STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont 2025 Large Group Rate Filing	)))	GMCB-001-24rr SERFF No.: BCVT-133971481

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board (Board). 8 V.S.A. §§ 4062, 4515a, 4587, 5104. This decision pertains to the 2025 large group rate filing of Blue Cross and Blue Shield of Vermont (BCBSVT). The approved rates will be used by BCBSVT to determine the premiums of experience-rated fully insured large groups with over 100 employees.

Procedural History

On February 9, 2024, BCBSVT submitted its 2025 large group rate filing to the Board via the System for Electronic Rate and Form Filing (SERFF). On February 16, 2024, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid that represents the interests of Vermont health insurance consumers, entered an appearance as a party to the filing. On April 4, 2024, Lewis & Ellis, Inc., the Board's contract actuary, submitted an actuarial report evaluating the filing (L&E Memo). On April 10, 2024, the Department of Financial Regulation (DFR) submitted an analysis and opinion regarding the impact of the filing on BCBSVT's solvency (Solvency Opinion). Each of these documents was subsequently posted on the Board's rate review website.[1]

The Board solicited public comments on the filing through April 24, 2024. No member of the public provided comment. The parties waived a hearing. *See* GMCB Rule 2.000, § 2.309.

Findings of Fact

1. BCBSVT is a non-profit hospital and medical service corporation that provides coverage to individuals, small and large group employers, and Medicare enrollees in Vermont. L&E Memo, 1. This filing applies to BCBSVT's large group products and establishes the formula, manual rate, and accompanying factors BCBSVT will use to establish premiums for large group renewals.[2] *See* L&E Memo, 1.

[1] The SERFF filings, as well as all documents referenced in this Decision and Order, can be found in the rate review section of the Board's website at https://ratereview.vermont.gov.

[2] BCBSVT states that while previous large group filings were applicable to all insured large groups, including Cost Plus, as of January 2024, there is no active Cost Plus membership. As such, the filing does not develop any Cost Plus specific factors, and the factors included in the filing will not be used to rate prospective Cost Plus business. BCBSVT Actuarial Memorandum, 2 n.1.

2. The filing is projected to affect 4,264 members (2,446 subscribers) in 33 groups. BCBSVT Actuarial Memorandum (Carrier Memo), 2; *see also* L&E Memo, 1.

3. The changes to the rating formula and factors proposed in the filing are expected to increase premiums by approximately 8.4% on average, or roughly $68.43 per member per month (PMPM). This increase can be itemized[3] as follows:

a. Change to Projected Claims: +8.2%
b. Change from Projected Pharmacy Rebates: +0.4%
c. Change in Administrative Charges: -0.7%
d. Change in Contribution to Reserve: +0.3%
e. Change in Additional Items[4]: +0.2%

L&E Memo, 1; Carrier Memo, 3.

4. The most important component of any group's premium is its past claims experience. Group-level premiums for coverage beginning 1Q2025, for example, will be based on the most current experience available at that time. For this reason, no group's actual premium increase under the current filing is known. *See* L&E Memo, 2; Carrier Memo, 4. However, if the filing is approved without modification, a newly formed large group would experience premiums in the first quarter of 2025 that are approximately 8.4% higher than a similar newly formed large group in the first quarter of 2024. *See* L&E Memo, 2.

5. For the combined BCBSVT block that is used for rate development, the projected claims are expected to increase 9.0% over what was assumed in the prior filing. Because there are non-claims components of the premium, this translates to an 8.2% premium increase. L&E Memo, 2.

6. To help maintain stability in the premiums, BCBVT replaced high-cost claims in the experience period (i.e., claims exceeding $120,000 annually for an individual) with a long-term average "pooling charge." Pooling is a typical industry practice and has been used by BCBSVT in prior filings. *See* L&E Memo, 2. Pooling is reasonable, as this block is small enough that some amount of random fluctuation is likely. L&E Memo, 3.

7. BCBSVT's pooling factor assumptions are based on a Milliman publication that utilizes nationwide information. BCBSVT likely does not have sufficient data to develop its own factors. *See* L&E Memo, 2.

8. BCBSVT's pooling charge was significantly less than the actual high-cost claims observed during the base period. This is the third year in a row that the pooling charge has been noticeably lower than actual high-cost claims. L&E Memo, 2; BCBSVT Response to Interrogatory 1 (Mar. 7, 2024), 5. If this pattern continues, BCBSVT will continue to experience significant financial losses on this block. L&E Memo, 2.

[3] The itemized changes are multiplicative and may not add up to the total.
[4] "Additional Items" include net cost of reinsurance, broker commissions, payment reform initiative costs, and fees paid to outside vendors. Carrier Memo, 4; L&E Memo, 1 n.2.

9. L&E cautions that it is difficult to know whether the pooling charges being used by BCBSVT are inadvertently producing an estimate of claim costs that is systematically high or low. L&E believes the uncertainty created by the recent unfavorable experience with high-cost claims should impact the Board's consideration of other assumptions in the filing, such as trend and contribution to reserves. While the uncertainty makes precise quantification difficult, L&E believes an increase to the manual rate could be reasonable. *See* L&E Memo, 3.[5]

10. Medical trend varies by plan type due to contracting differences. For all products combined, BCBSVT is requesting a total allowed medical trend of 7.8% per year, which is the product of unit cost trends and utilization and intensity trends for different types of claims, as reflected in the following table:

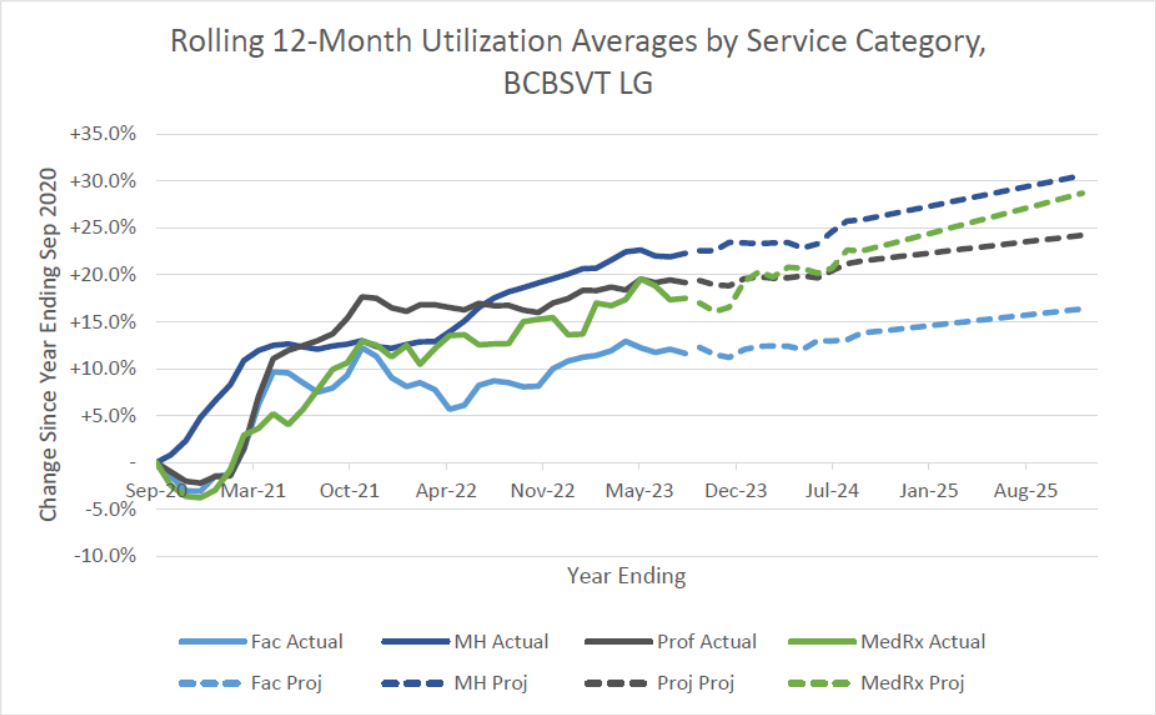
Category	Unit Cost	Utilization	Total	Share of Allowed
Hospital	6.2%	1.8%	8.1%	65%
Mental Health Professional	4.5%	3.0%	7.6%	3%
Other Professional	4.5%	1.8%	6.4%	25%
Outpatient Drugs	6.5%	4.0%	10.7%	7%
Total			**7.8%**	

See L&E Memo, 3.

11. BCBSVT's categorization of claims is reasonable due to the unique patterns of utilization and response to the COVID-19 pandemic that the claims have exhibited in recent years. L&E Memo, 4.

12. BCBSVT's historical utilization and projected utilization for each service category are summarized in the following chart:

[5] If the base period experience were used without any adjustments for outlier claims, which L&E does not believe would be reasonable, the implied premium increase would be 12.5% instead of 8.4%. L&E Memo, 2-3.



L&E Memo, 5.

13. BCBSVT's selected utilization trend for mental health professional services, 3.0% per year, is slightly lower than the average over the post-2020 period and is lower than the observed trend in any year since 2019. L&E Memo, 4.

14. Non-mental health professional claims exhibited a sharp increase coming out of 2020 and into 2021 and have exhibited a much lower but positive rate of utilization trend thereafter. BCBSVT's assumed 1.8% utilization trend for these claims is slightly lower than the observed trend in recent years. L&E Memo, 4.

15. Hospital (Facility) claims have exhibited a less clear pattern of utilization in recent years, but broadly show a pattern of increasing utilization since the end of the COVID-19 public health emergency. BCBSVT's assumed 1.8% utilization trend for these claims is, as with other service categories, slightly lower than has been observed in recent years. *See* L&E Memo, 4.

16. The "Outpatient Rx" service category consists of claims related to pharmaceuticals covered by the medical benefit, which are often dispensed in an outpatient medical facility. These pharmaceuticals are subject to medical deductibles and cost sharing rather than the deductibles and cost sharing of the prescription drug benefit. The utilization of Outpatient Rx has grown each year since 2020 and has fluctuated by year, as shown in the following table:

Year Ending	Utilization Change since prior 12 months
September 2021	+9.9%
September 2022	+2.5%
September 2023	+4.3%

17. L&E does not recommend any changes to the medical utilization trend assumptions in the filing. L&E Memo, 5.

18. BCBSVT projects the unit cost trend for medical costs to be 5.7%. This projection includes a 5.8% increase for Vermont facilities and providers impacted by the Board's hospital budget review and a 5.6% increase for other facilities and providers. L&E Memo, 5.

19. BCBSVT's projected 5.8% increase for Vermont facilities and providers impacted by hospital budget review assumes that the hospital budget increases approved by the Board in 2024 and 2025 will be the average of approvals over the last five years, excluding mid-year increases. *See* L&E Memo, 5.

20. L&E found that BCBSVT made a mistake when calculating the 5-year average rate change. Correcting the mistake would increase manual rate claims by 0.01%. L&E states that this amount does not appear material and L&E does not believe a revision to the filing is necessary to correct the mistake. *See* L&E Memo, 5-6.

21. L&E observes that the Board has issued hospital budget guidance that could result in lower hospital budget increases than in past years. L&E Memo, 5; *see also* Green Mountain Care Board, FY 2025 Hospital Budget Guidance & Reporting Requirements (eff. Mar. 29, 2024), 8-9 (adopting commercial rate growth benchmark of no more than 3.4% per payer). However, given the uncertainty of the impact of this guidance, L&E believes it is appropriate to approve BCBSVT's assumptions as filed and review a revised filing should hospital budget increases differ materially from the projections in the filing. *See* L&E Memo, 5.

22. Medical unit cost increases for providers outside the BCBSVT service area were derived from the Blue Trend Survey, a proprietary survey disseminated by the Blue Cross Blue Shield Association. L&E Memo, 6.

23. L&E does not recommend any changes to the medical unit cost trend assumptions. L&E Memo, 6.

24. BCBSVT projects a total allowed pharmacy trend, including the impact of contracting changes with the Pharmacy Benefits Manager (PBM), of 11.0%. This aggregate assumption is composed of the following: non-specialty utilization trend; generic cost trend, separately for new and established generics; brand cost trend, separately for new and established brands; impact of brand drugs going generic; specialty trend; and vaccines, OTC, etc. L&E Memo, 6.

25. BCBSVT modeled costs for generic and brand drugs separately but combined the data to analyze utilization. A separate adjustment was then made to incorporate the impact of brand drug patent expiration. BCBSVT separately modeled the total PMPM trends for specialty drugs. The following table shows the results of BCBSVT's analysis and the requested 11.0% overall allowed pharmacy trend:

Pharmacy Trends	Cost Trend	Utilization Trend	Total Annual Trend After Contract Changes
Generic	3.3%	3.1%	
Brand	4.5%	3.1%	
Brands Going Generic	N/A	3.1%	
Specialty			14.0%
Total			**+11.0%**

L&E Memo, 7.

26. BCBSVT's calculated unit cost trends of 3.3% for generic and 4.5% for brand drugs are consistent with recent cost trends observed for these categories. *See* L&E Memo, 7.

27. When the patent expires for a brand drug, lower-cost generic alternatives become available. BCBSVT projected the quantity and reduced cost for drugs which will become genericized during the projection period. BCBSVT's method of projecting brands going generic is reasonable and appropriate. L&E Memo, 7.

28. The assumed unit cost trends for generic, brand, and brand-going-generic are reasonable. L&E Memo, 7.

29. BCBSVT's projected 3.1% utilization trend for non-specialty drugs is based on historical utilization rising steadily between 2018 and 2022. Given the stability of recent trend experience, BCBSVT's non-specialty drug utilization trend projection is reasonable. *See* L&E Memo, 7.

30. Due to their high cost and low frequency, BCBSVT projected specialty drug costs in total, without splitting into unit cost and utilization. L&E agrees with BCBSVT's decision to analyze specialty cost trend this way, as the utilization trend would be difficult to assess given the low frequency and wide variance in unit costs. *See* L&E Memo, 8.

31. Specialty drug costs have increased at a steady, high rate for several years. The years ending in September 2021, 2022, and 2023 exhibited cost increases of 16.3%, 15.8%, and 12.9% respectively. BCBSVT's assumed specialty trend is 14.0%, based on regression analysis of historical claims. L&E believes this trend assumption is reasonable in light of the historical cost increases observed. *See* L&E Memo, 9.

32. L&E believes BCBSVT's total allowed pharmacy trend projection of 11.0% is reasonable in aggregate and when analyzed by its individual components. *See* L&E Memo, 9.

33. After calculating the total allowed pharmacy trend, BCBSVT applied a separate adjustment to reflect a component of the American Rescue Plan Act that removed the cap on Medicaid rebates. This provision is expected to reduce drug costs and rebates. The adjustment is based on projections from BCBSVT's PBM and reduces the overall trend from 11.0% to 9.4%. However, the reduction is coupled with a projected decrease in prescription drug rebates, and the

combined effect of these two changes is an approximate 0.3% increase to the full manual premium. *See* L&E Memo, 9.

34. Together, BCBSVT's 7.8% total allowed medical trend and 9.4% total allowed pharmacy trend produce an 8.1% total allowed trend, as reflected in the table below:

Category	Allowed Trend	Approx. % of Claims
Medical	7.8%	82%
Rx	9.4%	18%
Total	**8.1%**	**100%**

L&E Memo, 10.

35. While BCBSVT used allowed trends to analyze changes in cost and utilization, plan liability increases at the paid trend rate, not the allowed trend rate.[6] Consistent with last year's filing, BCBSVT used its benefit relativity models to convert the allowed trends into paid trends, namely a paid medical trend of 9.2%, a paid pharmacy trend of 10.0%, and a total paid trend of 9.4%. The approach BCBSVT used to adjust allowed trends to paid trends is reasonable and appropriate. *See* L&E Memo, 10.

36. As with last year's filing, the non-benefit (administrative) components of the premium rate are developed on a PMPM basis using historical costs. The administrative experience period for this filing is January 2022 through December 2022. Transitional costs related to one-time events, such as enabling full-time remote work, were removed. *See* L&E Memo, 10.

37. The administrative charge proposed in the last filing was $60.41 PMPM. The proposed administrative charge in this filing is $55.03 PMPM, a decrease of $5.38. The change in the administrative charge is attributable to several factors. L&E Memo, 10.

38. BCBSVT's actual 2022 administrative costs were lower than anticipated in the previous filing. Reflecting this updated information resulted in a decrease of about $1.50 PMPM, which flows through to the projected 2025 administrative costs. This amount includes $0.61 PMPM in savings expected from BCBSVT's affiliation with Blue Cross Blue Shield of Michigan, which is producing administrative savings that were not present in the base period 2022 administrative costs. L&E Memo, 10.

39. BCBSVT assumes that its administrative costs will increase at 4.0% per year, which is the same rate of increase that it assumed in last year's filing. *See* L&E Memo, 10.

40. BCBSVT projects an increase in overall membership across all lines of business between 2022 and 2025. L&E Memo, 11. Approximately 30% of BCBSVT's total administrative

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

expenses are variable. In calculating the proposed administrative charge, BCBSVT assumed that fixed costs would remain the same in total while variable costs would remain constant on a PMPM basis. Spreading fixed costs over more members results in a 3.4% reduction to the administrative charge. *See* L&E Memo, 11; Carrier Memo, 28-29.

41. The premiums were developed to include allowances for a variety of state mandates and assessments, as well as federal fees. *See* L&E Memo, 11.

42. L&E concludes that assumptions used in developing the administrative expense charge appear to be reasonable and appropriate. *See* L&E Memo, 11.

43. BCBSVT proposes a contribution to reserve (CTR) of 3.0%, which is the same CTR requested by BCBVT in its previous large group filing. *See* L&E Memo, 11.

44. L&E notes that the last few years have resulted in contributions to reserve that were lower than projected in the filing, due in part to the high pooled claims experience on this block:

Year	Fully Insured Actual CTR
2018	-8.5%
2019	-6.0%
2020	0.7%
2021	-12.0%
2022	-12.9%
2023	-3.9%

L&E Memo, 11.

45. If higher than expected pooled claims continue, the actual CTR for the plans covered by this filing will be substantially lower than proposed and may be negative. *See* L&E Memo, 12.

46. L&E recommends that the Board consider DFR's Solvency Opinion in evaluating BCBSVT's proposed CTR. L&E Memo, 12.

47. L&E believes that the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory and recommends that the Board approve the filing, resulting in an anticipated average premium change of approximately 8.4%. L&E also urges the Board to require BCBSVT to agree to submit a supplementary filing to modify the unit cost trend should hospital budget submissions differ materially from those assumed in the filing. L&E Memo, 12.

48. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR provided the Board with its assessment of the impact of the proposed filing on BCBSVT's solvency. DFR noted that BCBSVT's surplus and Risk Based Capital (RBC) ratio, two important indicia of solvency, have worsened when compared to the prior year end. BCBSVT's RBC ratio was below the targeted range as of December 31, 2023. DFR cautions that any downward adjustments to the rate that are not actuarially supported would likely further erode the carrier's surplus and RBC ratio. With this

background, DFR does not expect the proposed rate will have a significant impact on DFR's overall solvency assessment of BCBSVT. Solvency Opinion, 1.

49. Last year, BCBSVT argued that the filing produced rates that are affordable because of the projected medical loss ratio (MLR) and because the large group market is competitive. The Board rejected these arguments and stated that, "in future filings, we expect better evidence regarding the affordability of rates from a consumer perspective." GMCB-001-23rr, Decision and Order (May 11, 2023), 10.

50. In connection with its filing this year, BCBSVT submitted a letter stating that "resorting to economic factors like household income or wage data that are unrelated to the cost of health care would ignore [the reality that rates are driven by claims costs.]" Letter from Martine Lemieux to Rebecca C. Heintz and Tom Weigel (Feb. 9, 2024), 1. BCBSVT therefore did not present information as to how premiums for its large group plans compare to what groups or subscribers can afford. Instead, it summarized various programs that it implements or supports that are aimed at reducing the cost of health care while promoting quality and access to timely care, namely value-based payment models and payment integrity and integrated health management programs. *See id*.

51. In its Memorandum in Lieu of Hearing, BCBSVT argues that the filing should be approved without modification. With respect to the actuarial criteria – excessive, inadequate, or unfairly discriminatory – BCBSVT cites L&E's findings and L&E's conclusion that the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. With respect to the affordability, quality, and access criteria, BCBSVT cites the letter that it submitted in connection with its filing regarding the programs that it implements or supports. BCBSVT asserts that adequate rates are a prerequisite for the existence of funding to deploy these kinds of programs. With respect to solvency, BCBSVT also notes that DFR has found that BCBSVT's targeted surplus range is reasonable and necessary for the protection of policyholders and that DFR has cautioned that any downward adjustments to the filings rate components that are not actuarially supported will likely further erode BCBSVT's surplus and RBC ratio. *See* BCBSVT Memo in Lieu of Hearing.

52. The HCA did not submit a Memorandum in Lieu of Hearing.

Standard of Review

The Board reviews rate filings to determine whether a proposed rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State" and is not "excessive, inadequate, or unfairly discriminatory." 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b). Although the latter terms – excessive, inadequate, or unfairly discriminatory – are defined actuarial standards, other standards by which the Board reviews rate filings are "general and open-ended," the result of "the fluidity inherent in concepts of quality care, access, and affordability." *In re MVP Health Insurance Co.*, 203 Vt. 274, 284 (2016). The Board additionally takes into considerations changes in health care delivery, changes in payment

methods and amounts, and other issues in its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

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

Conclusions of Law

I.

First, we adopt L&E's recommendation to approve the filing without modification. *See* Findings, ¶ 47.

The filing does not produce rates that are excessive, inadequate, or unfairly discriminatory.[7] *Id.* It is notable that BCBSVT's proposed CTR is twice what it has been in prior large group filings, apart from the last filing. *See* Findings, ¶ 43; GMCB-001-23, Decision and Order, Findings, ¶ 32. We choose not to reduce the proposed CTR, however, given BCBSVT's recent experience with high pooled claims. *See* Findings, ¶¶ 8-9. BCBSVT's surplus and RBC ratio have worsened when compared to the prior year end and its RBC ratio was below the targeted range as of December 31, 2023. Findings, ¶ 48. If higher than expected pooled claims continue, the actual CTR for the plans covered by this filing will be substantially lower than proposed and may be negative, as it has been almost every year since 2018, due in part to the high pooled claims experience. *See* Findings, ¶¶ 44-45.

While the filing does not produce rates that are excessive, inadequate, or unfairly discriminatory, BCBSVT failed to provide us with the information we requested regarding the affordability of the rates. *See* Findings, ¶¶ 49-50. BCBSVT's failure to provide this information despite being specifically asked to do so suggests that we may need to establish guidance or data submission requirements on this subject. We may also consider drawing adverse inferences in future filings from the lack of this information.

II.

Second, we require BCBSVT to submit a supplementary filing to account for additional hospital budget information that will become available later this year.

BCBSVT's medical unit cost trend for hospital claims is based on assumptions about the results of the Board's hospital budget review process. *See* Findings, ¶ 19. These assumptions have a material impact on the rates since hospital claims make up a significant portion of

[7] L&E found that BCBSVT made a mistake when calculating the 5-year average rate change used for the medical unit cost trend for facilities and providers impacted by the Board's hospital budget review process. However, L&E concluded that the mistake does not have a material impact and a revision to the filing is not necessary to correct the mistake. *See* Findings, 20.

BCBSVT's allowed medical claims. *See* Findings, ¶ 10. Because more information on hospital budgets will become available later this year, requiring a supplementary filing is appropriate.

ORDER

For the reasons discussed above, we approve the filing without modification and order BCBSVT to submit a supplementary filing to account for additional hospital budget information that will become available later this year.

SO ORDERED.

Dated: May 10, 2024, at Montpelier, Vermont

s/ Owen Foster, Chair)
)
s/ Jessica Holmes)
)
s/ Robin Lunge)
)
s/ David Murman)

GREEN MOUNTAIN CARE BOARD OF VERMONT

Filed: May 10, 2024
Attest: s/ Jean Stetter
Green Mountain Care Board
Administrative Services Director

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by email, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (Email address: 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, if any, must be filed with the Board within ten days of the date of this decision and order.*