STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Blue Cross and Blue Shield of Vermont Third Quarter 2018 Large Group Rating Program Filing	)	GMCB-003-18rr SERFF No.: BCBSVT-131424513
In re:	The Vermont Health Plan Third Quarter 2018 Large Group Rating Program Rate Filing	)	GMCB-004-18rr SERFF No.: BCVT-131424558

DECISION AND ORDER

Introduction

Under 8 V.S.A. § 4062(a)(2)(A), health insurers are required to submit major medical rate filings to the Green Mountain Care Board which must approve, modify, or disapprove the filing within 90 calendar days of receipt. On review, the Board must determine whether the proposed rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading or contrary to Vermont law. 8 V.S.A. §§ 4512(b); 4062(a)(3).

This decision affects the large group filings for Blue Cross and Blue Shield of Vermont (BCBSVT) and the Vermont Health Plan (TVHP), a for-profit subsidiary of BCBSVT. The approved rates will be used for renewing members in BCBSVT's and TVHP's large group market.

Procedural History

On March 15, 2018, BCBSVT and TVHP submitted their Large Group Rating Program rate filings to the Board via the System for Electronic Rate and Form Filing (SERFF). Because the filings incorporate the factor and rate development from combined BCBSVT and TVHP experience, we review both filings concurrently.[1]

On March 22, 2018, the Office of the Health Care Advocate (HCA), a special project within Vermont Legal Aid representing the interests of Vermont health insurance consumers, entered an appearance as a party to this filing. On May 15, 2018, the Department of Financial Regulation (DFR) filed its analysis and opinion regarding the filings' impact on the carrier's solvency. On the same date, the Board's contract actuary, Lewis & Ellis (L&E), submitted an actuarial memorandum evaluating the filings. Each of these documents was subsequently posted on the Board's rate review website.

[1] For convenience, we refer to both insurers in this Decision and Order as BCBSVT or "the carrier." The SERFF filings, as well as all documents referenced in this Decision and Order, can be found at http://ratereview.vermont.gov/node/694 (BCBSVT) and http://ratereview.vermont.gov/node/695 (TVHP).

The Board solicited written public comments on the filings through May 30, 2018; no members of the public provided comment. The parties waived hearing and filed memoranda in lieu thereof. *See* GMCB Rule 2.000, § 2.309(a)(1).

Findings of Fact

1. BCBSVT is a non-profit hospital and medical service corporation and is Vermont's largest health insurer. TVHP is a licensed health maintenance organization (HMO) and for-profit, wholly owned subsidiary of BCBSVT. Together, the two companies offer a variety of plans and products in Vermont's large group market. L&E Memo (BCBSVT) at 2; L&E Memo (TVHP) at 2.

2. These filings establish the formula, manual rate, and accompanying factors that will be used to establish premiums as members renew their coverage. They combine five factors that had historically been filed separately: trend; benefit relatives; administrative costs and contribution to reserves (CTR); aggregate stop loss; and large claims factors. *Id.*

3. The BCBSVT filing affects approximately 5,800 subscribers and 11,216 covered lives across 47 groups. The TVHP filing affects approximately 1,600 subscribers and 2,800 lives across 17 groups. *Id.*

4. The filings propose an overall average 11.2% rate increase across all 64 groups. *Id.* The proposed rate increase is comprised of a 6.0% increase in trend; a 1.2% increase in administrative charges;[2] a -0.3% change in CTR; a -2.5% decrease as a result of changes to federal programs (including amounts for the suspension of the annual federal health insurance provider fee and Patient-Centered Outcomes Research Institute Fee); an increase of 7.1% for worse than expected experience, and a -0.3% decrease for "other." *Id.* at 1.

5. For the base experience period, the carrier used claims incurred between August 1, 2013 and July 31, 2017 from BCBSVT Cost Plus groups, BCBSVT administrative services only (ASO) groups with less than 5,000 members,[3] BCBSVT small and large groups (including small groups enrolled in qualified health plans), and TVHP small and large groups. *Id.* at 2.

[2] The carrier reported its costs attributable to Vermont's statutory billback—the amount the State allocates to regulated entities for the costs of health care oversight under 18 V.S.A. § 9374(h)(1) —within the "other" category, rather than in its administrative expense category. As a result, the 1.2% is understated by 0.5%, while the "other" category is overstated.

[3] ASO groups with less than 5,000 members generally have similar benefits and use the same network contracts as the insured and Cost Plus groups. Thus, adding their claims increases the statistical credibility of the carrier's experience.

6. BCBSVT projected adjusted claims forward using a 5.9% total allowed[4] medical trend based on a 3.0% utilization trend and a 2.8% unit cost trend.[5] SERFF Filings (Actuarial Memoranda)[6] at 2. The carrier attributes the increase in utilization over prior years to increased inpatient days per member, the economic recovery, and the continuing shift towards delivering care in more appropriate settings. *Id.* at 10.

7. BCBSVT projected a 2.3% unit cost trend increase for Vermont facilities and providers impacted by the Board's hospital budget review, and a 3.4% increase for other facilities and providers, resulting in an overall unit cost trend projection of 2.8%. In developing the unit cost trend, BCBSVT initially assumed that 2018 and 2019 hospital budget increases would be identical to those implemented in 2017; the carrier updated its trend calculation to account for adjustments made by the Board to the University of Vermont Medical Center's and Porter Medical Center's approved budgets. For providers outside its service area, BCBSVT derived unit cost increases from the Fall 2017 Blue Trend Survey. *Id.* at 4.

8. Using a regression analysis of 24 months of historical data, a projected generic dispensing ratio of 90.6% (an increase of 1.6% over the prior filing's assumption of 89%), and a 19.2% trend adjustment for high-cost specialty drugs, the carrier calculated an overall allowed pharmacy trend of 9.7%. L&E Memo at 4-5.

9. To account for the leveraging effect of deductibles and copays, BCBSVT used its benefit relativity models to convert the allowed trends into paid trends, which are applied to large group experience to develop premiums. The carrier calculated a 7.0% paid medical trend and a 10.6% paid pharmacy trend. BCBSVT Memo at 16.

10. The filing indicates that administrative costs—not including the costs attributable to the billback provision—have increased 16.6%. The carrier's administrative cost calculation corrects an error in previous filings that resulted in an understatement of administrative charges, reflects a 3.0% increase in employee wages and benefits, and assumes that overall membership for 2019 will decrease, which spreads the company's fixed expenses over a smaller pool of insureds. *Id.* at 29; L&E Memo at 6.

11. In January 2018, Congress imposed a moratorium on collection of the Health Insurance Providers Fee for plan year 2019 as part of a short-term government funding bill. *See* Pub. L. No. 115-120 (2018). The carrier estimates that the moratorium will decrease premiums by approximately 2.1% in 2019. L&E Memo at 10.

12. The federal Tax Cuts and Jobs Act, passed in 2017, repeals the corporate Alternative Minimum Tax (AMT) which has been paid by BCBSVT since 1987. BCBSVT anticipates receiving credits for the AMT over a four-year period from 2019 through 2022, based on filed federal tax returns from 2018 through 2021. BCBSVT intends to use these funds "for the direct benefit of [its] customers as they are received from the IRS." BCBSVT has not determined the

[4] Allowed cost trends are based on charges that reflect the total amount of claims paid by both the carrier and the policyholder. Paid trends reflect the actual claim payment made by the carrier only.
[5] The allowed trend is reported as 5.9%, instead of 5.8%, due to rounding.
[6] We refer to these documents collectively as the "BCBSVT Memo."

method by which it will return the credits to customers, but may lower premium rates, replenish surplus shortfalls, or use "other appropriate measures designed to protect and minimize the costs incurred by members." BCBSVT Responses to HCA Questions (April 25, 2018) at 2-3.

13. BCBSVT requests a 1.5% CTR for fully-insured large groups and a 0.375% CTR for Cost Plus groups. The carrier's request represents a 0.5% reduction for fully insured large groups and a 0.125% reduction for Cost Plus groups over the previous filings, which the carrier attributes to tax savings from changes in federal tax law. BCBSVT Memo at 30.

14. Pursuant to 8 V.S.A. § 4062(a)(2)(B), the Department of Financial Regulation (DFR) provided the Board its assessment of the impact of the proposed filing on the carrier's solvency. DFR states that that the rates as filed likely would not have a significant impact on the carrier's solvency, but warns that a downward departure from the filed rates without actuarial support could over time have a negative impact and affect the company's solvency and access to health insurance. *See* Solvency Analysis at 1-2.

15. The carrier's data indicates a recent upward trend in utilization, with a 7.1% one-year increase when high-claimants are included in the calculation, and 3.6% increase without their inclusion. On review, L&E opined that the large one-year utilization increase is likely an "anomaly" but agreed with the carrier that a "substantial, non-zero utilization trend" is warranted. L&E calculated a range of reasonable utilization trend spanning from 1.5% to 3.0%, with a best estimate of 2.25%. L&E Memo at 7-8.

16. For the overall medical trend, L&E calculated a range of reasonable trends from 4.1% to 6.1%, and opines that because BCBSVT's proposed medical trend of 5.9% is within the estimated range, the proposed trend is actuarially reasonable. *Id.*

17. L&E independently estimated a range of reasonable pharmacy trend from 5.2% to 10.5% and considers BCBSVT's allowed pharmacy trend of 9.7% to be reasonable and appropriate. L&E notes that the carrier's unit cost estimates are consistent with publicly available drug pricing information, and utilization estimates consistent with its experience. *Id.* at 8-9.

18. L&E found that BCBSVT understated its proposed 16.6% increase in administrative costs by not including the billback as an administrative expense as in previous filings. Nevertheless, L&E opined that the assumptions underlying BCBSVT's proposed increase, which include a 2.5% administrative trend; a 3.0% budgeted 2017 wage increase; a 2.4% correction for an error in how the trend was applied in previous filings; a 10.3% increase resulting from updates to the base experience; a 0.8% increase due to a decline in membership, and 0.6% increase as a result of a change in the percentage of administrative costs allocated to the large group population, were reasonable. The proposed increase in administrative costs, including the billback expenses, produces a 1.7% increase in premiums. *Id.* at 10.

19. L&E opined that the carrier's proposed CTR of 1.5% for fully-insured groups and 0.375% for cost-plus groups is adequate to maintain risk-based (RBC) capital levels, in light of medical trend. *Id.* at 10.

20. Based on its review and analysis, L&E opines that the filings do not produce rates that are excessive, inadequate, or unfairly discriminatory, and therefore recommends that the Board approve them without modification. *Id.* at 11.

21. Both the carrier and the HCA provided legal memoranda to the Board; additionally, the carrier provided a reply memorandum, to which the HCA provided a response. The HCA asserts that BCBSVT failed to meet its burden of proof because it did not specifically address statutory criteria such as affordability, and requests that the Board "define carrier rate filing guidance" and to reduce its requested premium increase by a minimum of one percent. HCA Memo in Lieu of Hearing at 6-7, 10; HCA Response (June 6, 2018) at 1. BCBSVT disputes this assertion, and requests that the Board approve the filing without modification. BCBSVT Memo in Lieu of Hearing at 4; BCBSVT Response at 1-4.

Standard of Review

The Board reviews rate filings to ensure that 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." 8 V.S.A. § 4062(a)(3); GMCB Rule (Rule) 2.000, § 2.301(b). Although the first several 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.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); Rule 2.000, § 2.401.

In arriving at its decision, the Board must consider the DFR's analysis and opinion of the impact of the proposed rate 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 burden falls on the insurer proposing a rate change to justify the requested rate. *Id.* § 2.104(c).

Conclusions of Law

This double-digit rate filing highlights the inherent tension in our standard of review. On the one hand, we are required, without specific statutory guidance or a standardized definition, to ensure that insurance rates are affordable for Vermont consumers;[7] on the other, we must protect insurers' solvency by finding that the approved rates are adequate to cover their costs of paying for members' claims and for administering the plan. The failure to meet either standard imperils Vermonters' access to care. Our task, therefore, is to strike an appropriate balance between achieving the most affordable rates possible while also safeguarding the financial solvency of our health insurers.

[7] We note, though we do not adopt as a measure of affordability, that the ACA requires that proposed rate increases of 10% or more in the individual and small group markets receive thorough review for reasonableness.

To that end, we first reduce the carrier's proposed 3.0% utilization trend to L&E's best estimate of 2.25%. By choosing L&E's best estimate, we acknowledge that a "significant, non-zero" increase in trend is warranted in light of an uptick in utilization (including a one-year increase of 3.6% excluding high claimants) and select a point that falls squarely within L&E's calculated reasonable trend range tof 1.5% to 3.0%. Findings of Fact (Findings) ¶ 15. In addition to reducing the utilization trend, we in turn decrease the proposed overall medical trend from 5.9% to 5.1%, again arriving at the midpoint of L&E's calculated range of actuarially reasonable medical trends. Finding ¶ 16. While we are fully aware of L&E's assessment that BCBSVT's proposed medical trend is reasonable because it falls within the calculated range, we are also cognizant of the financial burden that this sizable rate increase places on Vermonters renewing their insurance coverage, and on balance reduce the trend to the midpoint, rather than the high end, of the calculated range.

We further conclude BCBSVT must limit the significant increase in its administrative expenses, notwithstanding a smaller membership over which to spread costs and the need to correct for errors in prior filings. Finding ¶ 18. By ordering a minimal reduction in administrative cost growth, we encourage the company to find innovative ways to increase efficiencies and to review internal policies and practices that, for example, may unnecessarily require providers to obtain prior authorizations for patient referrals, or which assume standard wage and benefit increases for employees while increasing the financial burdens on members via premiums that are rising at an unsustainable pace. To incentivize the carrier, we order a reduction in the growth of administrative expenses (including billback) from 1.7% to 1.5%.

Next, we reduce BCBSVT's proposed CTR from 1.5% to 1.0%. This reduction takes into account a decrease in overall large group membership which will require lesser reserves to cover fewer lives and the federal tax changes that BCBSVT has expressly stated it will use to benefit its members, which include both a reduction in federal taxes and the pending refund of the corporate Alternative Minimum Tax beginning in 2019. *See* Findings ¶ 12, 13; *see also* Press Release, Blue Cross and Blue Shield of Vermont Members to Benefit from Federal Tax Cuts (Mar. 1, 2018), *available at* http://www.bcbsvt.com/wps/wcm/connect/16b8c8a5-4bc0-48a5-bc4f-7a3bd5725f26/2018-bcbs-members-benefit-from-fed-tax-cuts-03.01.18.pdf?MOD=AJPERES. While we acknowledge that this filing spans calendar years 2018 and 2019 and that the company will not begin to realize AMT credits until some point in late 2019—based upon its 2018 tax filing—we nonetheless believe that some portion of the significant anticipated credits should be attributed to lowering member premiums in this book of business, and indeed, lowering premiums more broadly across the company's membership going forward.

Finally, in addition to the specific areas discussed above, we remind the carrier of our reasonable expectation, voiced in prior decisions, that our continued downward pressure on premium rate increases will foster vigorous contractual negotiations between the insurer and providers—including those outside of our borders—in a way that promotes parity in reimbursements between academic medical centers, community hospitals and independent practices, and that the reimbursements reflect actual costs of care, rather than site of service.

Order

For the reasons discussed above, we modify and then approve the BCBSVT and TVHP large group rating program filings. Specifically, we reduce the utilization trend to 2.25%, allowed medical trend to 5.1%, administrative expenses (inclusive of the billback) from 1.7% to 1.5%, and CTR from 1.5% to 1.0%.

As modified, the resulting average annual rate increase is approximately 9.8%.

SO ORDERED.

Dated: June 13, 2018 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
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s/ Tom Pelham)
)
s/ Maureen Usifer)

Filed: June 13, 2018

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

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:Agatha.Kessler@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.