are transferred between carriers in the individual and small group markets based on the age, sex, and health status of the enrolled members. BCBSVT originally projected changes to risk adjustment to have a +0.3% impact on individual rates and a -1.7% impact on small group rates. BCBSVT agrees with L&E's recommendation and calculates that the impact of the recommendation will be +1.9% in the individual market and +1.7% in the small group market. See Ex. 14, 15 – 16; Ex. 15, 15 – 16; Ex. 20, 1 – 2, 5.

64. Population Morbidity Adjustment – This factor measures morbidity differences between the experience period and projection period populations due to voluntary disenrollment from BCBSVT ACA market coverage. Ex. 1, 17. In last year's filing, BCBSVT estimated that the 2023 population morbidity would be 0.5% lower than 2021 in the individual market and 1.8% lower than 2021 in the small group market. Because this filing was submitted after the 2023 Open Enrollment Period, BCBSVT knows which 2022 members remained in the block and which no longer had coverage. To assess changes to pool morbidity, BCBSVT separated the 2022 experience into those members who remained in 2023 and those who left. The impact of the members who left is expected to increase the average claims level by 1.6% in both markets. The impact on rates is the difference between the factor in this filing and the factor in last year's filing, or 2.1% in the individual market and 3.4% in the small group market. These effects are partially offset by risk adjustment transfers. Ex. 14, 13, 21; Ex. 15, 13, 21.

65. Demographic Shift – This factor represents the expected change due to demographic shifts between 2022 and 2024, such as aging of the population and newborns entering the covered population and is partially offset by changes in risk adjustment. Ex. 14, 13; Ex. 15, 13. In the individual market, last year's filing assumed that the age change of the population would lead to a 1.2% decrease in costs. Updated data suggests that the population will not be as young as expected, resulting in only a 0.4% decrease in cost, resulting in a net effect of increasing rates by

0.8% from the previous approved level. Ex. 14, 13. In the small group market, last year's filing assumed an increase of 0.4%, but this year's filing projects no change in the average age of the population. Removing a 0.4% increase has the effect of decreasing rates by 0.4% from the previously approved level. Ex. 15, 13.

66. Changes in Actuarial Value – Pricing Actuarial Value (AV) changes increased by 1.4% for the individual market and 1.3 % for the small group market from the 2023 filing and have a corresponding effect on rates. L&E's third recommendation to the filing is that rates be updated to reflect IRS-required changes to the HDHP benefit designs. This recommendation has no material impact on overall rates. Ex. 14, 16, 20; Ex. 15, 16, 20. BCBSVT agrees with this recommendation. *See* Ex. 20, 5.

67. Administrative Costs - As proposed, the 2024 administrative costs are projected to grow by 1.1% less than premiums in the individual market, resulting in a -1.1% projected impact on rates. Ex. 14, 16, 21. The 2024 administrative costs for the small group market are projected to grow by 0.5% less than premiums, resulting in a 0.5% projected impact on rates. Ex. 13, 16, 21. These base administrative costs are \$58.92 PMPM for individual plans and \$47.29 PMPM for small group plans. Ex. 14, 17; Ex. 15, 16.

68. To develop the plan year base administrative cost, the actual 2022 administrative cost for each filing was adjusted for two factors. First, BCBSVT applied a 4% per year cost trend. Given the current inflation environment, L&E believes this assumption is reasonable. Ex. 14, 17; Ex. 15, 16.

69. BCBSVT's second adjustment to the 2022 administrative cost is to include the estimated impact of membership changes. BCBSVT estimates that 70% of the allocated base administrative expenses are fixed costs, and therefore changes in enrollment cause changes in administrative costs PMPM. BCBSVT anticipates that the fixed portion of their administrative costs will be spread over more members in 2024 than in 2022, resulting in a 3.4% decrease to projected administrative costs on a per member basis. Ex. 14, 17; Ex. 15, 17. No adjustment was made to administrative costs for the third-party administration of dental and vision benefits. Ex. 14, 17; Ex. 15, 17. BCBSVT also includes transaction fees for members who pay their premiums with debit and credit cards. The average fees as a percentage of premium were approximately 0.25% for the individual market and 0.1% for the small group market. Ex. 14, 17; Ex. 1, 46. L&E considers BCBSVT's administrative expense assumptions to be reasonable. *See* Ex. 14, 19; Ex. 15, 18.

70. BCBSVT's administrative costs as a percentage of premium ranked in the 26th percentile on a PMPM basis and the 4th percentile as a percentage of premium, based L&E's review of individual and small group carriers nationwide, as reflected in the Center for Consumer Information & Insurance Oversight (CCIO) 2023 public use files (PUFs). Ex. 14, 17-18; Ex. 15, 17-18.

71. BCBSVT has proposed an affiliation with BCBS of Michigan. This affiliation has not been approved by DFR and would take time to implement, so BCBSVT has not projected any 2024 savings in these rate filings. BCBSVT Responses to Post-Hearing Board Questions, 15.

72. Contribution to Reserves and Risk Based Capital - Contribution to Reserves (CTR) is an important source of funding policyholder reserves, or member reserves, which in turn are the funds that ensure that insurance companies can remain solvent and can meet their obligations and pay member claims. *See* Ex. 4, 2. BCBSVT proposed a CTR of 3.0% in each filing. Ex. 14, 19; Ex. 15, 19. In addition, BCBSVT proposed a 0.2% provision for bad debt in the individual filing. The 0.2% provision for bad debt in the individual market is based on the actual unpaid premium experienced by BCBSVT on individual business between 2019 and 2022. L&E believes the bad debt provision appears reasonable. Ex. 1, 48; Ex. 14, 19.

73. BCBSVT's proposed CTR in these filings is double the 1.5% CTR that the company has requested in recent individual and small group filings. Ex. 14, 19; Ex. 15, 19; *see* Ex. 4, 1.

74. As a reasonableness check, L&E used the 2023 PUFs to compare BCBSVT's proposed CTR to the CTR of other carriers for individual and small group (QHP) plans in their 2022 filings. The mode for the filed CTR among these carriers was between 2.0% and 3.0% and the premium weighted average CTR for all carriers was 2.8%. BCBSVT's proposed base CTR of 3.0% places it around the 52nd percentile for all QHP carriers; adding the 0.2% bad debt margin for the individual market would place it in the 67th percentile. L&E believes that the proposed CTR is reasonable, given the Risked Based Capital (RBC) position of BCBSVT and the fact that the proposed CTR falls near the median targeted by individual and small group carriers nationwide. Ex. 14, 20; Ex. 15, 19 – 20.

75. RBC, a ratio that compares an insurer's available reserves to its risk, is an important tool for assessing the solvency of an insurer. DFR has approved a target RBC range for BCBSVT of 590% to 745%. Ex. 4, 3; Ex. 19, 4; Ex. 16, 2 n.2; Ex. 17, 2 n.2. BCBSVT's RBC as of the end of 2022 was below its targeted range at 434%. BCBSVT cites multiple factors, including economic volatility, competitive pressures, and uncertainty around hospital budgets, that make it difficult to predict where its RBC will be relative to the range at the end of 2024, although it doubts that it will reach the low end of the range by then. Ex. 4, 3. BCBSVT Administrative Services Only (ASO) uninsured plans had a loss of over \$14 million in 2022. Ex. 22, 53; Testimony of Ruth Greene, Hearing Tr. 168:1 – 5. Insurers such as BCBSVT often provide multiyear rate guarantees to retain the business of large ASO customers; this book of business is currently in a loss position that BCBSVT is taking steps to resolve over time. *See* Testimony of Ruth Greene, Hearing Tr. 172:6 – 12. BCBSVT's Medicare Advantage (MA) business is in its third year of enrollment and is currently losing money; the business case for the MA market is to lose money for the first four years, then break even, and then generate revenue as it gains scale. Testimony of Ruth Greene, Hearing Tr. 173:13 – 23. Investments were a big source of loss in 2022, which was the worst year in equities since 2008, but the long-term performance of equities has been a net positive. *See* Testimony of Ruth Greene, Hearing Tr. 184:20 – 185:9; BCBSVT Responses to Post-Hearing Board Questions, 8. BCBSVT could have made a more modest adjustment to CTR but felt that 3.0% was an appropriate adjustment to increase the likelihood that premiums would be fully maintaining reserves. *See* Testimony of Ruth Greene, Hearing Tr. 166:4 – 8.

76. BCBSVT developed a stochastic model designed to identify the most likely range of RBC results in future years. Based on updates to this modeling, BCBSVT expects its RBC results to be between [REDACTED] and [REDACTED] at the end of 2023 and between [REDACTED] and [REDACTED] at the end of 2024. The median forecasted RBC for 2023 is [REDACTED] and for 2024 is [REDACTED]. Ex. 12, 6-7.

77. In late 2022, BCBSVT changed its approach to payment reform initiatives for 2023. It paused its relationship with OneCare Vermont (OCV), the state's largest Accountable Care Organization (ACO), although the dollars allocated for the OCV initiative in 2023 premiums are being distributed to primary care physicians formerly in the OCV network in 2023. BCBSVT indicates that it does not anticipate contracting with OneCare Vermont in 2024. Testimony of Tom Weigel, Hearing Tr. 249:22 – 24. For calendar year 2022, 42.4% of BCBSVT's allowed charges were for fee for service with no link to quality and value. Ex. 12, 2. However, that percentage is likely to increase with the end of the OCV relationship. *See id.*

78. BCBSVT developed its own care model called Vermont Blue Integrated Care (VBIC) for primary care practices. VBIC provides \$7.00 PMPM to providers for enhanced care coordination and population health management, as well as an electronic medical record overlay. There are currently approximately 2500 attributed lives participating in VBIC. BCBSVT states that it will continue to support primary care providers in 2024, through an expansion of the VBIC program and a new payment reform program. Testimony of Tom Weigel, Hearing Tr. 253:1 – 10; *see* Ex. 1, 22; BCBSVT Responses to Post-Hearing Board Questions, 12 – 13. The amounts included in the 2023 rates were \$1.88 PMPM for the individual market and \$2.10 PMPM for the small group. As of June 2023, BCBSVT has paid \$0.38 PMPM for members in both markets attributed to VBIC and \$1.49 PMPM for members in both markets attributed to providers who were in OCV in 2022. BCBSVT Responses to Post-Hearing Board Questions, 14.

79. BCBSVT is still developing its 2024 payment reform initiatives [REDACTED]
[REDACTED] BCBSVT Responses to Post-Hearing Board Questions, 12-13. Testimony of Tom Weigel, Hearing Tr. 248:10 – 14. The new program would be based on a national program offered by the BCBS Association and would pay primary care providers based on quality, appropriateness, and utilization metrics. BCBSVT Responses to Post-Hearing Board Questions, 12 – 13; Testimony of Tom Weigel, Hearing Tr. 250:12 – 16.
[REDACTED] BCBSVT Responses to Post-Hearing Board Questions, 14 – 15. This program would replace the current quarterly payments that BCBSVT continued to make in 2023 to providers that were part of the OCV network.
[REDACTED] BCBSVT Responses to Post-Hearing Board Questions, 12 – 13.

80. For both Large Group and ACA markets, as of December 2022, BCBSVT attributed 22,719 members to the VBIC program and to providers who formerly participated in the ACO program. BCBSVT projects for 2024 that 25,246 members will be attributed to VBIC and the new payment reform programs, with an estimated cost of \$2.28 PMPM. BCBSVT has included \$2.25 PMPM in the 2024 premiums for these programs. BCBSVT Responses to Post-Hearing Board Questions, 12.


81. BCBSVT has not consulted with the Blueprint for Health in designing the new payment reform program. Testimony of Tom Weigel, Hearing Tr. 250:17 – 21. It is not yet clear what the quality metrics in the new program are, however, BCBSVT states that it has “learned that successful [payment reform] programs do not segment members by type of insurance.” Ex. 12, 5.

82. BCBSVT does not have specific numbers or formulas it uses to assess whether rates are affordable or promote access to care. Testimony of Martine Brisson-Lemieux, Hearing Tr. 50:16 – 51:2. BCBSVT does not consider the amount of money that members have available to pay for insurance in determining whether its rates are affordable, does not review relevant literature, nor does it consider how Vermont premium rates compare to other states in making that determination. Testimony of Martine Brisson-Lemieux, Hearing Tr. 96:15 – 98:24. BCBSVT understands that Vermont wages were not keeping up with requested health insurance rate increases. *Id.* 99:2 – 6. For Vermonters who currently receive subsidies, “it would be very difficult to afford those rates” without those subsidies. *Id.* 96:11 – 17. The HCA testified that as filed, the price for the BCBSVT Standard Silver Plan in the small group market would cost more than a quarter of the median income for a household of three just for premiums. Although employers share part of this cost burden, they do so to the detriment of their bottom lines or else pass a greater share of the burden onto their employees. Testimony of Mike Fisher, Hearing Tr. 20:22 – 21:15.

83. In practice, BCBSVT essentially passes money paid by consumers through to providers and Vermont providers receive the vast majority of premiums paid by consumers. Testimony of Martine Brisson-Lemieux, Hearing Tr. 92:15 – 21. Increases in hospital budgets can have an adverse effect on community provider fees; if hospital rates go up more in a particular year than was budgeted, BCBSVT is not able to increase fees paid to community providers. Testimony of Tom Weigel, Hearing Tr. 242:3 – 25. BCBSVT has limited flexibility to increase community provider rates because of the large proportion of rate increases allocated to Vermont hospitals. Testimony of Tom Weigel, Hearing Tr. 271:6 – 14.

Board-regulated hospitals have seen large rate increases, but most “community provider rates are fairly flat across the board.” Testimony of Tom Weigel, Hearing Tr. 270:22 – 271:5. BCBSVT may be able to provide “a slightly enhanced rate” to some community practices with very high quality and efficiency, but BCBSVT’s Chief Medical Officer testified that “most of our rates are pretty flat by practice, I should say, compared to what we might pay a larger hospital system.” Testimony of Tom Weigel, Hearing Tr. 270:22 – 271:5.

84.



85. DFR issued its solvency opinions on July 5, 2023. As they have the last few years, the opinions acknowledge the pandemic-related uncertainties that have affected, and could continue to affect, Vermont's health care system, while recognizing the positive impact of effective vaccines, treatment guidelines, and other factors. Ex. 16, 1; Ex. 17, 1. DFR does not expect the proposed rates will have a significant impact on its overall solvency assessment of BCBSVT. However, it notes that any downward adjustments to the filing's rate components that are not actuarially supported will reduce BCBSVT's surplus and negatively impact its solvency. Ex. 16, 3; Ex. 17, 3.

86. The Change in the Consumer Price Index for All Urban Consumer (CPI-U) for the Northeast Region increased 7.6% for the 12-month period ending June 2022. *See* Ex. 23, HCA-04. Cost inflation in 2024 is expected to continue at a higher rate than was experienced prior to 2022. *See* Ex. 14, 17; Ex. 15, 16.

87. The Health Care Advocate testified that he was concerned that rate increases of the magnitude proposed in these filings will price Vermonters out of the health care system. He also disputed DFR's emphasis on insurer solvency as the most fundamental aspect of consumer protection because while it may protect the consumers who can afford to pay the premiums and out-of-pocket costs, it offers little or no protection to those who cannot; it also fails to recognize the competing financial pressures on Vermonters. He expressed concern about the future impact of the current rate increases on affordability when enhanced subsidies are scheduled to end in two years. Testimony of Mike Fisher, Hearing Tr., 279:24 – 281:10.

88. The Board received approximately 147 written comments on the 2024 individual and small group rate filings. Comments were submitted by individuals, small businesses and non-profits. Commenters expressed frustration at continually increasing premiums and cost sharing requirements. Many commenters described how their lives are affected by these increases. For example, commenters described how they have foregone care due to high out-of-pocket costs and wrote about the burden that large premium increases place on their budgets. A small business owner described how premium increases this year may require the business to pass premium increases on to employees or to stop offering health care coverage altogether. An employee of a small business wrote about the impact of premium increases on wages. *See* Compilation of 2024 Vermont Individual and Small Group Rate Filing Comments.

89. BCBSVT filed a post-hearing memorandum pursuant to GMCB Rule 2.000, § 2.307(g) in which it argued that the Board should approve the proposed rates as modified by L&E's

recommendations, including the proposed 3.0% CTR assumption. It stated that its costs of insurance – administrative costs and CTR – are low compared to other insurers and that its solvency, as measured by its RBC, is at an all-time low. It recommended that the Board use available tools to maximize subsidies for low and middle-income Vermonters and reminded the Board of the “counterintuitive dynamics” created in the individual market by the interplay between gross premiums and subsidies. BCBSVT Post-Hearing Memorandum.

90. The HCA also submitted a post-hearing brief. It argued that the proposed rates do not meet the statutory criteria in that they are excessive, unjust, unfair, inequitable, and misleading; they fail to promote access; and they are not affordable. The HCA asserted that the proposed rates are one rate among a range of possible actuarially reasonable rates, pointing out actuarially supportable lower values for components including medical unit cost trend, specialty pharmacy trend, COVID-19 assumptions, and CTR. HCA Post-Hearing Memorandum.

Standard of Review

The Board is required to approve, modify, or disapprove a rate request within 90 calendar days of receiving an initial rate filing. 8 V.S.A. § 4062(a)(2)(A). The Board reviews proposed rates to determine whether they are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b). In its review, the Board considers changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401. The Board must also consider DFR’s analysis and opinion regarding the impact of the proposed rates on the insurer’s solvency and reserves, as well as any public comments the Board receives. 8 V.S.A. §§ 4062(c)(2)(B), (a)(3), (c)(2)(B); GMCB Rule 2.000, § 2.201.

The Board’s review of proposed rates is plainly not limited to actuarial considerations and mathematical calculations. The Vermont Supreme Court has recognized that the general and open-ended nature of the rate review standards reflects the practical difficulty of establishing more detailed, narrow, or explicit standards – a difficulty due to the fluidity inherent in concepts of quality care, access, and affordability. *See In re MVP Health Insurance Co.*, 2016 VT 111, ¶ 16 (internal quotations and citations omitted).

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

In addition to its authority to approve, modify, or disapprove rate requests, the Board is authorized to make reasonable supplemental orders and attach reasonable conditions and limitations to such orders as the Board finds necessary to ensure that benefits and services are provided at reasonable cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c) (applicable to nonprofit hospital service corporations), 4584(c) (applicable to nonprofit medical service corporations), 5104(b) (applicable to health maintenance organizations). This authority has been found to authorize supervision over an insurer’s contracting process with health care providers. *See In re Vermont Health Serv. Corp.*, 144 Vt. 617, 624 – 25 (1984).

Finally, the Board has temporary authority through March 31, 2024, to waive or permit variances from State laws, guidance, and standards with respect to health insurance rate review, among other regulatory activities, as necessary to prioritize and maximize direct patient care, safeguard health care provider stability, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic. Act 4, § 5 (2023).

Conclusions of Law

As we have recognized in prior decisions, the rate review criteria are interrelated and often in tension with one another and we seek to balance them as best we can in light of the facts and circumstances before us. *See In re Blue Cross and Blue Shield of Vermont 2023 Individual and Small Group Market Rate Filings*, GMCB-003-22rr & GMCB-004-22rr, Decision and Order (Aug. 4, 2022), 15.

Vermont’s return to “normal” from the shocks of COVID-19 has faced previously unanticipated challenges. The long-term impact of COVID-19 on the health care sector is evidenced by the extension for an additional year of the regulatory flexibilities initially given to the Board and other agencies during the pandemic. *See* Act 4, § 5 (2023). Higher than normal inflation rates continue to erode the fiscal wellbeing of many Vermonters. *See* Findings, ¶ 86. Many people are returning to the individual and small group markets after having lost Medicaid coverage following the resumption of Medicaid redeterminations. Findings, ¶¶ 54 – 55. Compounding these challenges, in July, Vermont experienced severe flooding; in many cases the devastation it wrought exceeded that of Tropical Storm Irene. In connection with the flooding, Vermont received a Presidential Major Disaster Declaration. *See* Addendum 2 to Executive Order No. 03-23 (Jul. 19, 2023).

BCBSVT’s proposed premium increases for 2024 are high and come on the heels of double-digit rate increases implemented for 2023. *See* Findings, ¶¶ 16 – 19. While ARPA’s enhancements to the PTC will thankfully continue to be in place through 2025, subsidies are not available to most employees of small employers or for people who enroll in an individual plan directly with BCBSVT or who are otherwise ineligible. *See* Findings, ¶ 23. We received many comments describing the real hardship that rising premiums and out-of-pocket-costs cause for individuals, small businesses, and nonprofits. *See* Findings, ¶ 88.

Given these facts, we have closely scrutinized the filings and are requiring BCBSVT to make several adjustments that are necessary to ensure that premiums are appropriate in light of the Board’s statutory charge. However, adjusting premiums will not bring about the kind of change that current circumstances require. We are therefore exercising our authority to require BCBSVT to act to ensure that its benefits are provided at reasonable cost under efficient and economical management.

I

First, we require BCBSVT to implement L&E’s recommendations to 1) reflect updated risk adjustment transfer figures; and 2) reflect updated benefits. BCBSVT has agreed to these changes, and we agree they are appropriate. *See* Findings, ¶¶ 63, 66.

II

Second, we require BCBSVT to reduce its specialty drug trend from 19.5% to 15.0% per year.

BCBSVT proposed an allowed pharmacy trend of 14.9% per year, net of changes to pharmacy rebates. Specialty drugs constitute an overwhelming majority of these pharmacy costs and BCBSVT is proposing a net increase of 19.5% per year. Findings, ¶ 49. The net annual allowed trend for specialty drugs has been volatile over the past four years, with an increase in 2020 of 18.6%, an increase in 2021 of only 3.2%, and an increase in 2022 of 23.0%. We believe that BCBSVT relied too heavily on the 2022 data in its methodology to arrive at the 19.5% increase. While BCBSVT said that 15.0% was at the low end of its assumption range, the three-year average of 14.9% was also a reasonable value. *See* Findings, ¶ 51. Given the recent great volatility in trend for this significant component of BCBSVT's rate as a whole, we require BCBSVT to use 15.0% as the allowed specialty drug trend, a figure that is slightly above the three-year average and not overly reliant on 2022's experience. We estimate this will result in a 1.2% reduction in individual rates and a 1.1% reduction in small group rates.

III

Third, we require BCBSVT to adjust its COVID projections to match April 2022 to March 2023 experience.

BCBSVT set 2024 COVID costs based on its calendar year 2022 COVID experience. We believe that using this time frame to project future experience overstates likely COVID-related costs. January through March 2022 was notable in Vermont for the emergence of the Omicron variant and resulted in peak COVID expenses in the state. Findings, ¶¶ 61 – 62. We believe that the first quarter of 2023 is more reflective of future COVID expectations than the first quarter of 2022. We recognize that COVID costs will continue to ebb and flow. Adjusting the base period to April 2022 through March 2023 still presents a broad range of increases and decreases in COVID expenses, without locking the state's peak COVID experience into 2024 rates. *See* Findings, ¶¶ 61 – 62.

We expect that matching BCBSVT's projected COVID expenses for 2024 to its experience from April 2022 to March 2023 will reduce rates in the individual market by 0.2% and in the small group market by 0.3%.

IV

Fourth, we order BCBSVT to assume the same membership movement from on-Exchange silver plans that L&E recommended with respect to MVP's filing, as BCBSVT presented prior to hearing. We agree with BCBSVT that a consistent approach between carriers is appropriate for the first year of guidance. We expect that aligning membership movement assumptions will reduce individual rates by 0.7%. It will have no effect on the small group market. *See* Findings, ¶¶ 54 – 58.

V

Fifth, to make rates more affordable and promote access to health care, we lower the base CTR assumption from 3.0% to 2.0%.

BCBSVT asked for a 3.0% CTR for the first time in recent memory. A CTR of 2.0% is still higher than BCBSVT has requested in recent years and represents a substantial increase over Board-ordered CTRs in the past several years. A figure between 2.0% and 3.0% was the mode for filed CTR among other carriers for individual and small group (QHP) plans for the 2022 plan year. Findings, ¶¶ 72, 74.

We commend BCBSVT for its strong performance containing administrative costs as compared to its peers nationally. *See* Findings, ¶ 70. We recognize the downturn in BCBSVT's RBC and agree that increasing BCBSVT's CTR from prior years is appropriate for its current financial position. However, in light of the pressures facing Vermont consumers this year, we believe a 2.0% CTR strikes the correct balance between BCBSVT's financial well-being and Vermonters' ability to afford health insurance.

As mentioned above, individuals and small businesses are having to bear the burden of general inflationary pressures and the second double-digit QHP rate increase in as many years. *See* Findings, ¶¶ 86 – 88. We are particularly mindful of the larger than usual number of people returning to the QHP market after having lost Medicaid eligibility and the Vermonters who have had their lives upended by the July 2023 floods. *See* Findings, ¶¶ 54 – 55.

In addition, we heard evidence that certain losses driving down BCBSVT's RBC, such as from Medicare Advantage and equity performance, were anticipated by BCBSVT but are part of a more long-term strategy to improve financial position. QHP ratepayers should contribute appropriately to BCBSVT's overall financial wellbeing but should not bear a disproportionate burden. BCBSVT acknowledged that a range of CTR adjustments were appropriate and had selected 3.0%. Findings, ¶ 75. While we agree that an upwards adjustment to CTR is appropriate, we select 2.0% to promote affordability and accessibility.

We anticipate that setting CTR at 2.0% will result in a 1.0% decrease in rates.

VI

Sixth, we require BCBSVT to reflect modified FY 2024 unit cost changes by using updated information for non-GMCCB facilities as presented at hearing, *see* Findings ¶ 42, and by using the FY 2024 hospital rate requests calculated by Board staff and then assuming that the Board will reduce these requested rates by 50%.

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

Unfortunately, we have yet to find a reasonable way to make this work. *See* GMCB Regulatory Alignment White Paper, Part 2: Options for Regulatory Timeline and Logistics (July 2021).¹⁶

BCBSVT assumes in its rates presented at hearing that the Board will reduce Vermont hospitals' proposed FY 2024 rates by 17% later this year. BCBSVT's assumption of a 17% reduction is consistent with our decision last year on BCBSVT's individual and small group filings, which was based on an analysis that L&E performed of historical budget submissions and approvals. *See* Findings, ¶ 42 n.14. However, the hospital budgets this year are anything but ordinary and historical budget submissions and approvals are not likely to predict the outcome of the FY 2024 hospital budget process. The Board has implemented significant changes to the process this year. The Board will use a variety of new factors and external benchmarks to scrutinize the hospital budgets. *See* Findings, ¶ 39. This improved, data-driven hospital budget review process is likely to increase accountability and ensure Vermont hospitals appropriately control their costs. Hospitals' expense growth and the revenue and rate needs that such growth drives are likely to be impacted.

While we cannot know the outcome of our hospital budget review process at this point, several factors suggest that hospital requests may be modified significantly more than in prior years. First, despite having received relatively large increases last year, Vermont hospitals are proposing rate increases for FY 2024 that significantly exceed the increases BCBSVT is expecting to pay to hospitals not regulated by the Board. *See* Findings, ¶ 37. Second, national CPI figures indicate that price growth for hospital and related services between June 2022 and June 2023 was 4.2%, while prices for inpatient services rose 3.7%, prices for outpatient services rose 5.7% and prices for physician services rose 0.5%. *See* Findings, ¶ 40. These growth trends are much lower than Vermont hospitals' rate proposals for FY 2023 or FY 2024. Third, the FY 2024 increase for Medicare inpatient reimbursements will be slightly higher for prospective payment system hospitals than anticipated and this will likely reduce the amount of revenue and "rate" that these hospitals need from commercial payers such as BCBSVT. *See* Findings, ¶ 41. Lastly, Vermont hospital budget submissions generally requested significant rate increases despite multiple Board members indicating that the Board would closely scrutinize rate-based growth in hospital budgets. *See* Recording of May 31, 2023, Green Mountain Care Board Meeting¹⁷

We conclude that a 50% reduction is a more reasonable and appropriate assumption than 17% and require BCBSVT to use it to calculate its 2024 individual and small group rates. This will make the rates more affordable, bringing BCBSVT's medical unit cost assumption back down closer to what it had initially assumed.

VII

While it does not impact the rates in this filing, we must take a moment to recognize the significance of BCBSVT's withdrawal from OCV at the end of 2022. *See* Findings, ¶ 77. BCBSVT plays an important role in promoting health care reform in Vermont, so this action was a significant

¹⁶ https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCBRegulatoryAlignment_Part2_20210730.pdf

¹⁷ Available at <https://www.youtube.com/@GreenMountainCareBoard/videos>

event. A fundamental premise of multi-payer payment reform is that alignment across payers in quality and payment promotes the effectiveness of the reform. For example, the All-Payer Model ACO Agreement includes a statewide quality framework, which includes population health metrics, ACO metrics, and provider-level metrics.

We are interested in additional information about the potential expansion of BCBSVT's VBIC program and the new program BCBSVT is implementing in collaboration with the national BCBS Association. BCBSVT expressed uncertainty at hearings and in follow up questions about the design of the new program and stated that the quality metrics will be based on the national program. Findings, ¶ 79. We are concerned that the metrics will not be well coordinated with state standards and may pose administrative burdens on providers. We often hear from providers, particularly in our Primary Care Advisory Group, about their challenge meeting non-coordinated program goals.

Therefore, we are requiring BCBSVT to align its payment reform design with the All-Payer Model quality framework and Blueprint for Health programs and to report to the Board by December 1, 2023, on the final design, including an explanation for how it is aligned with the Blueprint for Health programs and how the quality metrics are aligned with the above, existing frameworks. Where it is not aligned, BCBSVT must justify the divergence. We are also requiring BCBSVT to report actual spending in 2023 on payment reform programs and actual spending in 2024 to date at the time of the 2025 rate filing, as well as projected spending for the 2024 year-end if it differs from actual.

VIII

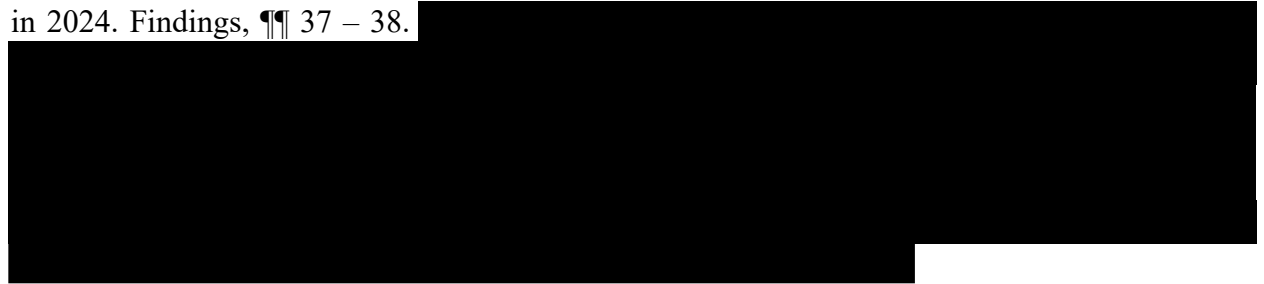
BCBSVT bears the burden of justifying its requested rates and in connection with making that determination the Board reviews whether they are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, §§ 2.104(c), 2.301(b).

BCBSVT failed to provide sufficient evidence to demonstrate its proposed rates are affordable and promote access and quality. While BCBSVT represented that it concluded the proposed rates were affordable, that conclusion was not credible. Indeed, BCBSVT's conclusion was not based on a review of any relevant literature, did not consider the amount of money Vermonters have available to pay the premiums, and did not consider how Vermont premium rates compared to other states. BCBSVT further testified that it understood that Vermont wages were not keeping up with requested health insurance rate increases. BCBSVT conceded that without subsidies "it would be very difficult to afford those rates." Findings, ¶ 82. Importantly, subsidies are not available to most employees of small employers and nor to individual members who enroll directly with the carrier or do not meet income qualification requirements. The Health Care Advocate also introduced evidence that the proposed rates would equal a quarter of the median income for a Vermont family. *Id.*


Moreover, BCBSVT does not consistently nor uniformly consider affordability, access, and quality in connection with its contract negotiations with providers. While Board-regulated

hospitals have seen large rate increases, most “community provider rates are fairly flat across the board.” And although BCBSVT may be able to provide “a slightly enhanced rate” to some community practices with very high quality and efficiency, most of its rates are “pretty flat by practice ... compared to what [it] might pay a larger hospital system.” BCBSVT testified that it had limited flexibility to increase community provider rates because of the large proportion of rate increases that are allocated to Vermont hospitals. Findings, ¶ 83.

The increases BCBSVT paid to GCMCB-regulated hospitals outpaced non-regulated providers for inpatient, outpatient and physician services in 2023 and is projected to do so again in 2024. Findings, ¶¶ 37 – 38.



The rate increases established by the Board in the hospital budget process, however, are a ceiling, not a floor. A central function of an insurance company is to negotiate rates on behalf of its members and to properly execute that responsibility affordability, quality, and access must be considered. We do not condone any effort by Board-regulated entities to utilize approved rates as an entitlement. Board-approved hospital rate increases are a cap, not a sword to be wielded in negotiations with insurers.



See Findings, ¶¶ 37 – 38, 83 – 84. Negotiated rate increases that award more money to an entity simply because it is regulated by the Board—as opposed to whether an entity provides affordable services, has high quality, and is accessible—are highly unlikely to result in affordable rates that promote access and quality.

In addition, we believe there is great potential for BCBSVT to expand its engagement in health care reform and to slow health care cost growth and improve quality. For calendar year 2022, 42.4% of BCBSVT’s allowed charges were for fee for service with no link to quality and value. Findings, ¶ 77. However, that percentage is likely to increase with the end of the OCV relationship. *See id.* While BCBSVT has expressed a desire to implement payments in the past and with its inclusion of a payment reform payment in this year’s rate request, it has not yet done so in a meaningful way. Moreover, in 2023, BCBSVT took a step backwards when it withdrew from OCV without having a fully established Vermont-specific program ready to take its place. *See* Findings, ¶ 78; Conclusions § VII, *supra*. BCBSVT should make meaningful progress towards value-based care, consistent with the state’s health care reform efforts in Vermont, as part of its demonstration that rates are affordable and promote access and quality.

The Board could conclude that BCBSVT has failed to satisfy its burden of justifying the requested rates because there is insufficient evidence demonstrating the rates are affordable and promote access and quality. While such a conclusion may be warranted, outright rejecting the rates

could negatively impact solvency and/or access. Consequently, we are requiring BCBSVT to consider affordability, access, and quality in its negotiations with its provider network. Specifically, we require BCBSVT to consider affordability, access, and quality in connection with negotiating contracts with Board-regulated and non-Board-regulated entities; and report back to the GMCB describing the rates awarded to Board-regulated and non-Board-regulated entities and explain how BCBSVT considered and utilized affordability, access, and quality in negotiating rates.

Order

For the reasons discussed above, we modify and then approve BCBSVT's 2023 Individual and Small Group Rate Filings. Specifically, we order BCBSVT to: (1) reflect updated risk adjustment transfer figures; (2) reflect updated benefits; (3) reduce its specialty drug trend to 15.0%; (4) replace January through March 2022 COVID costs with January through March 2023; (5) assume in its individual filing the same membership movement from on-Exchange silver plans as was recommended by L&E with respect to MVP's filing; (6) reduce the base CTR assumption from 3.0% to 2.0%; and (7) reflect modified FY 2024 unit cost changes by using updated information for non-GMCB facilities as presented at hearing and by using the FY 2024 hospital rate requests calculated by Board staff and assuming that the Board will reduce these requested rates by 50%.

With the modifications required by this order, we expect that the overall average rate increase for BCBSVT's individual plans will be reduced from approximately 18.0% to approximately 14.0% and the overall average rate increase for BCBSVT's small group plans will be reduced from approximately 17.5% to approximately 13.3%.

SUPPLEMENTAL ORDERS

For the reasons discussed above, we also order BCBSVT to (8) align payment reform design with the Blueprint; (9) report on the design of, and spending on, payment reform programs as described in Section VII, above; (10) consider affordability, access, and quality in connection with negotiating contracts with Board-regulated and non-Board-regulated entities; and (11) report back to the GMCB describing the rates awarded to Board-regulated and non-Board regulated entities and explain how BCBSVT considered and utilized affordability, access, and quality in negotiating rates.

SO ORDERED.

Dated: August 7, 2023, at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Thom Walsh)
)
/s David Murman)

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

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