STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Blue Cross and Blue Shield of Vermont Third Quarter 2019 Large Group Rating Program Filing	)	GMCB-002-19rr SERFF No.: BCBSVT-131835151
In re:	The Vermont Health Plan Third Quarter 2019 Large Group Rating Program Rate Filing	)	GMCB-003-19rr SERFF No.: BCVT-131835292

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board, which must approve, modify, or disapprove such filings within 90 calendar days of receipt. 8 V.S.A. §§ 4062(a), 4515a, 4587, 5104. On review, the Board must 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 Vermont law. 8 V.S.A. § 4062(a)(3).

This decision pertains to the large group rating program filings of Blue Cross and Blue Shield of Vermont (BCBSVT), a non-profit hospital and medical service corporation, and The Vermont Health Plan (TVHP), a licensed health maintenance organization and for-profit subsidiary of BCBSVT. The approved rates will be used by BCBSVT and TVHP to determine the rates of experience-rated fully-insured groups, including large groups with over 100 employees and grandfathered small groups with 51-100 employees.

Procedural History

On February 21, 2019, BCBSVT and TVHP (hereafter referred to collectively as either BCBSVT or "the carrier," except when specified) submitted their Large Group Rating Program rate filings to the Board via the System for Electronic Rate and Form Filing (SERFF). Because the filings incorporate the factor and rate development from combined BCBSVT and TVHP experience, we review both filings concurrently.[1]

On February 28, 2019, 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 April 19, 2019, the Department of Financial Regulation (DFR) filed its analysis and opinion regarding the filings' impact on the carrier's

[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/BCVT-131835151 (BCBSVT) and https://ratereview.vermont.gov/BCVT-131835292 (TVHP).

solvency. On April 23, 2019, the Board's contract actuary, Lewis & Ellis (L&E), submitted an actuarial memorandum evaluating the filings ("L&E Memo"). Each of these documents was subsequently posted on the Board's rate review website.

The Board solicited written public comments on the filings through May 8, 2019; no member of the public provided comment. The parties waived a 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 and a for-profit, wholly owned subsidiary of BCBSVT. Together, the two companies offer a variety of plans and products in Vermont's large group health insurance market. L&E Memo at 1.

2. These filings apply to insured large group products, including Cost Plus products, and establish the formula, manual rate, and accompanying factors BCBSVT will use to establish premiums as these groups renew their coverage. *Id.*; BCBSVT Memo at 3.

3. The filings affect 7,746 subscribers and 14,664 covered lives across 68 groups. BCBSVT Memo at 3; *see also* L&E Memo at 1.

4. BCBSVT estimates that the filings, if approved, would result in an average manual rate increase of 14.9% across all 68 groups. The overall increase is comprised of a 6.1% increase in trend; a 1.2% increase in administrative charges; a 0.7% increase in contribution to reserve (CTR); a 2.4% increase for changes to federal programs (including the resumption of the federal health insurance provider fee); a 3.6% increase for worse than expected experience; and a 0.3% increase for other factors.[2] L&E Memo at 1-2.

5. The actual premium increases experienced by groups will vary from the overall average manual rate increase of 14.9%. Each group's premium increase will account for its recent claims experience, changes in the distribution of members enrolled, and changes in benefits. L&E Memo at 2; *see also* BCBSVT Responses to Objection Letter #1, Q.1 (March 18, 2019) (stating that none of BCBSVT's insured groups are fully manually rated).

6. To develop medical trend, BCBSVT used claims incurred from July 1, 2014 to June 30, 2018 and applied completion factors to project the ultimate incurred claims based on best estimates (i.e., no margin for conservatism was included).[3] The claims used were from BCBSVT Cost Plus groups, BCBSVT administrative services only (ASO) groups with less than 5,000 members, BCBSVT Insured Small and Large Groups (including small groups enrolled in qualified health

[2] The components are multiplicative and therefore may not add up to exactly 14.9%.
[3] Settling claims with providers often takes enough time that not all claims from the experience period are known with certainty. Completion factors are used to estimate the ultimate incurred claims based on the historical pattern of paid claims.

plans), and TVHP Small and Large Groups. Adjustments were made to the data to reflect network differences between BCBSVT and TVHP. L&E Memo at 2; *see also* BCBSVT Memo at 11.

7. Medical trend varies by company and plan type due to contracting differences. For all products combined, BCBSVT projects a total allowed[4] medical trend of 7.1% per year, comprised of a total utilization trend of 3.5% and a total unit cost trend of 3.5%. L&E Memo at 2.

8. To develop its medical utilization trend, the carrier analyzed the claims data using exponential regression over the 24-month and 36-month time periods ending June 2018, which resulted in utilization trend estimates of 4.2% and 3.2%, respectively. The most recent 12 months showed utilization at 3.9% higher than the prior 12 months. The carrier also performed time series analyses using six different time series methods and calculated each of them over 24, 36 and 48 months of historical data. The results ranged from a minimum utilization trend of 0.4% to a maximum of 6.1%. After an evaluation of the different trend estimates produced by these methods, the carrier selected a 3.5% utilization trend. L&E Memo at 3, 7.

9. BCBSVT cites increased utilization across the spectrum of professional services as a driver of the overall utilization trend, including increases in utilization of primary care services, mental health and substance abuse services, and lab and radiology services. BCBSVT also cites an increasing cost in the mix of inpatient services, noting that inpatient cost per admission has increased 6% due to more expensive drugs and injectables being administered during inpatient stays. L&E Memo at 3; BCBSVT Memo at 13-14.

10. BCBSVT projects a 4.0% unit cost increase for Vermont facilities and providers impacted by the Board's hospital budget review and a 3.0% increase for other facilities and providers, resulting in an overall unit cost trend of 3.5%. In developing the unit cost trend, BCBSVT assumed the Board would approve hospital budgets for October 1, 2019 and October 1, 2020 that support identical commercial increases as the approved increases for October 1, 2018; these assumptions were replaced in instances where the carrier's contracting department was able to provide estimates for specific facilities. L&E Memo at 3-4. BCBSVT acknowledges that unit cost increases for Vermont hospitals have reached historic lows but claims the impact is largely offset by increasing utilization and intensity. BCBSVT Responses to Objection Letter #1, Q.4 (March 18, 2019); BCBSVT Memo at 14. For providers outside its service area, BCBSVT derived unit cost increases from the Fall 2018 Blue Trend Survey. L&E Memo at 4.

11. BCBSVT updated its method of developing pharmacy trends since the prior filing. It analyzed the components of trend (cost and utilization) separately for brand and generic drugs. It then made an adjustment for the estimated impact of brand drugs going generic in the projection period. L&E Memo at 8. Because of the high cost and low frequency of specialty drugs, BCBSVT developed an overall trend for these drugs instead of separating the trend into unit cost and utilization components. BCBSVT Memo at 15-16; L&E Memo at 8.

12. The initial filing projects an overall pharmacy allowed trend of 7.8% per year. This reflects not only unit cost and utilization changes, but also contracting changes with the Pharmacy

[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.

Benefit Manager (PBM) that reduced the trend from 8.5% to 7.8%. Included in this overall pharmacy trend are unit cost trends of 3.5% for generic drugs and 5.9% for brand drugs, as well as an 18.0% trend for specialty drugs. Based on L&E's review, the carrier agreed to revise its generic cost trend study to ignore the impact on historical costs of brand drugs moving to generic; this modification was recommended by L&E to correct an error in calculation which resulted in a slight "double-counting" of generics in the original filing. L&E Memo at 9. This reduces the projected unit cost trend for generics from 3.5% per year to 0.0% per year and reduces BCBSVT's overall requested pharmacy trend from 7.8% to 7.2%. L&E Memo 4-5, 8-9.

13. 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 an 8.0% paid medical trend and an 8.5% paid pharmacy trend. L&E Memo at 6.

14. The filing projects a 17.8% increase in administrative costs, resulting in a 1.2% increase in the manual rate. The carrier's administrative cost assumptions include a 2.5% administrative trend, including a 3.0% increase in personnel costs (wages and benefits); a 16.3% increase resulting from updates to the experience base and a significant decrease in large group membership over which to spread fixed costs; a 0.7% increase due to a decline in total carrier membership over which to spread fixed costs; and a 0.1% increase as a result of the large groups that are expected to renew in 2019 having higher administrative costs than the average across all groups. L&E Memo at 6, 9.

15. 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). It is expected that the fee will be collected again starting in 2020.[5] The carrier projects that the fee will be equal to $13.85 PMPM for BCBSVT and $14.12 PMPM for TVHP. L&E Memo at 6.

16. BCBSVT requests a 1.5% contribution to reserve (CTR) for fully-insured large groups and a 0.375% CTR for Cost Plus groups,[6] which are the same amounts as requested in the prior filing and would increase the rate by 0.7%. L&E Memo at 1, 7.

17. For the combined BCBSVT and TVHP large group block that is used for rate development, the carrier experienced a 7.9% loss in 2018. This contrasts with both the proposed CTR of 1.5% in this filing and the Board-ordered 1.0% from the last filing. As a result, the manual rates in this filing were increased by 3.6% to account for the deterioration in expected claims experience. L&E Memo at 7, 10.

18. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR provided the Board its assessment of the impact of the proposed filings on the carrier's solvency. DFR notes that BCBSVT's risk-based

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[5] BCBSVT stated it would "continue to update the rating formula in the event of a suspension of this fee." BCBSVT Memo at 39.

[6] Cost Plus groups are at risk for the claims incurred by their members and therefore pose less risk to the carrier. *See* BCBSVT Memo at 39

capital (RBC) ratio, a tool used by DFR to assess the adequacy of a carrier's surplus, has fallen below the current and former target ranges.[7] DFR states that the rates as filed likely would not have a significant impact on the carrier's solvency but warns 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 over time, thereby impacting access to health insurance in Vermont. DFR Solvency Analysis.

19. With respect to the 3.5% medical utilization trend selected by BCBSVT, L&E noted that each of the different analyses performed by the carrier produced varied results, which indicates uncertainty in the projected utilization trends. L&E concluded that the underlying trend over the last four years has variability such that a 90% confidence interval would be from 1.8% to 5.2% per year. L&E found BCBSVT's trend assumption to be reasonable, noting that BCBSVT could plausibly have assumed a higher number. L&E Memo at 7.

20. L&E concluded that the 3.5% medical unit cost trend selected by the carrier appears to be reasonable and appropriate. L&E Memo at 7.

21. For the overall medical trend, L&E calculated a range of 5.4% to 8.9% and opines that L&E's assumed trend of 7.1% is reasonable in light of the known and likely hospital budget increases and a consistent pattern of increasing utilization in recent years. L&E Memo at 7-8.

22. With regard to the proposed administrative cost increase of 1.2%, BCBSVT stated that it "removed any expenses incurred due to one-time, non-recurring events, as these fees are not expected to continue to occur in the projection period. These include transitional costs associated with the conversion to a new technology platform. Decreasing membership has reduced total variable costs, but BCBSVT has delayed reducing its administrative budget in order to support transition activities. This transition will be complete by the end of 2019, so we have reflected a transitional savings of $0.91 PMPM in 2020 for the large group line of business." BCBSVT Memo at 33.

23. L&E opined that the assumptions underlying BCBSVT's proposed administrative cost increase of 1.2% appear to be reasonable. L&E Memo at 9; *see supra* Findings ¶ 14.

24. L&E opined that the carrier's proposed CTR of 1.5% for fully-insured groups and 0.375% for cost-plus groups is reasonable in order to maintain RBC levels in light of medical trend and provide an adequate margin over and above the minimum to keep appropriate RBC levels in the case of an adverse event without being excessive. L&E Memo at 10.

25. Based on its review and analysis, L&E opines that the filings, modified to reduce the projected unit cost trend for generics from 3.5% per year to 0.0% per year, do not produce rates that are excessive, inadequate, or unfairly discriminatory, and therefore recommends that the

[7] Earlier this year, DFR approved a proposal from BCBSVT to change its target RBC range to 590% - 745%. Previously, BCBSVT's target range had been 500% - 700%. *See, IN THE MATTER OF: Blue Cross and Blue Shield of Vermont Risk-Based Capital Range Study*, Order, No. 19-007-1 (Feb. 7, 2019), https://dfr.vermont.gov/reg-bul-ord/bcbsvt-risk-based-capital-order.

Board approve the rates with the above modification, which would result in an overall manual rate increase of 14.6% ($79.55 PMPM). L&E Memo at 10.

26. Both the carrier and the HCA provided legal memoranda to the Board; additionally, the carrier provided a reply memorandum. BCBSVT requests that the Board approve the proposed rate filings with the modification recommended by L&E. BCBSVT Memo in Lieu of Hearing at 1. The HCA asserts that BCBSVT failed to demonstrate that the proposed rate meets statutory criteria, including evidence of affordability. HCA Memo in Lieu of Hearing at 9. In addition to adopting L&E's recommended reduction to non-specialty unit cost trend, the HCA asks the Board to "further reduce BCBSVT's high requested rate to increase affordability for Vermonters." HCA Memo in Lieu of Hearing at 9.

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" 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.*, 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. Rule 2.000, § 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;[8] 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.

[8] 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 projected unit cost trend for generics from 3.5% per year to 0.0% per year and reduce BCBSVT's overall requested pharmacy trend from 7.8% to 7.2%, a reduction to which BCBSVT has agreed. Findings of Fact (Findings) ¶¶ 12, 25. This modification was recommended by L&E to correct an error in calculation which resulted in a slight "double-counting" of generics in the original filing. Findings ¶¶ 12, 25.

Second, we reduce the carrier's annual medical utilization trend from 3.5% to 3.36%. A trend of 3.36%, while slightly below the carrier's requested trend, is also slightly above the midpoint of one of the carrier's ranges (0.4% to 6.1%) resulting from six different time series methods calculated using 24, 36 and 48 months of historical data; furthermore, 3.36% falls squarely within L&E's calculated range (1.8% to 5.2%), which has a 90% confidence interval. Findings ¶¶ 8, 19. We expect that reducing the annual medical utilization trend to 3.36% will decrease the overall medical trend from 7.1% to approximately 7.00%, which is near the midpoint of L&E's calculated range of actuarially reasonable medical trends (5.4% to 8.9%), and will result in an approximately 0.25 percentage point reduction in the overall manual rate. Findings ¶ 19. While we are fully aware of L&E's assessment that BCBSVT's proposed medical utilization trend is reasonable because it falls within the calculated range and that BCBSVT could plausibly have assumed a higher trend, BCBSVT could also plausibly have assumed a lower trend. *Id.* Given the financial burden that this sizable rate increase places on Vermonters renewing their insurance coverage and the fact that the increase will further decrease the affordability of coverage and access to coverage as premiums continue to rise faster than incomes, on balance, we find that a reduction in trend is appropriate.

Third, as we did last year, we conclude BCBSVT must limit the significant increase in its administrative expenses, notwithstanding a smaller membership over which to spread costs. Findings ¶¶ 14, 23. Related to the affordability criterion in the Board's rate review process is the expectation that BCBSVT provide benefits and services at minimum cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c), 4584(c), 5104(b). In approving BCBSVT's modified large group rate for 2018, where the company again had a smaller membership over which to spread costs, the Board ordered a minimal reduction in administrative cost growth from 1.7% to 1.5% to 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. *In re Blue Cross Blue Shield of Vermont Third Quarter 2018 Large Group Rating Program Filing,* Docket No. GMCB-003-18rr, Decision & Order (Jun. 13, 2018), 6. Similarly, in BCBSVT's Vermont Health Connect 2019 Filing, the Board stated its expectation that BCBSVT "actively and critically review its policies and procedures and institute best practices that reduce administrative burdens and inefficiencies, provide fair and equitable provider reimbursement, ensure appropriate utilization of services, and improve health outcomes" and that "administrative spending should be routinely examined by the carrier for opportunities for savings." *In re Blue Cross Blue Shield of Vermont 2019 Individual and Small Group Rate Filing,* Docket No. GMCB-009-18rr, Order & Decision (Aug. 14, 2018), 18.

As required by GMCB Rule 2.000, § 2.104(c), BCBSVT has the burden of justifying its proposed rate. In this filing, as with last year's large group filing, BCBSVT has stated that a portion

of the increase in administrative costs is the result of spreading fixed administrative costs over a smaller membership. The fact that BCBSVT is spreading fixed costs over a smaller membership is not in itself evidence that BCBSVT is not providing services and benefits at a minimum cost under efficient and economical management. However, we note that BCBSVT has provided no evidence in this filing that demonstrates it has made or plans to make any effort to streamline its operations and reduce costs in the face of decreasing membership, other than to indicate that it has delayed reducing its administrative costs in order to support one-time transition activities in 2019. Findings ¶¶ 22-23.

Therefore, in light of the Board's responsibility to ensure rates are affordable, and BCBSVT's failure to provide evidence that it has addressed or will address the growing impact of spreading its fixed administrative costs over a smaller membership, we reduce the overall rate increase resulting from administrative costs by 0.25 percentage points, from 1.2% to 0.95%.[9]

Finally, we note that the rate increase is impacted by the expected return of the Health Insurance Providers Fee in 2020, which BCBSVT assumes will be equal to $13.85 PMPM for BCBSVT and $14.12 PMPM for TVHP. Findings ¶ 15. We approve this component of the rate on the condition that BCBSVT is required to collect the fee in 2020; if collection of the fee is suspended again for 2020, we require BCBSVT to adjust its rates accordingly.

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 generic drug unit cost trend from 3.5% to 0.0%, which reduces the overall rate increase by approximately 0.3 percentage points, and we also reduce the annual medical utilization trend from 3.5% to 3.36% and the overall rate impact of administrative costs by 0.25 percentage points, which further reduces the overall rate increase by approximately 0.5 percentage points.

As modified, the resulting average annual rate increase is approximately 14.0%.

SO ORDERED.

Dated: May 23, 2019 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
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s/ Jessica Holmes) GREEN MOUNTAIN

[9] We expect this will require administrative cost increases to be reduced from 17.8% to approximately 14.1%.

) CARE BOARD
s/ Robin Lunge) OF VERMONT
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s/ Tom Pelham)
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s/ Maureen Usifer)

Filed: May 23, 2019

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