STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	Blue Cross and Blue Shield of Vermont Third Quarter 2020 Large Group Rating Program Filing	))))	GMCB-002-20rr SERFF No.: BCVT-132350241
In re:	The Vermont Health Plan Third Quarter 2020 Large Group Rating Program Rate Filing	))))	GMCB-003-20rr SERFF No.: BCVT-132350492

DECISION AND ORDER

Introduction

Health insurers must submit major medical rate filings to the Green Mountain Care Board (GMCB or "the Board"), which must approve, modify, or disapprove each filing within 90 calendar days. 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 premiums of experience-rated fully-insured large groups with over 100 employees.

Procedural History

On April 23, 2020, 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 April 27, 2020, 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 these filings. On June 22, 2020, the Department of Financial Regulation (DFR) filed its analysis and opinion regarding the filings' impact on the carrier's solvency. On

[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-132350241 (BCBSVT) and https://ratereview.vermont.gov/BCVT-132350492 (TVHP).

June 22, 2020, 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 July 8, 2020; 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. BCBSVT provides individual coverage, small and large group coverage to employers, and Medicare Supplement coverage in Vermont. TVHP is a licensed health maintenance organization and a for-profit, wholly owned subsidiary of BCBSVT. TVHP provides large group coverage to employers in Vermont. 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 the carrier will use to establish premiums as these groups renew their coverage. This filing includes support for key assumptions, such as trend, benefit relativities, administrative costs, aggregate stop loss, and large claim factors. The overall impact of these filings was estimated based on the previously approved factors from the prior filings. *Id.*

3. The filings affect 9,015 members (5,252 subscribers) in 49 groups. BCBSVT Actuarial Memorandum (BCBSVT Memo) at 3.

4. BCBSVT estimates that the filings, if approved, would result in an average manual rate increase of 1.9% (approximately $11.14 PMPM); this increase is comprised of a change to projected claims of 3.0%, a change in administrative charges of 1.0%, a change in contribution to reserve (CTR) of 0.1%, and changes in federal programs of -2.1%. L&E Memo at 1-2.

5. The 1.9% manual rate in this filing should not be interpreted as representing the expected premium change for the average covered members/groups; treating these amounts as equivalent assumes that all groups' experienced 2019 claims equal to 2018 claims, an assumption which is not expected to hold. L&E Memo at 1. Rather, the average group will likely experience a premium change of approximately 5.9%, comprised of a change to projected claims of 7.0%, a change in administrative charges of 0.9%, a change in CTR of 0.1%, and changes in federal programs of -2.1%. L&E Memo at 1-2.

6. The expected average premium change was calculated using a hypothetical group which has no group-specific experience; the actual premium increases experienced by groups will vary from the average of 5.9% and from the manual rate increase of 1.9%. Each group's premium increase will account for its recent claims experience, changes in the distribution of members enrolled, and changes in benefits. The most important component of any group's premium is its past claims experience. For this reason, no group's actual premium increase pursuant to this filing is currently known. L&E Memo at 1-2; *see also* BCBSVT Responses to Objection Letter #1 (March 18, 2019) (stating that none of BCBSVT's insured groups are fully manually rated).

7. To develop medical trend, BCBSVT used claims incurred from Nov. 2015 to Oct. 2019 and applied completion factors to project the ultimate incurred claims based on best estimates (i.e., no margin for conservatism was included).[2] 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 plans), BCBSVT AHPs and TVHP Small and Large Groups. Adjustments were made to the data to reflect network differences between BCBSVT and TVHP. L&E Memo at 2-3.

8. Medical trend varies by company and plan type due to contracting differences. For all products combined, BCBSVT projects a total allowed[3] medical trend of 7.0% per year. This total allowed medical trend is broken down into 2.0% for utilization and intensity and 4.4% for unit cost for most medical services. The 7.0% includes the impact of outpatient drugs which are trended at a higher rate (an 11.3% total allowed trend) compared to other medical costs. L&E Memo at 3, 5; BCBSVT Memo at 11-12.

9. To develop its medical utilization trend, the carrier performed year-over-year rolling PMPMs, exponential regressions, and times series analysis. These methods produced varied results, which indicates uncertainty in the projected utilization trends. The carrier noted that emerging 2020 professional experience may be trending higher than these historical trends would suggest. The carrier analyzed the claims data using exponential regression over the 24-month, 36-month, and 48-month time periods, which resulted in utilization trend estimates of 0.5% (24 rolling), 2.1% (36 rolling), and 1.9% (48 rolling). In consideration of these numbers and the year-over-year trends in recent years, BCBSVT assumed a 2.0% per year utilization trend (2.5% for facility claims and 1.0% for professional claims). L&E Memo at 3; BCBSVT Memo at 11.

10. L&E reviewed the regression analysis and considered the possibility of random fluctuation in the results. The data suggest that the underlying trend over the last 4 years has variability such that a 90% confidence interval would be from 0.6% to 3.1% per year. L&E opined that BCBSVT's utilization trend assumption is reasonable. L&E Memo at 4.

11. BCBSVT projects a 4.4% medical unit cost trend, comprised of a 5.4% increase for Vermont facilities and providers impacted by the Board's hospital budget review and a 3.3% increase for other facilities and providers. L&E Memo at 4. Unit cost increases for providers outside the BCBSVT service area were derived from the Blue Trend Survey. The 5.4% medical unit cost trend for facilities and providers impacted by the Board's hospital budget review assumes that GMCB-regulated hospitals will have to file higher increases for October 2020 than the increases approved in 2019 due to a variance in hospitals' budgeted and actual operating expenses. BCBSVT Memo at 9; Response to Objection Letter #3; L&E Memo at 4. BCBSVT supported this assumption by noting that, on a system-wide basis, hospitals' actual FY19 operating expenses were 2.9% higher than budgeted and hospitals' actual FY19 net patient revenue (NPR) was 0.8% lower

[2] 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.

[3] 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.

than budgeted. Based on these variances, the carrier increased the unit cost change at each GMCB-regulated hospital by 2.1 percentage points, which is the increase in operating expenses "rebased" for the overall change in NPR. Response to Objection Letter #3. L&E finds the calculations of this assumption to be reasonable and while L&E recommends that the Board consider these items and the potential impact of COVID-19 on the coming hospital budget decisions, it did not express an opinion on whether these adjustments are appropriate at this time. L&E Memo at 4-5.

12. A methodological change from last year's filing is that BCBSVT isolated claims related to pharmaceuticals covered by the medical benefit (as opposed to pharmaceuticals dispensed in a retail setting). These prescriptions are differentiated from others due to the fact that medical deductibles and cost sharing apply, rather than the prescription drug benefits. This is often because they are dispensed in an outpatient medical facility. Claims for these "outpatient drugs" were treated by BCBSVT as a special carve-out in the determination of medical trend. The trend for this category was not split into utilization and unit cost components. Historical cost for outpatient drugs was provided by incurral month for the last several years and shown to be increasing at a steady rate. The carrier assumed an 11.3% increase in cost per year for outpatient drugs. The assumed 11.3% increase is consistent with historical trends since late 2015. This higher trend rate was applied instead of the medical unit cost and utilization trends described above for the roughly 10-15% of medical cost associated with outpatient drugs. L&E Memo at 5; BCBSVT Memo at 11.

13. The utilization and intensity trend of 2.0% combined with the unit cost trend of 4.4% results in most medical claims being trended at a 6.4% annual rate. With the inclusion of outpatient drugs trended at 11.3% per year, the total medical allowed trend projected by the carrier in the filings is 7.0%. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. L&E's estimated range for the total allowed medical trend is 5.3% to 8.8%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range. L&E found BCBSVT's assumed total allowed medical trend of 7.0% to be reasonable in light of the known and likely hospital budget increases, as well as the consistent pattern of increasing utilization in recent years. L&E Memo at 5-6.

14. BCBSVT is requesting a total allowed pharmacy trend of 10.5%, which includes the impact of contracting changes with BCBSVT's Pharmacy Benefit Manager. The pharmacy utilization trend is developed for brand and generic drugs combined, with separate unit cost trends for each drug category. The carrier calculated unit cost trends of 0.0% for generic drugs and 8.6% for brand drugs. Both of these are consistent with recent trends in the observed changes in cost for these categories, as demonstrated in BCBSVT's filing exhibits. L&E Memo at 6. BCBSVT isolated drugs which were brand drugs during the base period, but which will have generic alternatives in 2021. For these drugs, the unit cost does not increase by the 8.6% assumed for other brand drugs. Instead, they are being reduced by 51% to reflect the price impact of cheaper competitors and/or members purchasing the generics instead of the brand drug. L&E Memo at 6-7. Due to their high cost and low frequency, specialty drugs were projected based on their allowed cost, without splitting into unit cost and utilization. BCBSVT selected a 19.0% trend for specialty drugs based on regression analysis of historical claims. L&E Memo 6-7; BCBSVT Memo at 13. L&E found the total pharmacy allowed trend of 10.5% to be reasonable in aggregate as well as when analyzed by the components described above. L&E Memo at 7.

15. To account for the leveraging effect of deductibles and copays, BCBSVT used its benefit relativity models to convert the allowed trends into paid trends. L&E found the carrier's approach to adjusting allowed trends to paid trends to be reasonable and appropriate. The carrier calculated a 7.8% paid medical trend and an 11.4% paid pharmacy trend. L&E Memo at 7-8.

16. The approved administrative charge in the prior filing was $50.20 PMPM. The proposed administrative charge in this filing is $53.91 PMPM. This increase, which has a 1.0% impact on the manual rate and an expected 0.9% impact on premiums for an average group, is attributable to three factors: administrative trend, updated experience, and a decrease in total membership. L&E Memo at 2, 8. The carrier's administrative trend projection assumes that wages and benefits (73.9% of administrative costs) will increase at 3.0%, while other operating costs will remain flat. This 3.0% wage increase results in a change to premiums of roughly 0.3%. L&E Memo at 8; BCBSVT Memo at 27. A significant portion of the administrative charge increase is attributable to the fact that actual 2019 administrative costs were higher than anticipated in the prior filing. This increase in administrative costs flows through to the projected 2021 administrative costs. Finally, BCBSVT is projecting a decrease in overall membership for 2021 across all lines of business. Since administrative expenses will be distributed among a smaller pool of members, an increase in the total PMPM administrative charge results. While BCBSVT did not reduce staff in response to its decreasing membership, BCBSVT did remove the variable costs associated with this reduction in membership. BCBSVT states that variable costs represent approximately half of total administrative expenses, so, rather than increasing the charge by 6% (the PMPM increase that results from using the lower enrollment), BCBSVT instead increased it by 3%. L&E Memo at 8; BCBSVT Memo at 27 ("BCBSVT is committed to providing insurance at the most affordable rates possible; as a result, even though it is impractical to react to enrollment shifts by immediately right-sizing staff, we nonetheless remove from our projection the entirety of variable costs associated with the reduced enrollment."). L&E found that the assumptions used in the each of the components appear to be reasonable and appropriate. L&E Memo at 8.

17. During L&E's review of the filing, BCBSVT discovered an error in the calculation of the administrative costs. The HCA billback paid by TVHP was inadvertently included in the administrative cost development, despite also being included as a separate line item. BCBSVT asked to remove this amount from the administrative fee and L&E agrees with this change. The impact of this change appears to be a reduction of approximately $0.20 to the proposed premiums, or less than a 0.1% change. L&E Memo at 8.

18. H.R.1865 - Further Consolidated Appropriations Act repealed the ACA's Section 9010 health insurer fee (HIF) for 2021. For groups renewing in 2020, the proposed rating manual applies a pro-rated fee of 2.2% of premium for coverage months in 2020. For coverage months during 2021 and later, the fee is 0.0%. L&E concluded that the 2.2% fee applied to coverage during 2020 is reasonable in relation to the historical cost of this fee and noted that the fee is applicable only to a portion of the coverage year for groups renewing prior to year-end. L&E Memo at 9.

19. BCBSVT requests a 1.5% increase to CTR for fully-insured large groups and a 0.375% CTR for Cost Plus groups,[4] which are the same amounts as requested in the prior filing. L&E Memo at 9. L&E believes the 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 9.

20. For the combined BCBSVT and TVHP block that is used for rate development, the carrier experienced 2019 claims that were 0.2% higher on a PMPM basis than what was implied in the carrier's 2020 rate filing. For this reason, the change in projected claims is approximately equal to an additional year of trend (8.6%) plus 0.2%. L&E Memo at 9.

21. Based on its review and analysis, L&E recommends that the Board approve the filing with the following modifications: (1) correct the administrative charges to remove the TVHP billback amounts included in the base period, (2) use the updated unit cost trend calculation which removes an immaterial formula error for BCBSVT Non-Managed Care groups, and (3) consider the impact of FY19 Year-End Actuals Hospital Budget reporting as well as potential disruptions from COVID when reviewing the medical unit cost assumptions. With these changes, the explicit increase resulting from this filing would be 1.9% and the expected premium increase experienced by policyholders would be 5.9%. L&E opines that the filings, modified as recommended, do not produce rates that are excessive, inadequate, or unfairly discriminatory. L&E Memo at 10.

22. Pursuant to 8 V.S.A. § 4062(a)(2)(B), DFR provided the Board with its assessment of the impact of the proposed filings on the carrier's solvency. DFR noted that two important indicia of BCBSVT's solvency, its surplus and RBC ratio, have improved when compared to the prior year end. However, DFR also noted that the carrier's RBC Ratio was below its targeted range as of December 31, 2019. DFR opined that any downward adjustments to the filing's rate components that are not actuarially supported will likely erode BCBSVT's surplus and RBC ratio. As additional context for this year's filing, DFR notes that the combined impact of COVID-19 is not fully known and, therefore, neither is the impact on solvency. With that background, DFR does not expect the proposed rates will have a significant impact on its overall solvency assessment of BCBSVT. DFR Solvency Analysis at 1-2.

23. Both the carrier and the HCA provided legal memoranda to the Board; neither party provided a reply memorandum. BCBSVT's Memo in Lieu of Hearing (BCBSVT Brief) requests that the Board approve the proposed rate filings consistent with L&E's recommendations. BCBSVT Brief at 1. In particular, BCBSVT raises concerns surrounding the adequacy of its filed unit cost and the unknown impact of COVID-19 on BCBSVT's reserves. BCBSVT notes that while it added 2.1% to anticipated hospital budget increases due to its observations about FY19 hospital expense overages, the University of Vermont Health Network recently released a notice to payers stating that it intends to implement a 9.7% chargemaster increase for the University of Vermont Medical Center (UVMMC) pending GMCB approval in its upcoming budget proceeding. BCBSVT asserts that UVMMC's proposed increase, which BCBSVT notes is significantly higher

[4] 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 31.

than the estimated increase included in this formula and factor filing, suggests that the filed unit cost assumptions may be inadequate. BCBSVT Brief at 5.

24. In addition, BCBSVT points in its brief to the GMCB hospital budget guidance allowing for a temporary upward adjustment to FY21 revenue "to reflect the unique circumstances caused by the pandemic and the associated decreased revenue and utilization experienced by the hospitals in FY20" and notes that the temporary increase is intended to "compensate [hospitals] for FY20 utilization that was not realized due to COVID-19." Should hospitals take advantage of the temporary increase, BCBSVT asserts that the FY21 unit cost assumptions in this filing will prove to be inadequate. BCBSVT echoes L&E's recommendation to consider FY19 fiscal results and the recent hospital budget guidance in issuing a decision on the medical unit cost assumptions submitted in these filings. Given what BCBSVT asserts are "strong indications that hospitals will submit budgets in excess of those assumed within the filings," BCBSVT urges the Board to avoid exacerbating the likely medical unit cost inadequacy by reducing the filed factors below actuarially adequate levels. BCBSVT Brief at 6.

25. BCBSVT acknowledges that the flip side of the FY20 hospital revenue shortfalls is a likely 2020 underwriting gain for BCBSVT and other insurers but it asserts that it is too early to tell with certainty what the long term consequences of COVID-19 will be on the health care spending of BCBSVT's large group fully insured clients, and particularly how the pandemic will impact 2021 health care expenditures. BCBSVT asserts that it has never increased rates to make up for previous years' losses, despite significant and persistent losses in the lines of business considered in these filings, and that it would be inappropriate to impose on 2021 rates a carry-forward of any 2020 gain realized by BCBSVT without also considering the cumulative losses over the previous several years, along with BCBSVT's current RBC position. BCSBVT Brief at 6-7.

26. The HCA asserts in its Memorandum in Lieu of Hearing (HCA Brief) that BCBSVT failed to demonstrate that the proposed rate meets statutory criteria, including evidence of affordability. HCA Brief at 3. Citing the 2018 Vermont Household Health Insurance Survey, the HCA asserts that, pre-COVID-19, 25% of uninsured Vermonters with access to employer sponsored insurance indicated they were not able to afford premiums. HCA Brief at 3. The HCA also asserts that from 2015 to 2019, BCBSVT's large group manual rate has substantially outpaced real GDP growth, as well as real wage growth in Vermont. HCA Brief at 3-5.

27. In its brief, the HCA argues that many of the affordability issues Vermonters have been facing are only getting worse as the COVID-19 crisis causes unemployment to increase, businesses to contract, incomes to decline, and prices for basic necessities to rise. HCA Brief at 5-6 (noting, for example, that unemployment in May 2020 was 12.7%, or 43,744 Vermonters, the food price index increased 4% over the 12-month period ending May 2020 and the price index for meat, poultry, fish and eggs in particular rose over 10% over the same period). The HCA also states that businesses challenged by premium cost growth must choose between reducing benefits and decreasing worker wages and thus an increase to rates would reduce access to care in either scenario. HCA Brief at 8 (citing Neeraj Sood, & Arleen Leibowitz, Wage and Benefit Changes in Response to Rising Health Insurance Costs, National Bureau of Economic Research Working Paper No. 11063, (2005)). To increase affordability for Vermonters during this unprecedented

economic and health crisis and in light of BCBSVT's anticipated receipt of money from alternative minimum tax credits and litigation against the federal government, the HCA requests that the Board eliminate BCBSVT's contribution to reserve. HCA Brief at 10.

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.*, 2016 VT 111, ¶ 16. The Board additionally takes into consideration 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 burden falls on the insurer to justify its requested rate. Rule 2.000, § 2.104(c).

Conclusions of Law

Before we analyze BCBSVT's requested rate increase, we first wish to address the unique circumstances in which we find ourselves as we review this year's rate filings. Vermont is facing a public health emergency of a magnitude not seen in 100 years, our health care system and economy are trying to adjust to the realities of the COVID-19 pandemic response, and individuals, businesses, and governments are experiencing an unprecedented level of financial hardship and uncertainty.

As we have noted in prior decisions, there is an inherent tension in our standard of review. On the one hand, we are required, without specific statutory guidance or a standardized definition, to consider whether an insurance rate is affordable for Vermont consumers;[5] on the other hand, we must consider whether the rate protects insurer solvency and is adequate to cover the costs of paying for members' claims and administering the plan. The failure of a rate to meet either criterion could imperil Vermonters' access to care, implicating yet another of our review criteria. 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.

The pandemic has only exacerbated the inherent tension in our rate review criteria. Raising insurance rates in the midst of this unprecedented crisis will compound the difficulties Vermonters are facing and make it less likely that they can afford to access the care they need. The pandemic

has also created an additional layer of uncertainty and made it difficult to predict health care costs over the next year. Insurers, as well as providers, are having to make plans and propose rates and budgets based on still emerging information in what is a very fluid and potentially volatile situation. This uncertainty implicates solvency and the need for insurers to be able to absorb future costs that are not currently known or quantifiable. With this context in mind, we turn to the specific issues in BCBSVT's large group filing.

Unit Cost

As is usually the case for large group filings this time of year, the Board has not yet received hospitals' budget proposals for the upcoming hospital fiscal year or the proposed charge increases that will be contained therein. However, carriers must still provide support for their estimated unit costs at the time of filing, incorporating new information during the review period to the extent possible. In this filing, the carrier developed its unit cost projections for GMCB-regulated hospitals by starting with the same hospital budget increases for fiscal year 2021 (FY21) as were approved by the Board last year. The carrier then adjusted these increases upward based on information from the Board's review of hospitals' FY19 performance. Specifically, the carrier's proposed 5.4% unit cost increase assumes that GMCB-regulated hospitals will have to file higher increases for October 2020 than the increases approved by the Board in FY19 due to a variance in budgeted and actual operating expenses. Findings of Fact (Findings), ¶ 11.

On a system-wide basis, hospitals' actual FY19 NPR was 0.8% lower than budgeted and hospitals' actual FY19 operating expenses were 2.9% higher than budgeted. Findings, ¶ 11. Based on these variances, the carrier increased the unit cost change at each GMCB-regulated hospital by 2.1 percentage points, which is the increase in operating expenses "rebased" for the overall change in net patient revenue. Findings, ¶ 11. The Board's actuaries did not opine on whether these adjustments are appropriate at this time and recommended that the Board consider the impact of FY19 year-end actuals as well as potential disruptions from COVID-19 when reviewing the carrier's medical unit cost assumptions. Findings, ¶ 11.

We do not agree with the reasoning the carrier presented to support adjusting last year's approved increases upwards by 2.1 percentage points. While the Board considers projected operating expenses in establishing hospital budgets, it has not historically allowed hospitals to exceed the NPR targets set forth in the hospital budget guidance due to unfavorable operating expense variances in prior years. To suggest that the Board would allow hospitals to do this for FY21 is speculative.

In its brief, the carrier raised concerns that even its proposed 5.4% medical unit cost assumption for GMCB-regulated facilities may be inadequate in light of information it received after submitting its filing. First, the carrier points to the recent notice that it received from the University of Vermont Health Network stating that UVMMC intends to implement a 9.7% chargemaster increase pending Board approval in the upcoming budget proceedings. Findings, ¶ 23. The carrier notes that a 9.7% increase is significantly higher than the estimated increase included in this filing, suggesting that the filed unit cost assumptions may be inadequate. Findings, ¶ 23. Second, the carrier points to the GMCB hospital budget guidance issued in May, which it says allows for a temporary upward adjustment to FY21 revenue to "compensate [hospitals] for FY20 utilization that was not realized due to COVID-19." BCBSVT asserts that, should hospitals

take advantage of the temporary increase, the FY21 unit cost assumptions in the filing will be inadequate. Findings, ¶ 24.

We can understand and appreciate the carrier's concern over the uncertainty of hospital budget submissions this year, and the unusual aspect of this year's budget guidance allowing hospitals to request a temporary increase to NPR and change in charge restrictions to reflect the circumstances of COVID-19. However, these temporary increases are not possible to quantify at this time (and BCBSVT has not attempted to do so). The total amount of state and federal funding that hospitals will ultimately receive is still uncertain, as is the amount of lost revenue hospitals will be able to recoup as utilization that was deferred between March and June returns. As noted in the budget guidance, in considering hospitals' requests for a temporary COVID-19-related increase, the Board will also be considering hospitals' expense reduction plans and long-term strategic and financial plans for sustainability, as well as the impacts of charge increases to Vermonters and employers in the commercial market. FY21 Abbreviated Hospital Budget Guidance and Reporting Requirements, (eff. May 31, 2020), 5. Thus, while the Board will entertain such requests, there are still many moving parts and considerations that will have to be taken into account.

Given the above considerations, we find that the carrier has not supported a 5.4% unit cost assumption based either on FY19 year-end actuals or new information learned during the filing review period, namely the University of Vermont Health Network's notice to payers and the Board's FY21 hospital budget guidance.

There is always the risk that a requested (or approved) rate will ultimately prove to be inadequate, which is one of the reasons carriers have reserves. The Board must evaluate the risks of rate inadequacy based on the information known at the time it makes its decision and in light of the other statutory considerations, including affordability. In this instance, the carrier has not provided sufficient support for a 5.4% medical unit cost trend assumption for GMCB-regulated facilities. Given the difficult financial circumstances facing Vermonters and Vermont businesses at this time and the need for rates that are as affordable as possible, the Board is not in a position to approve a requested rate component where the risk of inadequacy is uncertain and the rationale is speculative.

We therefore reduce the carrier's requested unit cost assumption for GMCB-regulated facilities from 5.4% to 4.0%, which reduces the carrier's total medical unit cost trend to approximately 3.7%. However, as discussed below, we will not reduce the carrier's contribution to reserve.

Administrative Expenses

Related to the affordability criterion in the Board's rate review process is the expectation that BCBSVT and TVHP provide benefits and services at minimum cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c), 4584(c), 5104(b). The Board has repeatedly encouraged BCBSVT to find innovative ways to increase efficiencies and limit increases in its administrative expenses as the membership over which these costs may be spread has decreased. *See In re Blue Cross Blue Shield of Vermont Third Quarter 2019 Large Group Rating Program Filing,* Docket No. GMCB-002-19rr, Decision & Order (May 23, 2019), 7; *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; *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.

In this filing, BCBSVT is projecting a decrease in overall membership for 2021 across all lines of business. Since administrative expenses will be distributed across a smaller pool of members, an increase in the total PMPM administrative charges results. Findings, ¶ 16. While BCBSVT did not reduce staff in response to its decreasing membership, reasoning that it is "impractical to react to enrollment shifts by immediately right-sizing staff," it removed from its administrative cost projection the variable costs associated with the reduced enrollment. Findings, ¶ 16. Because variable costs represent approximately half of total administrative expenses, rather than increasing the administrative charge by 6% (the PMPM increase that results from using the lower enrollment), BCBSVT instead increased it by 3%. Findings, ¶ 16.

While "immediately right-sizing staff" in response to a *sudden* enrollment shift would not be feasible, we disagree with the carrier's position that a decrease in staff is impractical at this time given the carrier's ongoing, continuing loss of membership over the past several years. And while we certainly appreciate the fact that BCBSVT has limited the rate increase that results from declining membership, BCBSVT must take steps to realize equivalent cost savings or else this strategy is not sustainable and will have a negative impact on reserves over time.

The Board is charged with determining whether a proposed rate is affordable. 8 V.S.A. § 4062(a)(3); Rule 2.000, § 2.301(b). As the HCA notes, this request comes at a time when Vermonters are facing unprecedented financial hardships and it is reasonable to expect that many of the affordability issues Vermonters are facing will only get worse as unemployment increases, incomes decline, and prices for basic necessities rise due to the COVID-19 pandemic and the associated economic downturn. Findings, ¶ 27. This year more than ever, it is imperative that BCBSVT provide services under efficient and economic management so that rates are as affordable as they can be.

BCBSVT has assumed a 3% increase in wages and benefits, which increases the rates in this filing by approximately 0.3%. Findings, ¶ 16. In light of the financial challenges facing Vermonters and the cost saving measures that individuals, businesses, schools, and state and local governments are implementing, we disagree with BCBSVT's choice to pass the cost of this increase on to ratepayers this year. We are also aware that cost savings can be found during this public health crisis, such as reduced travel and professional development costs due to trainings and conferences being cancelled or held remotely, and reduced costs for employees' medical expenses due to stay at home orders. In light of these considerations, we reduce the trend component of the administrative charge increase to 0.0%.

Contribution to Reserve

In recognition of the carrier's RBC range, DFR's solvency opinion, the substantial uncertainty of future costs and impacts from COVID-19 on the Vermont population, and our reduction of the carrier's requested 5.4% medical unit cost assumption for GMCB-regulated

hospitals, we find the carrier's proposed CTR of 1.5% for fully-insured large groups and 0.375% for Cost Plus groups to be reasonable and appropriate. Findings, ¶¶ 19, 22.

Health Insurance Providers Fee

Finally, we note that the rate increase is impacted by the return of the Health Insurance Industry Fee (HIF) for the 2020 calendar year at 2.2% of premium, which will be applied to accounts for coverage for months in calendar year 2020 and which is anticipated to be 0.0% in calendar year 2021. Findings, ¶ 18. We approve the 2.2% HIF component of the rate on the condition that the carrier adjusts its rates in 2021 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 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 modify the filings by: (1) reducing the medical unit cost assumption for GMCB-regulated facilities from 5.4% to 4.0%, which reduces the carrier's total medical unit cost trend to approximately 3.7%; (2) reducing the trend component of the administrative charge increase to 0.0%, which reduces the total administrative PMPM from $53.91 to $52.72; (3) approving the 2.2% HIF component of the rate on the condition that the carrier adjusts it to 0.0% in 2021; (4) correcting the administrative charges to remove the TVHP billback amounts included in the base period; and (5) using the updated unit cost trend calculation which removes the immaterial formula error for BCBSVT Non-Managed Care groups.

As modified, we expect the resulting manual rate increase is approximately 0.7% and the average group may experience a premium increase of approximately 4.7%.

SO ORDERED.

Dated: July 17, 2020 at Montpelier, Vermont

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

Filed: July 17, 2020

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.