STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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| In re: | Blue Cross and Blue Shield of Vermont 2026 Individual Market Rate Filing | ) ) ) ) | GMCB-004-25rr<br><br>SERFF No. BCVT-134524605 |
| In re: | Blue Cross and Blue Shield of Vermont 2026 Small Group Market Rate Filing | ) ) ) ) | GMCB-005-25rr<br><br>SERFF No.: BCVT-134524673 |

# DECISION AND ORDER

## Introduction

Blue Cross and Blue Shield of Vermont (BCBSVT or the Company), one of two carriers offering individual and small group health insurance coverage in Vermont, seeks to increase its premiums in 2026 by an average of 23.5% for its individual plans and an average of 13.5% for its small group plans. Based on our review of the record, we modify BCBSVT's proposed rates and then approve the filings. As modified, we expect BCBSVT's premiums to increase, on average, 9.6% for individual plans and 4.4% for small group plans. In orders issued today in connection with this decision, we also require the Company to implement reforms aimed at protecting its solvency and reducing its need for high premium increases.

During the Board's review of these filings, BCBSVT witnesses provided candid, thoughtful testimony that struck at the core of some of Vermont's health system challenges. The Board appreciates BCBSVT's diligence in responding to requests for information in these proceedings, as well as its efforts more generally to provide the Board, the Legislature, and the public with information needed to address many of the difficult dynamics in our healthcare markets. While this order is critical of some aspects of the Company's role in those dynamics, we recognize BCBSVT's professional and respectful approach in connection with our review and decisions, as well as the Company's collaborative efforts to try to improve healthcare for Vermonters.

BCBSVT's requests highlight the tension inherent in the rate review standard, which requires the Board to consider competing factors, including consumer affordability, access, and fairness, as well as actuarial soundness and insurer solvency. The affordability and access challenges presented by these filings are obvious: Vermont already has some of the highest individual and small group rates in the country; BCBSVT, which has higher rates than its competitor, seeks enormous increases after years of double-digit growth; and on top of the increases the Company implements next year, changes in federal law will make individual rates more expensive for most people. At the same time, BCBSVT's solvency remains challenged, and its insolvency would not promote affordability, access, or quality.

The Board's orders seek to strike a balance between the competing rate review factors. The orders also reflect that BCBSVT's solvency challenges are amplified by losses in other markets, and

by its relations with hospitals. BCBSVT has lost enormous reserves in recent years—more than it lost on its individual and small group plans—from other business lines, including its products for self-funded groups, Medicare Advantage and Part D products, Medicare Supplement offerings, and in connection with large litigation settlements. BCBSVT's filings seek to disproportionately and inequitably build back reserves from Vermonters on its individual and small group plans.

BCBSVT has also been ineffective in negotiating contracts with Vermont hospitals that reflect (1) BCBSVT's financial situation, (2) BCBSVT's members' ability to pay increased healthcare costs, and (3) the exceedingly high prices certain hospitals charge BCBSVT. The Company has failed to push back on hospital requests to increase rates for certain services *above* the commercial rate caps in the Board's budget orders and has failed to reject hospital assertions that budget orders provide a revenue guarantee. While BCBSVT explains that it is unable to effectively negotiate given market dynamics, recent history suggests the status quo does not work, and that simply increasing rates will be inadequate, perpetuate market dysfunction, and result in more large premium increases in the future.

The Board has appointed a liaison to oversee certain aspects of the University of Vermont Medical Center's (UVMMC) and the University of Vermont Health Network's (UVMHN) operations. The Department of Financial Regulation (DFR) recently issued an order prohibiting BCBSVT from contracting with certain hospitals without first demonstrating that the agreements "support a material reduction in commercial insurance premiums while protecting the insurer's solvency." DFR's order also allows for the appointment of a liaison. These steps, taken together, and in conjunction with the Board's supplemental orders, will promote BCBSVT's solvency, ensure fair and equitable contracting, support appropriate claims management, and reduce the need for large premium increases.

Lastly, the Board is concerned with the substantial pay increases that BCBSVT executives have received during a period of financial deterioration and while Vermonters have struggled under punishing premium increases. In 2022, 2023, and 2024, BCBSVT requested large, double-digit rate increases in these markets, ranging from 11.4% to 22.9%, and the Company's reserves plummeted, dropping $24.4 million in 2022, $23.8 million in 2023, and $29.3 million in 2024. Yet from 2021 to 2024, BCBSVT increased the salaries[1] of its CEO and VP/Treasurer by approximately 38% and 40%, respectively. It also paid its executives approximately $280,000 in retention incentives, $910,600 in affiliation/project incentives, and $1,852,275 in variable compensation ($3.04M in total).

We are encouraged that BCBSVT is considering adding goals to its variable compensation plan in 2026 related to, for example, quality and value-based contracts. However, the large payments made in 2022 – 2024 were not adequately justified, are inconsistent with BCBSVT's performance, and do not reflect efficient and economical management of a small, non-profit insurer in BCBSVT's situation. Variable compensation for 2025 also conflicts with Vermont's principles of healthcare reform as a key component of an award is directly tied to Vermonters paying *more* in healthcare premiums. Specifically, variable pay for 2025 is tied to underwriting gains, which, in turn, depend significantly on BCBSVT increasing its rates in these markets to fund the large CTR it requested.

[1] "Salary" figures were taken from the Act 152 reports submitted to DFR for 2021, 2022, 2023, and 2024. These figures include payments of deferred variable compensation earned in the prior year, as well as affiliation/project incentive payments and retention incentive payments.

## Procedural History

1. On May 12, 2025, BCBSVT filed its 2026 individual and small group rate filings with the Board using the System for Electronic Rate and Form Filing (SERFF). *See* Exhibits (Exs.) 1-7.

2. On May 14, 2025, the Office of the Health Care Advocate (HCA), a division of Vermont Legal Aid that represents the interests of Vermont consumers with respect to health care and health insurance, appeared as a party to the proceedings. *See* HCA Notices of Appearance; 8 V.S.A. §§ 4062(c), (e); 18 V.S.A. § 9603; GMCB Rule 2.000, §§ 2.105(b), 2.303.

3. From May 21 through July 18, 2025, BCBSVT responded to a series of interrogatories issued by the Board and its contracted actuaries at Lewis & Ellis (L&E). Exs. 8-17, 30. The interrogatories included questions from the HCA. *See* Ex. 17.

4. During the 2025 legislative session, the Board advocated for House Bill 266, which the Legislature passed, and the Governor signed on June 11, 2025, as Act 55 (2025). Effective January 1, 2026, Act 55 prohibits certain hospitals from charging insurers more than 120 percent of the average sales price (ASP)—as calculated by the Centers for Medicare and Medicaid Services (CMS)—for prescription drugs administered in an outpatient or office setting.[2] Act 55 (2025), § 4.

5. Vermont hospitals submitted their proposed fiscal year 2026 (FY 2026) budgets to the Board in early July 2025.

6. On July 11, 2025, L&E issued actuarial reports summarizing its analysis of each filing and recommending adjustments. Exs. 18-19. That same day, DFR issued opinions regarding the filings' impact on BCBSVT's solvency. Exs. 20-21.

7. On July 18, 2025, in response to a request from L&E, BCBSVT provided information on the extent to which the unit cost trends in its filings considered past and potential future hospital budget enforcement orders, as well as new legislation. *See* Ex. 30.

8. On July 18, 2025, with the consent of the parties, the Board extended the review period for the filings. *Compare* Scheduling Order *to* First Amendment to Scheduling Order.

9. On July 23 and 24, 2025, the Board held a hearing on BCBSVT's individual and small group rate filings. The hearing was held remotely. The Board designated its offices at 112 State Street in Montpelier as a physical location where members of the public could go to attend the hearing. Members of the public were also able to attend the hearing using Microsoft Teams® or their phone. At the hearing, the Board heard testimony from Ruth Greene, BCBSVT's Treasurer and Chief Financial Officer; Martine Brisson-Lemieux, BCBSVT's Chief Actuary; Andrew Garland, BCBSVT's Vice-President for Client Relations and External Affairs; Michael Fisher, Chief Health Care Advocate and Director of the Vermont Office of the Health Care Advocate; Jesse Lussier, Administrative Insurance

[2] For prescription drugs administered in an outpatient or office setting for which a hospital charged an insurer 120 percent or less of the ASP in effect as of April 1, 2025, the hospital may not charge the insurer a greater percentage of the ASP. ASPs will be updated annually on January 1 and July 1 based on CMS's ASP calculations for the most recent calendar quarter. Hospitals are not permitted to offset the impact of the Act 55 price caps by increasing other charges. Act 55 (2025), § 4.

Examiner at DFR; Kaj Samsom, Commissioner of DFR; and Kevin Ruggeberg, Senior Consulting Actuary at L&E. *See* July 23 P.Tr., July 23 C.Tr., July 24 P.Tr., July 24 C.Tr.[3]

10. On July 24, 2025, the Board held a public comment forum from 4:00 p.m. to 5:00 p.m. to hear from the public on the 2026 individual and small group rate filings of BCBSVT and MVP Health Plan, Inc. (MVP). *See* Public Comment Forum Tr.

11. On July 28, 2025, the Board closed a special public comment period it had opened on the 2026 individual and small group rate filings of BCBSVT and MVP. The Board received approximately 97 comments during the public comment period. *See* Compilation of 2026 Vermont Individual and Small Group Rate Filing Comments.

12. On July 29, 2025, in response to a request from L&E, BCBSVT provided information on how different hospital budget scenarios would impact its rates. *See* Resp. to Objection # 9.

13. On August 3, 2025, L&E responded to a request from the Board to estimate the impact of various potential budget scenarios on the proposed rates. *See* L&E Budget Deviation Impact Letter.

14. On August 5, 2025, BCBSVT responded to certain post-hearing questions issued by the Board. Resp. to Post-Hearing Questions (Aug. 5, 2025).

15. On August 7, 2025, the Board received a letter from Mike Smith, acting as the Independent Liaison under a settlement agreement between the Board, the University of Vermont Health Network (UVMHN), and the University of Vermont Medical Center (UVMMC). The letter, which was addressed to both the Board and DFR, recommended the establishment of an upper reimbursement limit for BCBSVT. The Board shared the letter with BCBSVT and the HCA. On August 11, 2025, BCBSVT responded to a request from L&E to quantify the impact of the Independent Liaison's recommendation. *See* Resp. to Objection # 10.

16. On August 8, 2025, the HCA and BCBSVT filed post-hearing memorandums pursuant to GMCB Rule 2.000, § 2.307(g).[4] HCA Post-Hearing Memorandum; BCBSVT Post-Hearing Memorandum.

17. On August 12, 2025, BCBSVT responded to the remainder of the Board's post-hearing questions. Resp. to Post-Hearing Questions (Aug. 12, 2025).

18. On August 14, 2025, the Commissioner of DFR issued an order prohibiting BCBSVT and MVP from entering, renewing, or amending agreements with certain hospitals on or after January 1, 2026, unless the terms of the agreements meet requirements relating to premium reduction, solvency protection, and cost containment. *In re Blue Cross and Blue Shield of Vermont and MVP Health Plan, Inc.*, Docket No. 25-024-I, Order. The Board took official notice of the DFR order on August 18, 2025.

## Findings of Fact

19. BCBSVT is a nonprofit hospital corporation and medical service corporation that offers

[3] "P.Tr." refers to the transcript of the public portion of the day's hearing, while "C.Tr." refers to the transcript of the non-public or confidential portion of the day's hearing.
[4] The parties requested an extension of two business days to file their briefs, which was denied.

health insurance products in several markets in Vermont. *See* Ex. 17, 9; Ex. 18, 1; Ex. 19, 1.

20. The filings under consideration in these dockets outline the development of premiums or "rates" for ACA-compliant Qualified Health Plans (QHPs) that BCBSVT proposes to offer in the Vermont individual and small group markets for the 2026 benefit year. The filings apply to plans available through Vermont Health Connect (VHC) and directly from BCBSVT (i.e., "On-Exchange" and "Off-Exchange" plans). Ex. 1, 3.

21. As of February 2025, there were approximately 15,058 members enrolled in BCBSVT's small group plans and 23,952 members enrolled in BCBSVT's individual plans. From 2024 to 2025, membership in the Company's individual plans grew slightly while membership in its small group plans declined significantly. The following table shows membership and membership changes in BCBSVT's individual and small group plans from 2019 through 2025:

**Individual and Small Group Membership by Coverage Year**

| Coverage Year | Small Group Members | Small Group % Change | Individual Members | Individual % Change |
|---|---|---|---|---|
| **2019** | 24,508 | -19.1% | 19,431 | -16.8% |
| **2020** | 21,568 | -12.0% | 17,627 | -9.3% |
| **2021** | 18,785 | -12.9% | 15,878 | -9.9% |
| **2022** | 19,581 | +4.2% | 16,556 | +4.3% |
| **2023** | 21,943 | +12.1% | 18,517 | +11.8% |
| **2024** | 22,018 | +0.3% | 23,164 | +25.1% |
| **2025** | 15,058 | -31.6% | 23,952 | +3.4% |

*See* Ex. 18, 1; Ex. 19, 1.

22. Plans in Vermont's individual and small group markets are offered in bronze, silver, gold, and platinum metal levels. "Catastrophic" coverage is also available to certain individuals.[5] Each metal level corresponds to an "actuarial value" (AV), which reflects the percentage of claims for essential health benefits that a health insurer expects to cover, on average. Bronze plans have the lowest AV and the least generous coverage, while platinum plans, with the highest AV, have the most generous coverage. *See* 42 U.S.C. §§ 18022(d) – (e); Ex. 3, 4.

23. BCBSVT's 2025 rates are generally higher than those of its competitor in these markets. *See* Resp. to Post-Hearing Questions (Aug. 5, 2025), Attachments, 1. In its individual filing, BCBSVT asks the Board to approve premiums for 2026 that are, on average, 23.5% or $245.81 per member per month (PMPM) higher than 2025 premiums, with plan-level increases ranging from 21.7% to 24.8%. Ex. 6, 3, 16; Ex. 18, 2. In its small group filing, BCBSVT asks the Board to approve premiums for 2026 that are, on average, 13.5% or $127.41 PMPM higher than 2025 premiums, with plan-level increases ranging from 12.0% to 14.5%. Ex. 7, 16; Ex. 19, 2.

24. The following tables show how the Company's proposed 2026 premiums compare to

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

its 2025 premiums across different plan types, as well as the percentage of membership in each plan type:

**2026 PROPOSED INDIVIDUAL RATE CHANGES**

| Plan Type | Average 2025 Premium PMPM | Average 2026 Premium PMPM | Percent Change | PMPM Change | Percent of Membership |
|---|---|---|---|---|---|
| Catastrophic | $381.55 | $476.95 | 25.0% | $95.40 | 1.2% |
| Bronze | $807.28 | $994.58 | 23.2% | $187.30 | 30.3% |
| Silver Loaded | $1,348.34 | $1,667.05 | 23.6% | $318.71 | 12.0% |
| Silver Reflective | $864.23 | $1,062.28 | 22.9% | $198.06 | 4.7% |
| Gold | $1,142.28 | $1,411.91 | 23.6% | $269.63 | 45.9% |
| Platinum | $1,288.72 | $1,597.18 | 23.9% | $308.45 | 5.9% |
| *Overall* | ***$1,045.66*** | ***$1,291.48*** | ***23.5%*** | ***$245.81*** | ***100.0%*** |

Ex. 18, 3.

**2026 PROPOSED SMALL GROUP RATE CHANGES**

| Plan Type | Average 2025 Premium PMPM | Average 2026 Premium PMPM | Percent Change | PMPM Change | Percent of Membership |
|---|---|---|---|---|---|
| Bronze | $693.79 | $780.91 | 12.6% | $87.12 | 8% |
| Silver | $838.68 | $946.99 | 12.9% | $108.31 | 32% |
| Gold | $958.06 | $1,087.21 | 13.5% | $129.15 | 38% |
| Platinum | $1,162.39 | $1,329.48 | 14.4% | $167.09 | 22% |
| *Overall* | ***$943.48*** | ***$1,070.89*** | ***13.5%*** | ***$127.41*** | ***100%*** |

Ex. 19, 2.

25. The rate increases BCBSVT is proposing for 2026 come on the heels of double-digit increases approved for the Company for each of the last three years, as reflected in the following table:

| Plan Year | Individual Rate Increase | Small Group Rate Increase |
|---|---|---|
| 2025 | 19.8% | 22.9% |
| 2024 | 14.0% | 13.3% |
| 2023 | 11.4% | 11.7% |

*See In re Blue Cross and Blue Shield of Vermont 2025 Individual and Small Group Market Rate Filings*, GMCB-003-24rr & GMCB-004-24rr, Decision and Order, Findings of Fact, ¶ 17 (Aug. 12, 2024).

26. People who purchase one of BCBSVT's individual plans through VHC may be eligible for subsidies that help lower premiums, cost sharing, or both. Subsidies are not available for most employees of small group employers, however. People who enroll in an individual plan directly

with BCBSVT are also not eligible for subsidies. *See* 26 C.F.R. § 1.36B-2(a)(1).

27. Premium subsidies take the form of federally funded premium tax credits (PTC), as well as supplemental state funded premium assistance. *See* 26 U.S.C. § 36B; 33 V.S.A. § 1812(a). Cost sharing subsidies take the form of federally mandated but "unfunded" cost sharing reductions, as well as supplemental state funded cost-sharing assistance. *See* 42 U.S.C. § 18071; 33 V.S.A. § 1812(b). The mechanics of the federal subsidies are described briefly below.

28. The PTC is typically paid directly to the insurance carrier by the federal government to lower an eligible individual's monthly premium.[6] The PTC covers the difference between the premium for the second-lowest cost silver plan in the market (the "benchmark plan") and a specified percentage of an individual's household income (the "applicable percentage"). *See* 26 U.S.C. § 36B(b). While the PTC is calculated by reference to the benchmark plan, it can be used to purchase a plan at any metal level.

29. The applicable percentages vary with income such that individuals with lower incomes are eligible for a larger credit than individuals with higher incomes. Stated differently, individuals with higher incomes are required to contribute a larger percentage of their household income to purchase the benchmark plan.

30. In 2021, the American Rescue Plan Act (ARPA) made significant enhancements to the PTC. *See* 26 U.S.C. § 36B(c)(1). For individuals who were already eligible for the PTC, ARPA increased the credit they could receive. ARPA also expanded eligibility for the PTC to individuals with household incomes above 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(c)(1)(E). ARPA's enhancements to the PTC were extended through 2025 by the Inflation Reduction Act of 2022 but, under current law, will not be available in 2026. *See* Pub.L. 117-169, Sec. 12001; Ex. 1, 5; Ex. 18, 18.

31. The table below shows how the applicable percentages used to determine PTC will change from 2025 to 2026 due to the expiration of ARPA's PTC enhancements:

| Household Income | 2025 Applicable Percentage | 2026 Applicable Percentage |
|---|---|---|
| <133% FPL | 0.00% | 2.10% |
| 133% - 150% | 0.00% | 3.14% - 4.19% |
| 150% - 200% | 0.00% - 2.00% | 4.19% - 6.60% |
| 200% - 250% | 2.00% - 4.00% | 6.60% - 8.44% |
| 250% - 300% | 4.00% - 6.00% | 8.44% - 9.96% |
| 300% - 400% | 6.00% - 8.50% | 9.96% |
| >400% | 8.50% | Unlimited |

*See* IRS Rev. Proc. 2024-35, https://www.irs.gov/pub/irs-drop/rp-24-35.pdf Rev. Proc. 2025-25, https://www.irs.gov/pub/irs-drop/rp-25-25.pdf.

32. If ARPA's enhancements to the PTC expire at the end of 2025, as they are expected to, most of BCBSVT's individual subscribers will experience net premium increases that are higher

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

than the increases reflected in the individual filing. *See* Ex. 18, 3. The net premium increases experienced by subscribers above 400% FPL will be especially large, as they will no longer receive any PTC. *See supra*, Findings of Fact (Findings), ¶¶ 30-31.

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

34. L&E reviewed BCBSVT's individual and small group filings to assist the Board in assessing whether the proposed rate increases are excessive, inadequate, or unfairly discriminatory according to guidance set forth in Actuarial Standard of Practice (ASOP) No. 8. Rates may be considered excessive under ASOP No. 8 if they exceed the rate needed to provide for payment of claims, administrative expenses, taxes, regulatory fees and reasonable contingency and profit margins. Rates may be considered inadequate under ASOP No. 8 if they do not provide for payment of claims, administrative expenses, taxes, regulatory fees and reasonable contingency and profit margins. Finally, rates may be considered unfairly discriminatory under ASOP No. 8 if they result in premium differences among insureds within similar risk categories that are not permissible under applicable law or regulation or, in the absence of an applicable law or regulation, do not reasonably correspond to differences in expected costs. *See* Ex. 18, 3; Ex. 19, 2. L&E did not review or provide an opinion as to whether the proposed rates are affordable, promote quality care, promote access to health care, protect insurer solvency, or are unjust, unfair, inequitable, misleading, or contrary to law. Ex. 18, 3; Ex. 19, 2.

35. Based on its review, L&E made six recommendations in each of the filings. The recommendations relate to medical trend (medical utilization and medical unit cost trends), new legislation, pharmacy utilization trend, risk adjustment transfers, and contributions to reserves. *See* Ex. 18, 27, Ex. 19, 25.

36. The medical cost trend reflects projected changes the cost of medical services (medical unit cost trend) and members' use of those services (medical utilization trend).[7] Ex. 18, 7; Ex. 19, 6. In each filing, BCBSVT set the medical unit cost trend at 2.7% and the medical utilization

[7] The utilization trend also reflects changes in the intensity of services. *See* Ex. 18, 7; Ex. 19, 6.

trend at 5.0%, which together produce an overall medical cost trend of 7.9%. Ex. 18, 7; Ex. 19, 6.

37. BCBSVT selected a 5.0% medical utilization trend after analyzing historical data for the following claim categories: Facility (Inpatient/Outpatient), Professional (Mental Health/Substance Use Disorder and Other), and Outpatient Drug. Ex. 18, 8; Ex. 19, 7. When analyzing medical utilization trend in prior filings, BCBSVT sought to control for historical changes in population characteristics by using a "matched population" approach, selecting individuals from different time periods who mirror each other in important demographic and diagnostic characteristics and removing data from unmatched members. Ex. 18, 8. BCBSVT stopped using this matched population approach this year because it found its results to be unreasonable. Ex. 18, 8; Ex. 19, 7. Using the matched population approach would have resulted in medical utilization trends approximately 2% per year lower than the trends in the filings. *See* Ex. 18, 11; Ex. 19, 10.

38. L&E considered BCBSVT's medical utilization trend assumptions against a wide range of data points, including BCBSVT's unmatched and matched trends over the past two years; the 3.8% medical utilization trend assumption in BCBSVT's recently approved large group filing; MVP's trend data, which show an average medical utilization trend over the past two years of approximately 3.7%; and QHP carriers' medical utilization trend assumptions nationally, which indicate that a 5.0% trend is quite rare and would represent a significant outlier within the industry. L&E also considered that utilization has exceeded BCBSVT's projections in recent years. Ex. 18, 10-14; Ex. 19, 9-14.

39. L&E concluded that 5.0% is not a reasonable best estimate of the two-year medical trend and that it is reasonably likely the true medical utilization trend is notably lower than 5.0%. L&E's opinion is that a range between 3.0% and 4.0% appears highly likely and a 4.0% trend is a more appropriate assumption. L&E therefore recommends that the Board reduce BCBVT's medical utilization trend to 4.0% on average, which would reduce premiums by approximately 1.4% in each filing. Ex. 18, 14; Ex. 19, 13.

40. BCBSVT agrees that a 4.0% utilization trend is in the range of reasonableness for Facility claims and Non-Mental Health/Substance Use Disorder Professional claims. Ex. 27, 2. However, BCBSVT does not agree with a 4.0% utilization trend for Mental Health/Substance Use Disorder Professional claims or Outpatient Drug claims, arguing that a 6.0% - 6.5% trend for Mental Health/Substance Use Disorder Professional claims is reasonable (BCBSVT selected a 6.5% trend for these claims) and that utilization has been higher than 4.0% for Outpatient Drug claims (BCBSVT selected an 8.0% trend for these claims). *See* Ex. 18, 10; Ex. 19, 9; Ex. 27, 2; Testimony of Martine Brisson-Lemieux, Jul. 23 P.Tr., 214:3-9.

41. L&E's analysis and recommendation regarding the medical utilization trend are not inconsistent with BCBSVT's objections because they are based on a review of holistic measures of trend that were not necessarily broken out by service categories. *See* Testimony of Kevin Ruggeberg, Jul. 24, P.Tr., 9:18-10:15.

42. Approximately 59% of BCBSVT's medical costs are related to Vermont facilities and providers impacted by the Board's hospital budget review process. Ex. 18, 7; Ex. 19, 6. The proposed medical unit cost trends in the filings are 1.4% for Board-regulated facilities and providers and 4.7% for other medical facilities and providers. *See* Ex. 18, 7; Ex. 19, 6.

43. To project medical unit costs from 2024, the base experience period, to 2025, BCBSVT used actual negotiated provider payment changes. To project medical unit costs from 2025 to 2026, the projection period, BCBSVT used several approaches. For providers and facilities regulated by the Board's budget review process, BCBSVT started by assuming that the commercial rate cap approved by the Board in its FY 2026 and FY 2027[8] hospital budget decisions will be equal to the Board's FY 2026 hospital budget guidance maximum of 3.0%. For providers within the broader BCBSVT service area that are not regulated by the Board, BCBSVT used expected contract changes based on negotiations. Finally, for providers outside its service area, BCBSVT used the fall 2024 Blue Trend Survey conducted by the Blue Cross Blue Shield Association. Ex. 18, 7-8; Ex. 19, 6-7.

44. L&E recommends updating the assumed unit cost trends in each filing if new information is known at the time of the Board order. Ex. 18, 27; Ex. 19, 25. BCBSVT agrees with this recommendation, provided that savings associated with Act 55 are not double-counted as both a stand-alone adjustment and a component of hospital budgets. *See* Testimony of Martine Brisson-Lemiuex, Jul. 23 P.Tr., 214:13-215:2; *see also* Ex. 27; *Infra,* Findings, ¶ 45.

45. On June 11, 2025, the Governor signed Act 55 into law. The new law imposes limits on the amount that Vermont hospitals can charge for drugs administered in an outpatient or office setting. Assuming reduced costs are not offset by increases in other areas, the bill is expected to significantly lower total claims for BCBSVT policies in 2026. BCBSVT estimates that Act 55 will reduce individual premiums by 4.1% and small group premiums by 3.3%. L&E concluded that BCBSVT used reasonable methods to estimate the impact of the legislation and recommends that the final premiums reflect these adjustments. Ex. 18, 21, 27; Ex. 19, 19, 25. BCBSVT does not disagree with L&E's recommendation to adjust the 2026 QHP premiums to reflect the estimated impacts of Act 55, provided that savings from Act 55 are not double counted across the rate review and hospital budget review processes. *See* Ex. 27.

46. Hospitals' budget submissions were inconsistent in their treatment of Act 55. *See* Ex. 27. The Board's staff have worked to understand whether hospitals included the impacts of Act 55 in their budget submissions, and, where they did, to back these impacts out so that they are not "double counted" in the rate review process.[9] On July 24, 2025, L&E shared the Board's then-current understanding of hospital budget requests excluding Act 55 and asked BCBSVT to calculate the impact on the proposed rates. *See* Objection # 9. BCBSVT responded that the hospital requests, as understood by the Board, would reduce the rates in each filing by approximately 0.4%. *See* Resp. to Objection #9. Since then, the Board's understanding of budget requests has changed slightly with respect to several hospitals,[10] and the following table reflects the Board's current understanding of the requests excluding Act 55.

[8] Hospital fiscal years run from Oct. 1 through Sept. 30, while individual and small group premium rates are in effect for a calendar year. Thus, to develop unit cost trends for Board-regulated facilities and providers in these filings, BCBSVT makes assumptions about two hospital fiscal year budget approvals.

[9] Because BCBSVT's estimates regarding the impact of Act 55 are specific to its covered populations, they will be more accurate than using a hospitals' estimates, which are across multiple payers.

[10] The hospitals are Central Vermont Medical Center, Copley Hospital, Rutland Regional Medical Center, and Southwestern VT Medical Center. The impact of the changes for these four hospitals compared to the numbers that were previously shared is expected to be minimal.

| Hospital | Request Excl. Act 55 |
|---|---|
| **Brattleboro Memorial Hospital** | 3.0% |
| **Central Vermont Medical Center** | 2.3% |
| **Copley Hospital** | 4.2% |
| **Gifford Medical Center** | 3.0% |
| **Grace Cottage Hospital** | 0.0% |
| **Mt. Ascutney Hospital & Health Ctr** | 3.0% |
| **North Country Hospital** | 0.5% |
| **Northeastern VT Regional Hospital** | 3.0% composite; 3.3% IP/OP, 0.0% Phys |
| **Northwestern Medical Center** | 2.6% composite; 3.0% IP/OP, 0.0% Phys |
| **Porter Medical Center** | 2.7% |
| **Rutland Regional Medical Center** | 1.5% composite; 2.3% IP/OP, 0.0% Phys |
| **Southwestern VT Medical Center** | 7.8% |
| **Springfield Hospital** | 3.0% |
| **The University of Vermont Medical Center** | -0.8% |

47. L&E also recommends that new information regarding hospital budget adjustment and enforcement actions be considered by the Board, noting that UVMMC and Central Vermont Medical Center (CVMC) have proposed lowering their FY 2025 prices, and that the Board could also enforce the FY 2024 budget deviations of CVMC and Springfield Hospital through reductions to those hospitals' commercial rate caps. *See* Ex. 18, 8; Ex. 19, 7.

48. In total, the FY 2024 budget deviations of CVMC and Springfield Hospital amount to approximately $25.3 million. If the Board were to "enforce" the full amount of these deviations through a reduction to the hospitals' FY 2026 commercial rate caps, the estimated premium impact would be -0.7% for each filing. Enforcing half of the overages in this manner is estimated to have a premium impact of -0.3% for each filing. *See* L&E Budget Deviation Impact Letter. An enforcement of half the NPR overages would be consistent with the action the Board took in 2024 with respect to Rutland Regional Medical Center's FY 2023 budget deviation. *See In re Rutland Regional Medical Center Fiscal Year 2023*, Docket No. 22-012-H, Order Correcting Budget Deviation and Denying Budget Amendment Request (Oct. 10, 2024).

49. UVMMC and CVMC are implementing rate reductions for major commercial payers (BCBSVT, MVP, and Cigna) for the remainder of 2025 to offset some of their projected FY 2025 NPR overages. *See* Letter from UMVMHN (July 1, 2025).[11] These actions are expected to reduce revenue from these payers by approximately $20 million for UVMMC and $6 million for CVMC. *Id.* at 4. The Board asked L&E to calculate what the impact would be on BCBSVT's 2026 rates if the hospitals' rate reductions were applied in 2026. L&E calculated that the -$20 million for UVMMC would amount to a rate impact of approximately -0.4% in each filing and the -$6 million for CVMC would amount to a rate impact of approximately -0.2% in each filing. *See* L&E Budget Deviation Impact Letter.

50. In both filings, BCBSVT projects an allowed pharmacy trend of 14.7%, net of rebates.

[11] https://gmcboard.vermont.gov/sites/gmcb/files/documents/2025-7-1%20Proposed%20FY25%20Mid-Year%20Commercial%20Rate%20Reduction%207.1.25.pdf.

BCBSVT determined pharmacy changes by adjusting historical experience, analyzing cost and utilization trends for Brands, Generics, and Specialty drugs separately, reflecting some drugs' transition to generic status, and excluding oGLP-1s, which will not be covered in 2026.[12] Ex. 18, 15-16; Ex. 19, 14-15. L&E recommends that BCBSVT's assumption for non-specialty drug utilization in both filings be reduced from 4.5% to 3.3% per year, consistent with the most recent two-year average and the Large Group assumption. This adjustment will reduce premiums for both filings by approximately 0.2%. Ex. 18, 16; Ex. 19; 15. BCBSVT does not object to this recommendation. *See* Ex. 27; Testimony of Martine Brisson-Lemieux, Jul. 23 P.Tr., 213:19-215:2.

51. L&E recommends the filings be updated to reflect final risk adjustment numbers. Under the Affordable Care Act's risk adjustment program, premiums are transferred between carriers in the individual and small group markets based on the age, sex, and health status of the enrolled members. BCBSVT consistently receives funds through this program, which reduces premiums. Anticipating less funds than last year, BCBSVT included increases of 1.5% in its individual filing and 0.2% in its small group filing for risk adjustment. CMS published actual risk adjustment transfers on June 30, 2025, which showed that BCBSVT will receive more funds under the program than it had originally expected, resulting in decreases of approximately 0.9% in the proposed individual premiums and 0.7% in the small group premiums. Ex. 18, 21; Ex. 19, 20. BCBSVT does not object to this recommendation. *See* Ex. 27; Testimony of Martine Brisson-Lemieux, Jul. 23 P.Tr., 213:19-215:2.

52. To project changes in population morbidity in each market, BCBSVT assessed the 2024 experience of members who disenrolled in 2025. The impact of the members who disenrolled in 2025 is expected to increase the average claims level by 2.5% in each market. *See* Ex. 18, 18; Ex. 19, 17. In the small group market, this results in a 1.7% increase to the rates (the difference between +2.5% and the +0.8% in the prior filing). Ex. 19, 17. In the individual market, BCBSVT assumed an additional 6.4% increase in claims due to the expiration of the enhanced premium tax credits, which are expected to lead some people to lapse coverage due to high net premium increases. This assumption, combined with the assumed impact of 2025 disenrollments, results in an overall morbidity adjustment of 8.7% in the individual market and a rate impact of +9.2% (the difference between +8.7% and the -0.5% in the prior filing). *See* Ex. 18, 18.

53. To estimate how the expiration of the enhanced premium tax credits will impact claims, BCBSVT grouped enrollees by the projected change in net premium as a percentage of their income and their historical claim level and applied varying retention assumptions by premium increase and claim level. Based on this analysis, as explained above, BCBSVT selected a 6.4% adjustment. L&E reviewed industry studies regarding enhanced PTC expiration and noted that an Oliver Wyman study found morbidity in the individual market would increase by 5.9%. Ex. 18, 18. L&E did not recommend any adjustments to BCBSVT's population morbidity adjustments. Ex. 18, 18; Ex. 19, 17.

54. L&E reviewed the development of BCBSVT's proposed administrative charge, which is projected to grow by 1.0% less than premiums in both filings. Ex. 18; 20; Ex. 19. Base administrative costs from 2024 were projected to 2026 using a 5% annual trend. In past filings, a lower rate was applied solely to personnel costs. BCBSVT cited its recent discretionary spending freeze as a

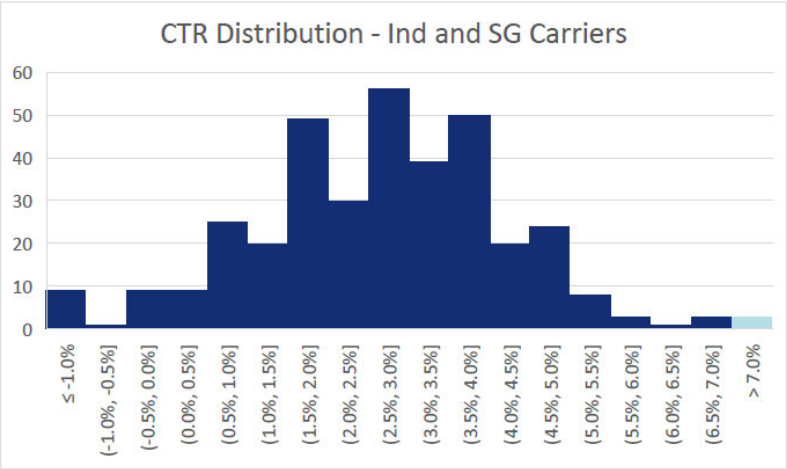
[12] oGLP-1 are GLP1 drugs for weight loss. DFR has determined that are not essential health benefits. *See* Ex. 1, 11.

reason why costs will likely increase faster than inflation in the near future. Ex. 18, 22; Ex. 19, 21. Base administrative costs were also adjusted for the expected impact of membership changes. BCBSVT estimates that 70% of its base administrative expenses are fixed costs; therefore, anticipated declines in enrollment will increase administrative costs PMPM as those fixed costs are spread over fewer members. Ex. 18, 22; Ex. 19, 21. It is anticipated that administrative costs will be slightly higher in the individual market than the small group market because of the additional costs involved in billing, marketing, and enrollment. Ex. 18, 23.

55. L&E compared BCBSVT's combined administrative costs across the individual and small group markets to other nationwide individual and small group plans using the public use files (PUFs) produced by the Center on Consumer Information & Insurance Oversight (CCIIO). These files contain 2025 data on all individual and small group carriers nationwide. BCBSVT's administrative costs were in the 33rd percentile on a PMPM basis and the 1st percentile on a percentage of premium basis. As indicated by the large disparity between BCBSVT's administrative costs on a PMPM basis and a percentage of premium basis, BCBSVT's administrative costs as a percentage of premium are significantly depressed by the fact that BCBSVT has some of the highest premiums in the nation. *See* Testimony of Testimony of Ruth Greene, Jul. 23 P.Tr., 45:5-14. L&E considers the administrative cost assumptions in the filings to be reasonable. *See* Ex. 18, 22-24; Ex. 19, 21-22.

56. BCBSVT is requesting an aggregate contribution to reserve (CTR) of 7.0% in each filing, with an additional 0.1% provision for bad debt in the individual filing. Ex. 18, 24; Ex. 19.

57. As a reasonableness check of the proposed CTR, L&E compared it to filed CTR requests nationally. Based on a review of the 2025 PUFs, there were 359 carriers that submitted On-Exchange individual or small group ACA filings nationally. The filed CTR varied from -14% to +9%, but most often fell between 0% and +5%. The premium weighted average CTR for all carriers was filed as +3.1%. BCBSVT's filed CTR of +7.0% would place it at around the 99th percentile for all QHP carriers—a notably high level for these markets, as seen in the chart below:




Ex. 18, 26; Ex. 19, 24.

58. Given BCBSVT's current financial situation, L&E generally considers it unreasonable for the CTR to fall below the industry median of about 3%. *See* Ex. 18, 26; Ex. 19, 24. However, L&E did not consider recent legislation that provides additional solvency for BCBSVT in the event its RBC ratio falls below 150%. *See infra*, Findings, 63. L&E noted that determining the most appropriate CTR involves balancing the Board's statutory criteria, some of which fall outside of L&E's actuarial evaluation, and advised the Board to consider its statutory criteria and consult with DFR to determine the appropriate level of CTR. Ex. 18, 26; Ex. 19, 24.

59. Risk-based capital (RBC) is a method of measuring the amount of capital that is appropriate for an insurance entity to support its overall business operations in consideration of its size and risk profile. Ex. 23, 28. RBC is expressed as a ratio between the amount of the insurer's reserves and a figure that represents its risk. Ex. 23, 5. In 2019, DFR approved a target RBC range for BCBSVT of between 590% and 745%. *See* Ex. 23, 28-30. The BCBS Association (BCBSA) monitoring level is 375% RBC. *See* Ex. 23, 29.

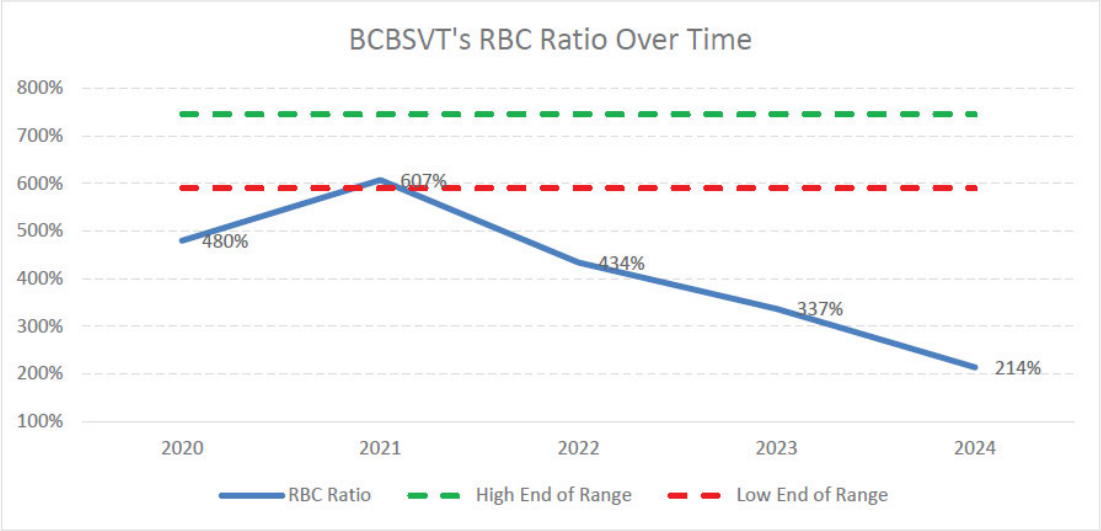
60. Vermont law authorizes or requires different regulatory interventions as a health insurer's RBC ratio declines. *See* 8 V.S.A. §§ 8301-13; 18 V.S.A. § 9384. If an insurer's RBC falls below 300% and the insurer has a negative trend, it constitutes a "company action level event" and the insurer is required prepare and submit an RBC plan to the Commissioner of DFR. *See* 8 V.S.A. §§ 8303(a)(1)(B), (b). The Commissioner may approve or disapprove the plan. *See* 8 V.S.A. § 8303(c).

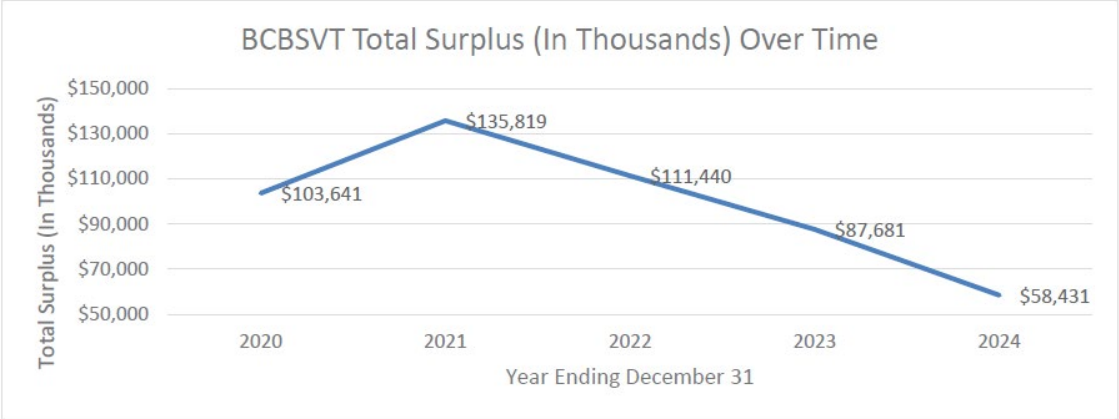
61. If an insurer's RBC falls below 150%, it constitutes a "regulatory action level event" and the Commissioner may order an examination and analysis of the insurer's assets, liabilities, operations, and RBC plan, and may order corrective actions. *See* 8 V.S.A. §§ 8301(13), 8304; *see also*, Testimony of Jesse Lussier, Jul. 23 P.Tr., 187:17-22.

62. If an insurer's RBC falls below 100%, it constitutes an "authorized control level event" and the Commissioner is authorized to take regulatory control of the insurer. *See* 8 V.S.A. §§ 8301(13), 8304; Testimony of Jesse Lussier, Jul. 23 P.Tr., 188:9-15. If an insurer's RBC falls below 70%, it constitutes a "mandatory control level event" and the Commissioner must take regulatory control of the insurer. 8 V.S.A. §§ 8301(13), 8305; Testimony of Jesse Lussier, Jul. 23 P.Tr., 188:16-19. Regulatory control can take different forms, depending on the circumstances, including supervision, rehabilitation, or liquidation. *See* 8 V.S.A. §§ 7031-7100; Testimony of Jesse Lussier, Jul. 23 P.Tr., 188:13-15; Testimony of Kaj Samsom, Jul. 23 P.Tr. 191:22-24.

63. Pursuant to a new law enacted earlier this year, a low RBC ratio may also trigger regulatory intervention by the Board. Under this law, if the Board determines, after consulting with the Commissioner, that a domestic health insurer, such as BCBSVT, faces an acute and immediate threat to its solvency because its RBC has fallen below 150% (the regulatory action level), the Board may order that the insurer's reimbursement rates to certain Vermont hospitals be reduced until such time as the insurer's RBC ratio exceeds 150%. *See* 18 V.S.A. § 9384(b). BCBSVT's CFO testified that this legislation increased the Company's confidence that it could stay in the QHP market in 2026 and commit to paying all its policyholders' claims, no matter what. *See* Testimony of Ruth Greene, Jul. 23 P.Tr., 99:11-100:20 (describing the legislation as a "safety net").

64. BCBSVT's RBC ratio and surplus have continued to trend negatively over the past several years. Ex. 20, 1; Ex. 21, 1. The following graphs show BCBSVT's RBC ratio in relation to its target range, as well as its total surplus, from 2020-2024:




Ex. 20, 2; Ex. 21, 2.

65. The decline in BCBSVT's reserves from 2021 - 2024 is due primarily to underwriting losses, as well as equity losses that BCBSVT incurred in connection with the Medicare Advantage plans it offers through a joint venture with BCBS of Michigan. However, other factors, such as litigation settlements have also contributed. *See* Ex. 23, 35; Resp. to Post-Hearing Questions (Aug. 5, 2025), Attachments, 2; Testimony of Ruth Greene, Jul. 23 P.Tr., 94:6-97:12.

66. The following table shows changes in BCBSVT's reserves from 2014 – 2024 based on the Company's Annual Statements. BCBSVT's share of the losses on Medicare Advantage plans is reflected in the "Equity gains & losses (VBA)" row. BCBS of Michigan suffered its own proportional share of the losses on this business, which are not reflected in the table. Payments for multi-district litigation settlements, net of estimated insurance recoveries, are reflected in the "Other income (expense)" rows for 2020 [redacted] and 2024 [redacted], along with other items. Resp. to

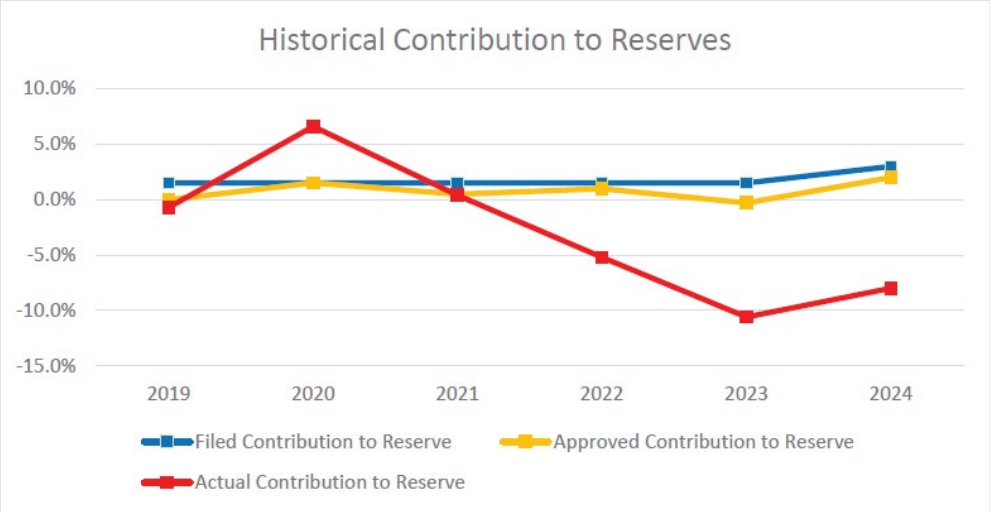
Post-Hearing Questions (Aug. 12, 2025), 4; *see also* Testimony of Ruth Greene, Jul. 23 P.Tr., 96:16-97:6.

| Annual Statement Reference | Changes in Member Reserves | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| p. 4 L24 | Underwriting gain/ loss (includes PDR) | 5.1 | 8.8 | (18.2) | (1.5) | (15.5) | (13.8) | 13.0 | (17.9) | (46.8) | (24.8) | (62.1) |
| p. 4 L25 | Investment income (excluding affil. dividends) | 3.9 | 3.8 | 3.8 | 4.2 | 4.2 | 3.1 | 2.5 | 3.0 | 3.1 | 3.0 | 2.6 |
| p. 4 L26 + p. 5 L36 | Equity gains & losses | 0.9 | (0.7) | 1.9 | 3.0 | (1.8) | 1.6 | 0.4 | 0.4 | (3.1) | (1.0) | (0.9) |
| p. 4 L26 + p. 5 L36 | Equity gains & losses (VBA) | - | - | - | - | - | - | (3.4) | (6.0) | (11.5) | (22.5) | (7.8) |
| p. 4 L26 + p. 5 L36 | Equity gains & losses (other affiliates) | 3.7 | 0.9 | 4.1 | 3.7 | (0.9) | 5.8 | 10.1 | 5.5 | (3.9) | 9.4 | 4.8 |
| p. 4 L29 | Other income (expense) | 3.2 | 2.6 | 2.6 | 2.7 | 1.9 | 2.6 | (2.1) | 2.8 | 3.6 | 5.7 | (0.3) |
| p. 4 L31 + P. 5 L38 | Income taxes and change in deferred tax | (1.6) | (3.6) | 2.1 | 30.0 | 3.5 | 0.7 | 1.7 | 0.3 | 3.1 | 0.7 | - |
| p. 5 L39 | Change in non-admitted assets | (2.4) | (3.9) | (7.7) | (12.9) | (7.3) | 1.8 | (1.6) | 5.9 | 1.9 | (0.5) | 6.7 |
| p. 5 L39 | AMT credit impact | - | - | - | (33.2) | (2.6) | 18.0 | (2.6) | 20.4 | - | - | - |
| p. 5 L42 | Change in surplus notes | - | - | - | - | - | - | - | - | - | - | 30.0 |
| | Pension asset losses & litigation recovery | - | - | - | - | - | - | (35.2) | - | 26.7 | - | - |
| P. 5 L4701 | Impact of pension freeze | - | - | - | - | - | - | - | 10.3 | - | - | - |
| | Change in pension | (6.8) | 2.1 | (1.8) | 2.7 | (5.4) | 3.6 | (12.7) | 7.6 | 2.5 | 6.3 | (2.3) |
| P. 5 L48 | **Total Change in Member Reserves** | **$ 6.0** | **$ 10.1** | **$ (13.2)** | **$ (1.2)** | **$ (23.9)** | **$ 23.4** | **$ (29.9)** | **$ 32.2** | **$ (24.4)** | **$ (23.8)** | **$ (29.3)** |
| * 2019 - 2023 have been adjusted for intercompany dividends from subsidiaries shown on page 42 of the Annual Statement in column 4 | | | | | | | | | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Member Reserves | $138.4 | $148.4 | $135.3 | $134.1 | $110.2 | $133.5 | $103.6 | $135.8 | $111.4 | $87.7 | $58.4 |
| ACL Risk-based Capital | $20.8 | $22.4 | $22.9 | $24.0 | $22.2 | $23.6 | $21.6 | $22.4 | $25.7 | $26.0 | $27.3 |
| RBC | 666% | 663% | 591% | 558% | 495% | 567% | 480% | 607% | 434% | 337% | 214% |

Ex. 23, 35.

67. BCBSVT's actual CTR on QHP plans from 2022 – 2024 was highly negative. The graph below shows how actual CTR compared to the filed and approved CTR on BCBSVT's QHP plans from 2019 – 2024:




68. The Board approved the inclusion of a 7% CTR in BCBSVT's 2025 QHP rates. *See In re Blue Cross and Blue Shield of Vermont 2025 Individual and Small Group Market Rate Filings*, 003-24rr & GMCB-004-24rr, 17, Decision and Order. So far in 2025, BCBSVT is realizing a 4% CTR. *See* Testimony of Ruth Greene, Jul. 23 P.Tr., 30:1-4; Testimony of Martine Brisson-Lemieux, Jul. 23 P.Tr., 244:5-15.

69. BCBSVT's losses in recent years have not been limited to the QHP plans; they have spanned virtually the Company's entire book of business. The following table shows BCBSVT's underwriting gains and losses by line of business for 2020 - 2026, as well as its operating gains and losses for non-underwriting items in those same years:

Resp. to Post-Hearing Questions (Aug. 5, 2025), Attachments, 2.[13]

70. From 2020 – 2024, BCBSVT's underwriting loss across all lines of business totaled approximately . Resp. to Post-Hearing Questions (Aug. 5, 2025), Attachments, 2. BCBSVT's underwriting loss on QHP plans was around , or around 38% of the total. *Id*. For 2025 and 2026, BCBSVT is projecting/budgeting net underwriting gains of approximately across all lines of business, with approximately (81%) coming from QHP plans—a little over 4.2 times the contribution of the remainder of BCBSVT's business. *Id*. Based on these projected/budgeted numbers for 2025 and 2026, the Company's loss on QHP plans from 2020 – 2024 would be almost entirely reversed in two years, leaving a loss from 2020 – 2026. *Id*.

71. In 2024, BCBSVT's RBC ratio fell below 300%, triggering a "company action level event." *See* Ex. 23, 6, 13; Testimony of Kaj Samsom and Jesse Lussier, Jul. 23 P.Tr., 189:23-190:5; Ex. 17, 17. BCBSVT submitted an RBC recovery plan to DFR on August 30, 2024, . *See* Ex. 23, 6; Testimony of Jesse Lussier, Jul. 23 C.Tr., 12-15.

72. As 2024 progressed, BCBSVT secured a $30 million surplus note from BCBS of Michigan, which BCBSVT had to draw on to stay above 200% RBC. Testimony of Ruth Greene, Jul. 23 P.Tr., 27:2-8. The surplus note is essentially a loan with special terms that require DFR's approval before any interest or principal is repaid. Testimony of Ruth Greene, Jul. 23 P.Tr., 28:2-8.

73. BCBSVT ended 2024 with surplus of approximately $58.4 million and an RBC ratio of 214%, including the $30 million surplus note, which is reflected in capital and increased BCBSVT's RBC by 110 points. Ex. 4, 3; Ex. 20, 1; Ex. 21, 1. Without the surplus note, BCBSVT's reserves were $28.4 million, and its RBC ratio was 104%. Ex. 4; Ex. 20, 1; Ex. 21, 1; Ex. 23, 4. BCBSVT's surplus at the end of 2024 was equal to approximately 15 days of reserves without the note and approximately 30 days of reserves with the note. *See* Testimony of Ruth Greene, Jul. 23 P.Tr., 22:24-23:4.

[13] The QHP figures in this table differ from those in other tables included in the record. *See, e.g.*, Ex. 1, 6 (reflecting a 2024 loss of $36.4 million on QHP business); Ex. 20, 3 (same); Ex. 21, 3 (same). This is because this table reports actual results as report at year-end while the results in the other tables include restatements. Resp. to Post-Hearing Questions (Aug. 5, 2025), 5.

74. From 2022-2024, BCBSVT paid its executives variable compensation, affiliation/project-related incentives, and retention incentives totaling over $3.04 million, or 10.7% of BCBSVT's total reserves as of year-end 2024 (without the surplus note). *See* Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 29-30. Stated another way, had BCBSVT *not* paid its executives $3.04 million in variable compensation and incentives from 2022-2024, its "unassigned" or free surplus at the end of 2024 would have been 10.7% higher.

75. BCBSVT is paying an annual interest rate of 8% on the surplus note. *See* Testimony of Ruth Greene, Jul. 23 P.Tr., 43:19; Ex. 17, 10. [redacted] *See* Testimony of Ruth Greene, Jul. 23 C.Tr., 12:9-13:5.

76. BCBSVT's recovery plan aims to recover RBC first to above 300%, then to above the BCBSA monitoring level of 375%, and ultimately to the target range of 590-745%. Ex. 9, 2, 9.

77. Due to the Board's negotiations and efforts in connection with UVMMC budget overages, BCBSVT received $12 million from UVMMC on June 3, 2025, in connection with alleged overpayments made by BCBSVT in FY 2022 and FY 2023. The Company retained $6.88 million of this settlement and shared the remainder with self-funded groups for their allocated portion of the settlement. Ex. 15, 22; Testimony of Ruth Greene, Jul. 23 P.Tr., 135:14-136:14. The additional $6.88 million BCBSVT retained increased its RBC ratio by approximately 25-30 points. Ex. 15, 22.

78. [redacted] *See* Testimony of Ruth Greene, Jul. 23 C.Tr., 7:13-15. Without the surplus note, as of June 2025, BCBSVT's RBC was [redacted] Testimony of Ruth Greene, Jul. 23 C.Tr., 6:2-19. When asked to provide a projected year-end 2025 RBC, BCBSVT responded that it does not currently have one. Resp. to Post-Hearing Board Questions (Aug. 5, 2025), 1. BCBSVT did, however, provide projected 2025 underwriting gains and losses for various lines of business, including QHP. *See id*. at 4.

79. Using the year-end 2024 RBC, BCBSVT would need to add $73-74 million to surplus to reach 375% RBC without relying on the surplus note. *See* Ex. 23, 11 ($74.0 million); Resp. to Post-Hearing Questions (Aug. 5, 2025), 1 (approximately $73 million). Using the mid-year 2025 RBC, however, far less additional surplus is required, only [redacted] or so.

80. Using the filed rates, the proposed 7.0% CTR would require purchasers of the Company's individual plans to pay an additional $90 PMPM on average. Ex. 2, 48. Purchasers of the Company's small group plans, meanwhile, would have to pay an additional $75 PMPM on average. Ex. 2, 63. In total, BCBSVT's QHP members would be expected to contribute approximately $36.2 million to the Company's reserves in 2026 with a 7.0% CTR, $22.7 million from the individual market and $13.5 million from the small group market. Ex. 15, 26; Ex. 23, 11. This is worth around 132 percentage points of RBC. *See* Ex. 15, 26.

81. BCBSVT's current outlook for recovering its RBC to 375%, excluding the surplus note, is two to three years, although the pace of the recovery will be impacted by a number of factors. *See* Ex. 15, 26; Testimony of Ruth Greene, Jul. 23 P.Tr., 46:16-19.

82. [redacted] Ex. 23, 16. [redacted] *See supra*, Findings, ¶ 69; Testimony of Kaj Samsom, Jul. 23 P.Tr., 202:24-203:1.

83. The Commissioner vigorously recommends that the filed CTR of 7.0% be maintained to prevent further erosion of BCBSVT's solvency and put the Company on a path of restoring surplus to adequate levels. Ex. 20, 4; Ex. 21, 4. The Commissioner notes that the filed CTR is consistent with BCBSVT's RBC plan and previous rate filings and states that the filed CTR is critical to increase and stabilize surplus and protect the Company from underwriting losses it has seen in the past. *See* Ex. 20, 4-5; Ex. 21, 4-5. In light of BCBSVT's low reserves, the Commissioner also advises extreme caution in ordering any reductions to the rates that have not been quantified by BCBSVT and submitted as a modification to the filing. Ex. 20, 5; Ex. 21, 5.

84. When asked to explain DFR's analysis of why a 7.0% CTR is appropriate, DFR testified that it analyzed whether the CTR puts BCBSVT on a path toward greater stability in a time frame that DFR thinks is appropriate and provides an appropriate buffer for uncertainty that exists in the individual and small group block of business. Testimony of Kaj Samsom, Jul. 23 P.Tr., 199:19-24. When asked why not 8.0%, or 9.0%, or 6.0%, DFR responded: "Because we give some deference to Blue Cross Blue Shield in asking for seven percent knowing that they believe that they are the stewards of their surplus. And they believe that seven percent . . . is a good compromise of all those factors. And then our job is to say, do we find that excessive or unnecessary? We do not." Testimony of Kaj Samsom, Jul. 23 P.Tr., 200:2-10.

85. DFR testified that a lower CTR that allowed BCBSVT's reserves to continue to increase, although at a slower pace than the 7.0%, may be reasonable, although any reduction to the rates increases the likelihood that the rates are inadequate, and the Board would have to consider the additional risk that there would be a repeat of the last couple of years in the QHP market. *See* Testimony of Kaj Samsom, Jul. 23 P.Tr., 197:4-198:1.

86. DFR's August 14 Order prohibits BCBSVT from entering, renewing, or amending a contract with certain hospitals unless 1) BCBSVT demonstrates that the terms of the agreement support a material reduction in commercial insurance premiums while protecting BCBSVT's solvency, and 2) the agreement contains industry-standard discount provisions and other cost containment provisions. The Order also anticipates that DFR may appoint a liaison to work with BCBSVT to ensure compliance with the Order and improve BCBSVT's solvency position. *See* DFR Order.

87. Earlier this year, the Board issued guidance describing different analyses that it would begin to request and consider in determining whether a carrier's proposed individual and small group

rates are affordable under 8 V.S.A. § 4062. *See* Green Mountain Care Board, Guidance on the Assessment of Affordability in the Review of Health Insurance Rates (Affordability Guidance), 2 (April 2, 2025).[14] The templates BCBSVT was required to complete and submit in connection with the Affordability Guidance contain a great deal of information. We make several high-level observations below:

a. The results of the premium affordability calculations are stark. Excluding the 100% FPL rows,[15] 113 of the 140 premium cells (81%) in the individual market and 77 of the 128 premium cells (65%) in the small group market are red, indicating that the premium for the household is higher than the premium affordability standard. Variances from the standard are often quite large. For example, an adult couple with an annual income of $95,175, or 450% FPL, would need to pay 3.95 times the premium affordability standard (or approximately $33,900 per year) to purchase BCBSVT's Standard Gold plan in the individual market. *See id*., Individual Tab, Row 96.

b. The premium table for BCBSVT's individual plans highlights the unfairness of the premium subsidy cliff at 400% FPL. The reason the couple in the prior example would have to pay 3.95 times the premium affordability standard to purchase BCBSVT's Standard Gold plan is because premiums are very high *and* because they are not eligible for premium assistance. In contrast, if the couple made $84,600 per year, or 400% FPL, instead of $95,175 per year, they would have to pay 1.32 times the affordability standard, rather than 3.95 times the standard, because they would be eligible to receive PTC. *See id*., Row 95.

c. In the individual market, there are very few households that can purchase a plan for a premium that meets the affordability standard, even with premium assistance. BCBSVT's Standard Platinum Plan fails the premium affordability test across the board—every household type at every income level up to 500% FPL fails. *See id*., Cells G:80-115. The Standard Silver plan also fails for every household type and every income level, due in part to Vermont's approach to silver loading, but also due to the widening gap between BCBSVT's premiums and MVP's premiums. *See id*., at Cells J:80-115; *see also* Resp. to Post-Hearing Questions (Aug. 5, 2025), Attachments, 1. BCBSVT's Standard Gold plan passes the affordability test for certain households (Single Adult and Parent and Two Children households) with incomes of 250% FPL or lower. *See id*., Cells H:80-115. Finally, BCBSVT's Standard Bronze plan passes the premium affordability test for most households up to around 400% FPL but fails for households with higher incomes due to the absence of premium assistance. *See id*., Cells I:80-115.

d. Plans with an affordable premium often come with an unaffordable deductible.[16] For example, as mentioned above, the premium for BCBSVT's Standard Gold plan passes the premium affordability test for Single Adult and Parent and Two Children households with an

[14] https://ratereview.vermont.gov/sites/dfr/files/documents/Rate%20Review%20Affordability%20Guidance%20-%20Adopted.pdf.
[15] The Affordability Guidance states that FPL increments used in the analyses will start at 138%, which is the Medicaid eligibility threshold. In the templates, the FPL increments mistakenly begin at 100%.
[16] The Board measured deductibles and overall cost sharing burdens in addition to premiums so that it could understand these kinds of dynamics.

income of approximately 200% FPL or lower. *See id*., Cells H:80-115. However, 200% FPL is around the income level where the deductible for this plan begins to fail the deductible affordability test. *See id*., Cells H:283-318. And while the premium for BCBSVT's Standard Bronze plan passes the premium affordability test until approximately 400% FPL, the deductible for this plan fails the deductible affordability test for all households analyzed. *See id*., Cells I:80-115, I:283-318.

e. Unsurprisingly, due to the absence of premium tax credits and silver loading, small group premiums are estimated[17] to be more affordable for higher income households and less affordable for lower income households. The small group data also show that Vermont's tiered rate structure[18] disadvantages adult couples compared to other household types. *See* Small Group Tab.

88. Cost is a significant barrier to accessing care. *See generally* Vermont Department of Health, 2025 Vermont Household Health Insurance Survey (May 2025), Ex. 28.

89. If the Board a 15.7% rate increase for BCBSVT's individual plans and an 8.0% rate increase for BCBSVT's small group plans,[19] BCBSVT's individual and small group rates will have increased by approximately 84% and 55% respectively since 2021. *See* HCA Post-Hearing Memo, 5. Increases in BCBSVT's individual and small group rates have far outpaced Vermont real GDP and Vermont real wage growth since 2021, and approving BCBSVT's proposed rates would continue that trend. *See* HCA Post-Hearing Memo, 6.

90. BCBSVT's reimbursements to Vermont hospitals, particularly its outpatient reimbursements, are high in relation to the rates that other Blues plans pay. Blue Health Intelligence (BHI) provides Blues plans with comparative analytics on aggregated claims data from across the Blues system. In response to Board questions, BCBSVT requested and received limited permission to share some high-level aggregate data from BHI with the Board. According to this data, BCBSVT's hospital costs are higher than the northeastern and national averages even after adjusting for demographics; its outpatient PMPM is the highest of all Blues plans reported and is increasing faster as well; and its outpatient PMPM is greater than the national average due to higher-than-average utilization and higher than average costs per service. *See* Ex. 15, 8. BCBSVT provided the following examples from the BHI data of services that are contributing to the company's high costs:

a. Inpatient stays for nervous system disorders are $15,678 more expensive per stay for BCBSVT's members than members in other states and the cost is increasing by $4,426 more per year than other states annually. Ex. 15, 10.

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[17] Small group premiums are estimates because small employers typically pay for some portion of the premium cost for their employees and this amount varies by employer.

[18] 33 V.S.A. § 1811(e) (requiring carriers to offer a plan rate structure that differentiates at a minimum between single person, two person, and family rates); Department of Financial Regulation, Docket No. 13-002-I, Order Establishing Tier Rate Structure and Multipliers (Mar. 13, 2013) (establishing uniform tiers and multipliers for use in premium development), https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-order-docket-13-002-i-vermont-health-benefits-exchange.pdf.

[19] BCBSVT states that these are its proposed rates, after adjusting for agreed-upon recommendations from L&E. *See* BCBSVT Post-Hearing Memo, 1, n.1.

b. An inpatient stay for pregnancy/childbirth is $4,013 more expensive for BCBSVT members than members in other states and the cost is increasing by $847 more than other states annually. *Id*.

c. An outpatient visit for an MRI is $2,082 more expensive for BCBSVT members than members in other states and the cost is increasing by $261 more than other states annually. *Id*.

d. An outpatient lab is $35 more expensive for BCBSVT members than members in other states and the cost is increasing by $9 more than other states annually. *Id*.

91. BCBSVT has largely been unsuccessful in negotiating commercial rate increases for its members below the caps established by the Board in the hospital budget process. *See* Ex. 15, 14; *see also* Testimony of Andrew Garland, Jul. 24 C.Tr., 20:2-21:3. Moreover, BCBSVT has allowed UVMHN hospitals to increase reimbursement rates for certain services *above* the Board's budgetary rate caps. *See* Testimony of Andrew Garland, Jul. 24 P.Tr. 72:19-73:15 (describing how some codes are higher than the rate cap and some codes are lower and providing an example of a rate increase for a particular code with no volume or very little volume in the study period "getting a significant rate increase" followed by "tremendous volume" in the performance period); *see also* Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 2 ([redacted]), 3-4 [redacted]). This practice challenges BCBSVT's reserves and ultimately results in greater healthcare costs, contributing to requests by BCBSVT for unsustainable rate increases. BCBSVT explains that it is unable to successfully push back on UVMHN's demands due to market dynamics and network adequacy requirements. *See* Ex. 15, 14; Testimony of Ruth Greene, Jul. 23 P.Tr., 105:19-106:9; Resp. to Post-Hearing Questions (Aug. 5, 2025), 7. BCBSVT urges the Board to address this issue in the hospital budget process, by ordering that [redacted] *See* Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 8.

92. In August 2024, BCBSVT alleged that the rates it paid UVMMC in FY 2022 and FY 2023 exceeded the Board-ordered commercial rate caps by $16.7M and $11.6M, respectively. *See* Ex. 17, 23; Ex. 23, 7.[20] UVMMC denied the allegations. *See* Ex. 17, 23. Pursuant to a settlement agreement between UVMMC, UVMHN, and the Board, UVMMC paid BCBSVT $12 million to settle the dispute. *See* Ex. 15, 22; *see also supra*, Findings, ¶ 77. While BCBSVT calculates that there was no similar overpayment to UVMMC in FY 2024, based on one quarter of data, there was a 5.8% variance from the target in FY 2025. *See* Ex. 15, 21. BCBSVT states that there are many dynamics that cause the actual spend to be greater than the commercial rate increase allowed by the Board. *See* Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 9. [redacted]

[20] While the record materials cited were designated as confidential, the allegations by BCBSVT and the denials by UVMMC were well-publicized and the letters from BCBSVT and UVMMC to the Board are posted on the Board's website.

[redacted] *See* Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 2.

93. BCBSVT also urges the Board to order a [redacted] *See* Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 9. [redacted] *See* Ex. 24, 5-10. [redacted] *Id.* at 5. [redacted] *Id.* at 7. [redacted] *See id.* at 5-10.

94. BCBSVT alleges that UVMHN has long asserted a "revenue neutral" position when it comes to contracting with BCBSVT. "This means that if Blue Cross VT identifies an area where there have been overcharges or areas where there appear to be opportunities to reduce prices, UVMHN will only agree to a reduction if that revenue will be made up by increasing prices in other areas." Ex. 15, 15. This "revenue neutrality" often takes the form of refusing to lower reimbursements for some codes without increasing reimbursements for other codes, and has also surfaced in the form of responses to BCBSVT's payment integrity programs and cost containment initiatives. *See* Resp. to Post-Hearing Questions (Aug. 5, 2025), 5-6; *see also* Ex. 15, 15 (stating that UVMHN "takes this 'revenue neutral' approach even when cost reductions are associated with systemic billing errors or where the Network's costs to deliver a service have been reduced."); Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 2 ("[redacted])

95. BCBSVT was unable to quantify the total financial impact of the "revenue neutrality" dynamic but explained that it has hampered BCBSVT's efforts to control costs and set reasonable rates for drugs, inpatient stays, labs, surgical services, and more. Resp. to Post-Hearing Questions (Aug. 5, 2025), 5-6. BCBSVT provided examples of how this "revenue neutrality" dynamic plays out, using its 2023 contract negotiations with UVMHN. [redacted]

[21] [redacted]

. *See* Resp. to Post-Hearing Questions (Aug. 5, 2025), 6-7.

96. BCBSVT provided much more detail regarding the , both at hearing and in post-hearing responses to Board questions. *See* Testimony of Andrew Garland, Jul. 24 C.Tr., 21:6-23:1; Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 5. Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 5-6; *see also* Testimony of Andrew Garland, Jul. 24 C.Tr., 21:10-14 (stating that Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 5. *Id.* at 5-6.

97. With respect to the Resp. to Post-Hearing Question 32 (Aug. 5, 2025), 7. *Id*. at 8.

[22]

[redacted] *Id.* at 7-8.

98. BCBSVT has two[23] value-based payment programs, Vermont Blue Integrated Care (VBIC) and Enhanced Community Primary Care (ECPC). The programs are both limited in reach and focused on independent primary care practices. Ex. 5, 5. The proposed rates include $3.00 PMPM for these programs, an increase of $0.50 PMPM, which is expected to be spent approximately 28% for VBIC and 72% for ECPC. *See* Resp. to Post-Hearing Questions (Aug. 5, 2025), 8.

99. The VBIC program is in its third year. There are four practices participating. Ex. 5, 4. In 2024, there were approximately 7,200 members attributed to VBIC practices, 3,260 of whom were QHP members (around 7.2% of BCBSVT's QHP membership that year). *Id.*; Resp. to Post-Hearing Questions (Aug. 5, 2025), 8; *supra*, Findings, ¶ 21. VBIC focuses on implementing quality metrics for disease management, particularly for diabetes, hypertension, wellness (prevention), and colorectal screening. Providers are financially rewarded for participating, and then again for reaching quality and utilization metrics that improve outcomes and reduce costs. The maximum a VBIC practice can earn as of Jan. 2025 is $7.00 PMPM; the average payment is $5.88 PMPM. Ex. 5, 4.

100. [redacted]. Resp. to Post-Hearing Question 16 (Aug. 5, 2025), Attachment, 2. BCBSVT states that [redacted]. Resp. to Post-Hearing Questions (Aug. 5, 2025), 7.

101. The ECPC program was introduced in 2024. It is designed to pay independent community primary care practices for delivering high quality care while encouraging low-cost referrals. The maximum an ECPC practice can earn as of January 2025 is $5.60 PMPM, and the average payment is $2.72 PMPM. BCBSVT states that this is a new program, so it is too early to quantify results. Ex. 5, 4-5.

102. Every year, the Board asks BCBSVT to complete a table that breaks down the payments it has made in the individual and small group markets under different payment models, using the framework created by the Health Care Payment Learning & Action Network (HCP-LAN). Below are the results for calendar year 2024:

[23] While BCBSVT also participates in the Blueprint for Health, by law, it must participate in that program to do business in Vermont. Ex. 5, 5; 18 V.S.A. § 706(b).

| Category | Allowed Charges | Percentage |
|---|---|---|
| 1. Fee for Service – no link to Quality & Value | $413,554,514 | 97.4% |
| 2A. Fee for Service – Link to Quality & Value – Foundational Payments for Infrastructure & Operations | $225,279 | 0.1% |
| 2B. Fee for Service – Link to Quality & Value – Pay for Reporting | $0 | 0.0% |
| 2C. Fee for Service – Link to Quality & Value – Rewards for Performance | $7,645,818 | 1.8% |
| 3A. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing | $0 | 0.0% |
| 3B. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing/Downside Risk | $0 | 0.0% |
| 3N: Risk based payments NOT linked to quality | $0 | 0.0% |
| 4A. Population-Based Payment – Condition-Specific Population-Based Payment | $937,910 | 0.2% |
| 4B. Population-Based Payment – Comprehensive Population-Based Payment | $1,729,033 | 0.4% |
| 4C. Integrated Finance & Delivery System | $0 | 0.0% |
| 4N. Capitated payments NOT linked to quality | $581,883 | 0.1% |

Ex. 15, 2. Allowed charges in this table include all payments to providers, such as Blueprint payments, payments for VBIC and ECPC, and fee-for-service claims and capitations. Categories 4B and 4N of the table include Blueprint and VBIC payments, and capitations, respectively. *Id.* Category 2C includes fee-for-service claims for attributed ECPC members at ECPC practices. *Id*. at 3.

103. The table below shows what percentage of BCBSVT's payments in the individual and small group markets were in an alternative payment model each year from 2020 – 2024:

| **HCP-LAN Category** | **Year** | | | | |
|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** |
| APM | 49.8% | 47.7% | 57.5% | 0.9% | 0.8% |
| FFS | 50.2% | 52.3% | 42.5% | 99.1% | 99.2% |

Ex. 15, 3. The significant decrease from 2022 to 2023 in the percentage of payments made under an APM is the result of BCBSVT not contracting with the accountable care organization OneCare Vermont and instead working directly with independent primary care practices through its VBIC and ECPC programs. *Id*.

104. BCBSVT does not have quality incentives in its contracts with hospitals. Therefore, if a hospital has declining quality, that doesn't impact the rates that BCBSVT pays. See Testimony of Andrew Garland, Jul. 24 P.Tr., 69:1-12.

105. The Company's Vice-President for Client Relations and External Affairs acknowledged that "when pricing is out of line with value, it's wasteful." Testimony of Andrew Garland, Jul. 24 P.Tr., 75:17-18. He also acknowledged that paying 500% or 600% of Medicare for an MRI or CT scan does not create value. *Id*. at 75:11-14.

106. BCBSVT has improved the terms of its PBM contract as a result of its affiliation with BCBS of Michigan. Testimony of Ruth Greene, Jul. 23 P.Tr., 138:6-14. The effect on premiums, however, is relatively small; [redacted].

*See* Ex. 1, 24; Ex. 2, 38; Testimony of Martine Brisson-Lemiux, Jul. 23 C.Tr., 19:8-24.

107. BCBSVT has utilization management programs. These programs primarily consist of prior authorization and post-service review, which are done by both internal BCBSVT teams and third-party vendors. The prior authorization program requires healthcare providers to obtain prior approval before certain medical services or procedures are administered. Services and procedures requiring prior approval are identified based on the likelihood of over-utilization based on market trends, high costs, or safety concerns. Prior authorizations are also typically required for services from an out-of-network provider. Post-service reviews assess healthcare resource utilization after services have been provided, for example comparing the length of hospital stays or frequency of medical visits to establish guidelines and medical necessity. *See* Ex. 5, 8.

108. BCBSVT's "Better Beginnings" program is a care management program for pregnant persons to support maternal wellness and reduce the risk of pregnancy complications. The program offers specialized services during and after pregnancy, delivered by nurses who act as a resource and assist members in navigating the health care system. *See* Ex. 5, 7.

109. BCBSVT has partnered with a third-party vendor to help ensure that its members only undergo advanced imaging (e.g., MRIs, CTs, and PET scans) when clinically necessary. Advanced imaging is widely used but poses risks like radiation exposure and high costs, and provider margin on advanced imaging tends to be high, encouraging over-utilization. *See* Ex. 5, 9.

110. BCBSVT uses a vendor to manage its lab network and is currently working with a vendor to implement genetic testing oversight to ensure that extremely expensive genetic tests are only used when the evidence supports their effectiveness. *See* Ex. 5, 9.

111. BCBSVT also has a program that provides support for members with rare, complex conditions, in partnership with a third-party vendor, to identify risks and gaps in care early and create personalized care strategies.

112. BCBSVT has payment integrity programs to limit fraud, waste, and abuse. *See* Ex. 5, 10-12. Exhibit 3B of the filing indicates that BCBSVT's fraud, waste, and abuse recoveries and savings increased from 2021 – 2023 but were worth approximately 0.2% less in 2024 than in 2023, causing an equal increase in observed utilization. *See* Ex. 2, 24.

113. In March 2024, in response to a rapid increase in claims, BCBSVT increased its resources around claims monitoring to take a deeper look at claims processing and keep up with the reviews on larger-than-historical volumes of claims. *See* Ex. 5, 10; *see also* Ex. 17, 17. The claims reviews in 2024 and into 2025 indicated that the increase in claims was across all lines of business and types of services. BCBSVT has not identified any large-scale fraud and states that its fraud work has identified mostly areas of abusive billing practices rather than outright fraud. BCBSVT states it has begun working more closely with DVHA (Medicaid) to align fraud programs and share problem areas, and has set up regular communication channels with BCBS of Michigan for real time fraud risk identification. *See* Ex. 5, 10.

114. BCBSVT states that while it routinely identifies misbilled claims, either through internal review or with support from vendors, and works with providers to ensure accurate billing, it

is not always able to recoup those claims; providers sometimes refuse to allow recoupment, claiming the need for mutually agreed upon contract amendments or payment policies. BCBSVT also states that recovering payments in some circumstances is burdensome because it must request medical records and have a clinician review them. Ex. 5, 10-11.

115. Since falling below 400% RBC in mid-2023, BCBSVT states that it has placed limits on its discretionary spend and recruiting in support of its financial recovery. Ex. 23, 18. [redacted] Ex. 23, 7-8.

116. From 2021-2024, BCBSVT increased the salaries of its CEO and VP/Treasurer by approximately 38% and 40%, respectively. BCBSVT also paid its executives approximately $280,000 in retention incentives, $910,600 in affiliation/project incentives, and $1,852,275 in variable compensation ($3.04M in total). *See* Ex. 31, 12, 66; Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 29-30.

117. In response to follow-up questions from the Board regarding increases in executive compensation from 2023 – 2026, BCBSVT stated that in 2022, its Executive and Compensation Committee [redacted] Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 4.

118. Within BCBSVT, variable compensation [redacted] Variable compensation is paid the year after it is earned.

a. In 2022, BCBSVT's reserves fell by approximately $24.4 million and BCBSVT raised its QHP rates for 2023 by an average of 11.4% for individual plans and 11.7% for small group plans. *See supra*, Findings, ¶¶ 25, 64. Corporate goals for 2022 scored at 99% and, in 2023, approximately $634,616 was paid out in variable compensation [redacted]. Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 3, 29.

b. In 2023, BCBSVT's reserves fell by approximately $23.8 million and BCBSVT raised its QHP rates for 2024 by an average of by 14.0% for individual plans and 13.3% for small group plans. *See supra,* Findings, ¶¶ 25, 64. Corporate goals for 2023 scored at 102%, and in 2024, approximately $669,712 was paid out in variable compensation [redacted]. Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 3, 29. A retention incentive [redacted] was also paid out to [redacted] in 2023, [redacted] *Id*. at 3. These payments sum to approximately $392,500. *See id*. at 29. [redacted] *Id.* at 3.

c. In 2024, BCBSVT's reserves fell by approximately $29.3 million and BCBSVT

raised its QHP rates for 2025 by an average of 19.8% for individual plans and 22.9% for small group plans. *See supra*, Findings, ¶¶ 25, 64. Corporate goals for 2024 scored at 98%. Resp. to Post-Hearing Questions 7-9 (Aug. 5, 2025), 3. It is unclear how much will be paid out in deferred variable compensation in 2025 in connection with 2024 performance. [redacted] retention incentive was paid to [redacted] in 2024 (a total of just over $490K), [redacted] *Id*. at 3, 29.

d. For 2025, BCBSVT has [redacted] *Id*. at 2, 26.

119. The Board received approximately 97 written comments on the 2026 individual and small group rate filings and 12 members of the public spoke at the public comment forum. Comments were submitted by individuals and small businesses. Commenters expressed concern that they, loved ones, or members of their community will be unable to absorb the premium increases. People expressed that they would need to make difficult choices such as dropping insurance coverage or moving out of the state. Particular concern was expressed about the impact of the expiration of the enhanced PTCs. *See* Compilation of 2026 Vermont Individual and Small Group Rate Filing Comments.

120. In its post-hearing memorandum, the HCA urges the Board to a) implement all of L&E's recommended adjustments to the filing; b) tie BCBSVT's executive compensation to company performance, for example, by ordering a 10% reduction in executive compensation for 2026, with resulting savings applied to reserves; c) reduce rates by an additional 1.4% in each market, funded through full enforcement of hospital budget deviations through a reduction of the hospitals' FY 2026 commercial rate caps; and d) further reduce rates by 1% in each market, funded through FY 2026 hospital rate caps that achieve the 2.5% expenditure reduction contemplated in Act 68.

121. The HCA asserts that BCBSVT's proposed rates are not affordable, citing data from the affordability data templates, public comments, and cumulative premium growth since 2021. The HCA argues that while BCBSVT seeks to burden its members with a 7% CTR this year, and plans to continue seeking CTR at that level in future years, and while BCBSVT's solvency position has deteriorated, BCBSVT's executives have seen their salaries rise. The HCA states that while these executives' salaries may be modest by national industry standards, they are high by Vermont standards. The HCA urges the Board to make orders related to executive compensation and suggests a 10% reduction in total executive compensation for 2026, with the savings directed to rebuilding reserves.

122. The HCA also urges the Board to use all available regulatory tools to drive costs downward and limit rate increases to as close to 5% as possible. The HCA states that this cannot be achieved through insurer-side actions alone and recommends that the Board commit to 100% enforcement of current hospital budget deviations, which it says could reduce rates by 1.4%, and implement a 2.5% systemwide expenditure reduction contemplated by Act 68 by adjusting FY 2026

hospital rate caps accordingly, which the HCA says would reduce premium rates 1.0%.

123. In its post-hearing memorandum, BCBSVT asserts that the Board must approve the proposed rates, including a 7.0% CTR, so that it can cover its members' 2026 health care claims in the individual and small group markets without returning to (or falling off) the solvency brink where its stood just eight months ago. BCBSVT states that where, as here, the relevant legal standard incorporates multiple criteria that pull in different, mutually exclusive directions, the only practicable way to apply the standard is through a balancing approach. In light of the evidence in the record, BCBSVT states that there are only two legally viable outcomes of that balancing process: approve the rates as currently requested or reduce them but only to the extent the reductions can be tied to quantifiable, bankable reductions in 2026 health care costs.

## Authorities and Standards of Review

The Board reviews proposed rates to determine whether they are affordable; promote quality care; promote access to health care; protect insurer solvency; are not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and are not excessive, inadequate, or unfairly discriminatory. 8 V.S.A. § 4062(a)(3); GMCB Rule 2.000, § 2.301(b).

In its review, the Board considers changes in health care delivery, changes in payment methods and amounts, and other issues at its discretion. 18 V.S.A. § 9375(b)(6); GMCB Rule 2.000, § 2.401. The Board must also consider DFR's analysis and opinion regarding the impact of the proposed rates on the insurer's solvency and reserves, as well as any public comments the Board receives. 8 V.S.A. §§ 4062(a)(2)(B), (a)(3), (c)(2)(B); GMCB Rule 2.000, §§ 2.201(d), 2.401(d). Finally, the Board is required to execute its duties, including those related to rate review, consistent with certain principles that the General Assembly has adopted as a framework for reforming health care in Vermont. 18 V.S.A. §§ 9371, 9375(a).

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

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

In addition to its authority to approve, modify, or disapprove rate requests, the Board is authorized to make reasonable supplemental orders and attach reasonable conditions and limitations to such orders as the Board finds necessary to ensure that benefits and services are provided at minimum cost under efficient and economical management. *See* 8 V.S.A. §§ 4513(c) (appliable to nonprofit hospital service corporations), 4584(c) (applicable to nonprofit medical service corporations). This authority has been found to authorize supervision over an insurer's contracting process with hospitals, as well as measures aimed at limiting administrative expenses. *See In re Vermont Health Serv. Corp.*, 144 Vt. 617, 624 – 25 (1984); *In re Vermont Health Serv. Corp.*, 155 Vt. 457, 464 (1990).

## Conclusions of Law

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

### I. Not Excessive, Inadequate, or Unfairly Discriminatory

For the rates to not be excessive, BCBSVT must adjust its medical utilization trend, pharmacy trend, projected risk adjustment receivable, and medical unit cost trend, and must account for recent legislation.

#### A. Medical Utilization Trend

BCSVT must reduce its overall allowed medical utilization trend in each filing from 5.0% per year to 3.5% per year. Five percent is not a reasonable best estimate of the annual medical utilization trend. Findings, ¶ 39. A trend between 3.0% and 4.0% is highly likely. *Id*. Although lower than L&E's recommendation, a 3.5% trend assumption is in the middle of this range and is a more appropriate assumption than 5.0%. *See id*.

We are not persuaded by BCBSVT's objections regarding the reasonableness of a lower utilization trend for certain categories of medical services. L&E's conclusions regarding the medical utilization trend were based on holistic measures that were not broken out by service categories. Findings, ¶¶ 40-41.

#### B. Pharmacy Trend

BCBSVT must reduce its non-specialty drug utilization trend in each filing from 4.5% per year to 3.3% per year, as recommended by L&E. BCBSVT did not object to this recommendation. Findings, ¶ 50.

#### C. Risk Adjustment Transfer

BCBSVT must change the projected risk adjustment receivable to reflect the final market-wide figure announced by CMS, as recommended by L&E. BCBSVT did not object to this recommendation. Findings, ¶ 50.

#### D. Act 55

BCBSVT must reduce the individual premiums by 4.1% and the small group premiums by 3.3% to account for the impact of Act 55. BCBSVT does not object to this recommendation, although it cautions that the impact of Act 55 should not be double counted as both a stand-alone adjustment and as part of the hospital budget submissions. *See* Findings, ¶ 45.

#### E. Medical Unit Cost Trend

BCBSVT must use the Board's updated calculation of hospital budget submissions, excluding the impact of Act 55. *See* Findings, ¶ 46.

For CVMC, which took in substantially more NPR in FY 2024 than budgeted, BCBSVT must also assume that the Board will enforce half of the NPR overage through a reduction in the hospital's FY 2026 commercial rate cap. This is expected to result in a 0.3% reduction to the proposed rates in each filing.[24] *See* Findings, ¶ 48. While we cannot prejudge this enforcement matter, we must also evaluate the reasonableness of BCBSVT's unit cost assumptions. Assuming no enforcement is not reasonable, while assuming enforcement of half the overage is consistent with recent budget enforcement actions. *See id*.

As explained elsewhere in this decision, we require BCBSVT to reduce the CTR in its individual filing from 7.0% to 3.5% and to reduce the CTR in its small group filing from 7.0% to 5.7%. These reductions produce an overall CTR across both filings of approximately 4.3%.[25] CTR relates, in part, to the actuarial aspect of our review standard. *See* Findings, ¶¶ 34, 58. We therefore discuss both the proposed CTR and the approved CTR in this section, as well as other sections.

### F. CTR

For rates to be "not excessive" and "not inadequate," they must have a "reasonable" contingency or profit margin. Findings, ¶ 34. We evaluate the reasonableness of a CTR provision in light of the functions it serves. The CTR provision of a rate is a mechanism for an insurer to add to reserves to meet financial or solvency objectives. *See* Findings, ¶ 84. The CTR provision also acts as a buffer against risk that the rates will be inadequate, and the insurer will incur a loss. *See id*. The CTR or profit margin on similar products offered by other carriers is also relevant to a CTR's reasonableness. *See* Findings, ¶ 57.

<u>*Need to Add to Surplus*</u>: BCBSVT needs to add to its surplus. In 2024, the Company's RBC fell below 300%, triggering a "company action level event." Findings, ¶ 71. BCBSVT had to take out a $30 million loan to stay above 200% RBC. *See* Findings, ¶ 72. The Company ended 2024 with a surplus of $58.4 million – approximately 30 days of reserves – and an RBC of 214%. Findings, ¶ 73. Without the benefit of the loan, the year-end 2024 surplus was $28.4 million – approximately 15 days of reserves – and RBC was 104%, just above the point at which DFR can take control of the company. *Id*.

BCBSVT plans to recover RBC first to above 300%,[26] then to above 375%, and ultimately to the target range of 590%-745%. Findings, ¶ 76. While BCBSVT's timeframe for recovery to 375% RBC is two to three years, Commissioner Samsom testified that a longer timeframe could

[24] While Springfield Hospital also deviated from its FY 2024 budget, given the size of the hospital, potential enforcement of the deviation would have an immaterial impact on premiums.

[25] The projected earned premiums were filed at $324,445,453 for BCBSVT's individual plans and $193,505,096 for small BCBSVT's group plans, or $517,950,549 in total. Ex. 6, 7; Ex. 7, 7. Three and one-half percent of $324,445,453 (the projected individual premium) is $11,355,591 and 5.7% of $193,505,096 (the projected small group premium) is $11,029,791, which sum to $22,385,382, which is 4.3% of $517,950,549. While the earned premium amounts for each market and overall will be less than initially filed based on our order, the result is the same—an overall CTR of approximately 4.3%.

[26] During the proceedings, BCBSVT frequently described 300% RBC as the "company action level." This is not entirely accurate. The company action level risk-based capital is 200% (or "the product of 2.0 and [BCBSVT's] authorized control level risk-based capital"). *See* 8 V.S.A. § 8301(13)(A). However, having an RBC above 200% but less than 300% and having a negative trend constitutes a "company action level event" under 8 V.S.A. § 8303(a)(1)(B).

also be reasonable. Findings, ¶¶ 81, 85. BCBSVT has seen progress in 2025 and, as of June 2025, its RBC was [redacted] without the surplus note. Findings, ¶ 78. While that number may decrease some by the end of the year, it is unclear by how much; BCBSVT did not provide projections for year-end 2025 surplus and RBC. *Id*.

If realized, a 7.0% CTR on the filed rates would add around $36.2 million to BCBSVT's reserves and 132 points to its RBC. Findings, ¶ 80. BCBSVT's year-end 2024 RBC of 104% (without the benefit of the loan) was 271 points below the Company's near-term goal of 375%, requiring an additional $73-74 million of surplus. However, the Company's mid-year 2025 RBC of [redacted] is substantially higher than the year-end 2024 RBC and is only [redacted] short of the 375% goal, requiring an additional [redacted] million or so in surplus. *See* Findings, ¶¶ 78-79.

Risk of Rate Inadequacy: We are, as we were last year, concerned that BCBSVT's actual CTR in these markets has been both significantly negative and significantly below the approved CTR in recent years. *See* Findings, ¶ 67. However, the deviation from expectations appears to be decreasing this year; the Board approved a 7.0% CTR in the 2025 QHP rates and BCBSVT is tracking to a 4.0% CTR. Findings, ¶ 68. The price reductions UVMMC and CVMC are implementing for the remainder of 2025 should help prevent further deterioration in BCBSVT's 2025 financial performance. *See* Findings, ¶ 49.

DFR's recent order reduces the risk that BCBSVT's rates will prove to be inadequate. The order prohibits BCBSVT from entering, renewing, or amending a contract with certain hospitals unless 1) BCBSVT demonstrates that the terms of the agreement support a material reduction in commercial insurance premiums while protecting BCBSVT's solvency, and 2) the agreement contains industry-standard discount provisions and other cost containment provisions. Finally, DFR may appoint a liaison to work with BCBSVT to ensure compliance with the order and improve BCBSVT's solvency position. *See* Findings, ¶ 86.

The actions required by the Board's supplemental orders also reduce the risk that the rates will be inadequate. These supplemental orders seek to address specific contracting problems identified by BCBSVT. For example, they encourage BCBSVT to continue to negotiate for a 2026 risk-sharing model with UVMHN, which would protect BCBSVT from unexpectedly high claims costs; they prohibit BCBSVT from allowing hospitals to disparately increase their rates at the code level or acquiesce to demands for "revenue neutrality;" and they require BCSVT to reform its DRG outlier payments.

[redacted]. Findings, ¶ 75. Therefore, should the rates prove to be inadequate and should BCBSVT experience further losses, the surplus note can continue to bolster reserves. Other solvency backstops also exist; if BCBSVT's RBC falls below 150%, the Board is now authorized to reduce its payments to certain Vermont hospitals. Findings, ¶ 63. DFR can also order BCBSVT to take corrective actions if RBC falls below 150% (e.g., by prohibiting BCBSVT from paying erroneous bills). *See* Findings, ¶ 61.

Comparison to Industry: A 7.0% CTR request is a notably high outlier compared to requests nationally—around the 99th percentile. Findings, ¶ 57. Given BCBSVT's financial situation, L&E

believes a CTR below the industry median of about 3.0% would not be reasonable. Findings, ¶ 58. L&E did not consider the unique solvency protections available to BCBSVT, however. *See id*. Nor did L&E consider the recent DFR order or the Board's supplemental orders. Finally, L&E observed that determining the most appropriate CTR involves balancing the Board's statutory criteria. *See id*.

*Conclusion*: Based on the above, we conclude that CTRs of 3.5% for the individual rates and 5.7% for the small group rates are reasonable and will allow BCBSVT to continue to recover its RBC at an appropriate pace—contributing an additional $20.2 million to surplus,[27] if realized—while providing adequate protection from the risk of rate inadequacy. While a 7% CTR would allow BCBSVT to add even more to its reserves and provide even greater protection, we decline to approve such a high CTR since it is an outlier nationally, fails to reflect recently passed State law, and conflicts with many other statutory criteria.

## II. Protects Insurer Solvency

A higher rate is more protective of an insurer's solvency than a lower one. Accordingly, BCBSVT's filed rates, which include a 7.0% CTR, protect its solvency to a greater degree than the ones we are approving. As we explained above, however, the rates we are approving, which balance the competing statutory rate review factors, adequately protect BCBSVT's solvency. Should the rates prove to be inadequate, there are backstops in place to prevent insolvency, including the surplus note BCBSVT has through BCBS of Michigan, potential regulatory actions by DFR, and potential regulatory actions by the Board. *See* Findings, ¶¶ 61, 63, 75.

We respectfully disagree with DFR's opinion that a 7.0% CTR is critical to increase and stabilize BCBSVT's surplus and protect it from losses. *See* Findings, ¶ 83. DFR did not conduct its own independent analysis of the proper CTR and deferred to BCBSVT's selection of 7.0%. *See* Findings, ¶ 84. DFR acknowledged that a lower CTR that allows reserves to increase at a slower pace could be reasonable, although risk of rate inadequacy would need to be considered. Findings, ¶ 85. We have considered this risk and, to make rates more affordable, and to reflect fairness across BCBSVT's book of business, conclude that a lower CTR is appropriate.

There are actions BCBSVT can take to ensure that it realizes at least the 4.3% overall CTR we are approving in these filings and to protect itself against losses in 2026. The record establishes that BCBSVT has simply negotiated rate increases with Vermont hospitals based nearly entirely on the commercial rate caps established by the Board's hospital budget orders. *See* Findings, ¶ 91. BCBSVT has also acceded to UVMMC's "revenue neutrality" arguments, permitted disparate rate increases at the code level, and failed to correct problematic payment provisions. *See* Findings, ¶¶ 91-97. Our supplemental orders are aimed at correcting these issues.

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[27] Slightly over $10 million from each market.

IND: ($324,445,453/1.235)*1.096 = $287,928,920
$287,928,920*0.035 = $10,077,512

SG: ($193,505,096/1.135)*1.044 = $177,990,591
$177,990,591*0.057 = $10,145,463

## III. Are Affordable

The Board issued guidance earlier this year informing carriers that they would need to complete and submit templates as part of the 2026 individual and small group rate review cycle. *See* Findings, ¶ 87. These templates analyze, for a variety of household types and income levels, how the expected premium and cost-sharing burdens associated with each carrier's standard plans compare to established standards from the ACA and the Commonwealth Fund. The Affordability Guidance notified the HCA and the carriers that the template data was not the only data the Board might consider regarding affordability—that they could submit, and the Board could request, additional data.

The Affordability Guidance also explained how the Board would request data from carriers regarding their efforts to control health care cost growth, and the effectiveness of these efforts, focusing on the following areas: 1) reducing or constraining growth of unit prices, particularly hospital inpatient and outpatient facility prices; 2) expanding adoption of value-based payment methodologies; 3) reducing or constraining growth of prescription drug costs, for example through formulary or benefit design; 4) reducing the wasteful and unnecessary use of health care services; 5) limiting fraud and abuse; and 6) reducing administrative costs. *See* Affordability Guidance.

### A. Template Data

The data in the Affordability Guidance's templates are very troubling. They confirm, in numeric terms, what the Board has long heard from Vermonters in the comments they submit— affordability is a tremendous problem in these markets. While different subscribers will have different experiences based on their household composition and income, the plan they choose, and how much health care they and their family members use during the year, the tables in the templates are filled with red numbers, indicating that the variable being measured (i.e., the premium, the deductible, or the total cost sharing burden), is greater than the relevant standard.

Of the different household/plan combinations analyzed, 81% in the individual market and 65% in the small group market do not meet the premium affordability standard. Findings, ¶ 87.a. In many instances, the variance from the standard is very large. *Id*. For example, an adult couple with an annual income of $95,175 would need to pay almost four times the premium affordability standard (or approximately $33,900 per year) to purchase BCBSVT's Standard Gold plan in the individual market. *Id*. Moreover, plans that do meet the premium affordability standard often come with a deductible that fails the deductible affordability standard. Findings, ¶ 87.d.

### B. Other Affordability Data

Expiration of Enhanced PTC: If ARPA's enhancements to the PTC expire at the end of 2025, as they are expected to, most of BCBSVT's individual subscribers will experience net premium increases that are higher than the increases reflected in the individual filing. Findings, ¶ 32. While the template data described above reflect the net premiums that different households could be expected to pay without the PTC enhancements, they do not reflect the *increase* in net premiums that most individuals will experience from 2025 to 2026. For individuals above 400%, this increase will be especially large, as they will lose eligibility for any premium assistance. *See* Findings, ¶¶ 31-32.

Cumulative Rate Growth Compared to Other Measures: The rate at which BCBSVT's premiums have grown in relation to other economic indicators is also relevant to whether its proposed rates are affordable. If the Board were to approve rate increases of 15.7% for BCBSVT's individual plans and 8.0% for BCBSVT's small group plans, BCBSVT's individual and small group rates will have increased by approximately 84% and 55% respectively since 2021. Findings, ¶ 84. BCBSVT's individual and small group rate increases have far outpaced real GDP and real wage growth in Vermont since 2021, and the proposed rates would continue that trend. *See id*.

### C. Efforts to Reduce or Constrain Unit Cost Growth

The rates at which BCBSVT reimburses Vermont hospitals, particularly for outpatient services, are high compared to what other Blues plans pay. *See* Findings, ¶ 90. BCBSVT's hospital costs are higher than the northeastern and national averages even after adjusting for demographics; its outpatient PMPM is the highest of all Blues plans reported and is increasing faster as well; and its outpatient PMPM is greater than the national average due to higher-than-average utilization and higher-than-average costs per service. *Id*.

BCBSVT's efforts to control unit cost growth have not been successful. BCBSVT cites network adequacy rules and limited competition as barriers to successful negotiations with hospitals, and reports that it has had little success negotiating commercial rate increases below the caps established by the Board in the hospital budget process. *See* Findings, ¶ 91. BCBSVT also described, in detail, certain contractual problems it has with Vermont hospitals that contribute to its high costs. These include the following:

- [redacted] *See* Findings, ¶¶ 91-92.
- [redacted] Findings, ¶¶ 96-97. [redacted] (see below).
- In its interactions with BCBSVT, UVMHN has insisted on "revenue neutrality," meaning that revenue reductions, whatever their source, must be made up by increasing prices in other areas. BCBSVT reports that this has hampered BCBSVT's efforts to control costs and set reasonable rates for drugs, inpatient stays, labs, surgical services, and more. *See* Findings, ¶¶ 94-95.
- [redacted] Findings, ¶ 93.

It is clear from the record that key aspects of BCBSVT's contractual relationships with

Vermont hospitals, UVMHN especially, need to be reformed if BCBSVT is to provide benefits and services for its members at minimal cost under efficient and economical management. Accordingly, we order BCBSVT to implement some of these reforms—an action that we see as complimentary to, not duplicative of, the recent order issued by DFR. *See* Findings, ¶ 86. The reforms we are requiring BCBSVT to implement should limit the risk that its rates prove to be inadequate next year and may even allow the Company to realize a higher CTR than is built into these rates.

BCBSVT may object that it has already tried and failed to fix its contracting issues with Vermont hospitals and that the Board needs to order *hospitals* to make changes. But hospitals are not parties to these proceedings. The Board regulates hospitals through a different process, one that has not historically focused on contracting dynamics with individual payers or the specifics of the various payment methods that commercial payers utilize. We will consider ordering hospitals to take whatever actions may be appropriate in the hospital budget process, but we do not think it is futile to order BCBSVT to fix the specific problems it has identified.

Given the widely reported deterioration in BCBSVT's financial condition; the growing public outcry about the lack of affordable health insurance in the state; and now under compulsion from both the Board and DFR to implement changes, we believe BCBSVT can achieve these reforms. We saw how some of these factors resulted in bold legislative action this year, including Act 55 (caping the cost of hospital-administered outpatient drugs), Act 68 (directing the Board to implement referenced-based prices for hospitals), and Act 49 (allowing the Board to reduce hospital reimbursement rates if BCBSVT's RBC ratio falls below 150%).

### D. Efforts to Expand Adoption of Value-Based Payments

The scope of BCBSVT's value-based programming dropped precipitously in 2023 when the Company ended its collaboration with OneCare Vermont. Findings, ¶ 103. In 2023 and 2024, less than 1% of the Company's payments in these markets were made under an alternative payment methodology. *Id*. Since 2023, BCBSVT has focused on two value-based programs aimed at independent primary care practices, VBIC and ECPC. Findings, ¶ 98-99, 101, 103. These programs provide support to independent primary care practices, which have historically been funded at much lower levels than other areas of Vermont's health care system. Findings, ¶¶ 99-101.

### E. Efforts to Reduce or Constrain Prescription Drug Cost Growth

BCBSVT has seen some progress in this area because of its affiliation with BCBS of Michigan. However, the impact is not large. *See* Findings, ¶ 106.

### F. Reducing Wasteful and Unnecessary Use of Health Care

BCBSVT has several programs designed to reduce wasteful and unnecessary use of health care services. *See* Findings, ¶¶ 107-111.

### G. Efforts to Reduce Administrative Costs

BCBSVT has below-average administrative costs on a PMPM basis[28] despite not being very large. *See* Findings, ¶ 55. This is positive. However, BCBSVT is projecting a 5% annual administrative cost trend, which is greater than inflation. *See* Findings, ¶ 54. Furthermore, in 2022 – 2024, as the Company was pitching towards insolvency and raising its QHP rates by double digits, it increased the salaries of its CEO and VP/Treasurer by 38% and 40%, respective, and paid variable compensation and retention incentives totaling $3.04 million. Findings, ¶ 116. These actions do not reflect efficient and economical management of an insurer in BCBSVT's situation.

### H. Conclusion

Based on the above, BCBSVT has not demonstrated that its proposed rates are affordable. To make the rates as affordable as possible, we reduce the proposed CTR by 3.5 percentage points in the individual market (from 7.0% to 3.5%) and 1.3 percentage points in small group market (from 7.0% to 5.7%). The larger CTR reduction in the individual rates is justified by the fact that the expiration of the enhanced premium tax credits will result in substantial hardship for many in the individual market next year. *See* Findings, ¶¶ 31-32. The reductions above are expected to yield a CTR of approximately 4.3% for 2026, contributing towards BCBSVT's financial recovery.

## IV. Promotes Access and Quality

The "access" and "quality" criteria overlap somewhat with the "affordability" criterion. For example, high costs—in the form of high health insurance premiums, deductibles, copayments, and coinsurance—are a significant barrier to Vermonters' ability to access care. *See* Findings, ¶ 88. Poor quality care (e.g., avoidable hospital readmissions and unnecessary or duplicative tests and procedures) also increases the underlying claims costs that must be covered by premiums and member cost sharing, negatively impacting affordability. Our discussion of the affordability criterion is therefore also relevant here.

BCBSVT has several programs designed to help its members navigate the health care system and improve the quality of care they receive. *See* Findings, ¶¶ 98-101, 107-111. However, despite having access to hospital quality data, BCBSVT does not have any quality incentives in its contracts with hospitals and does not consider quality in connection with hospital contracting. *See* Findings, ¶ 104. Payments are one of the primary tools BCBSVT has to influence provider behavior. For the benefit of its members, BCBSVT should financially incentivize high quality care and disincentivize poor quality care.

BCBSVT can also do more to proactively educate its members about cost and quality differences between providers, steer members to low-cost/high-quality providers, and educate legislators and the public about problems in Vermont's health care system. For example, BCBSVT described how it shared information sheets with the Legislature this year, which it said were "extremely impactful" in the passage of Act 55. BCBSVT is working on a social media campaign to make some of this information available to Vermonters via social media platforms. *See* Testimony

[28] Given how high BCBSVT's premiums are, the PMPM metric is more relevant than a percentage of premium metric. *See* Findings, ¶ 55.

of Andrew Garland, Jul. 23 P.Tr., 93:12-19. BCBSVT should increase its efforts in this area.

## V. Not Unjust, Unfair, or Misleading

BCBSVT's 7.0% CTR request is unjust and unfair in that it requires disproportionally large increases from the QHP market as compared to BCBSVT's other product lines and is not a sustainable way to finance BCBSVT's recovery.

BCBSVT's losses on QHP plans have been significant in recent years. Findings, ¶¶ 68-69. However, losses on QHP plans only account for around 38% of the Company's total losses from 2020 – 2024. Across all lines of business, BCBSVT's is projecting a [redacted] million gain over 2025 and 2026, with approximately [redacted] million or 81% coming from QHP plans, meaning that the contribution of the QHP market is around 4.2 times that of the rest of BCBSVT's business in these two years. Findings, ¶ 68. While QHP plans may drive a substantial portion of the Company's capital requirement, this is not a fair or just plan, and supports the Board's reductions to CTR.

## VI. Not Contrary to Law

BCBSVT's proposed rates include an anticipated medical loss ratio above 80%, as required by 33 V.S.A. § 1811(j), and were developed using an acceptable community rating methodology, as required by 33 V.S.A. § 1811(f)(1). As required by 33 V.S.A. § 1813(a), BCBSVT's proposed rates for On-Exchange silver plans include funding to offset the loss of federal cost-sharing reduction payments and BCBSVT's proposed rates for Off-Exchange reflective silver plans do not include such funding. And as required by 33 V.S.A. § 1811(e), the rate structure used by BCBSVT differentiates between single person, two person, and family rates.

BCBSVT has provided insufficient evidence, however, to allow the Board to conclude that the proposed rates are consistent with the principles of healthcare reform. Pursuant to 18 V.S.A. § 9375(a), the Board "shall execute its duties consistent with" the principles of healthcare reform found at § 9371. The Board's duties include reviewing health insurance rates. 18 V.S.A. § 9375(b)(6). Indeed, 18 V.S.A. § 9375(b)(6) requires the Board to review proposed rate requests "taking into consideration the requirements of the underlying statutes . . . ." The underlying statutes, 18 V.S.A. § 9375(a) specifically, require the Board to consider the reform principles.

BCBSVT does not adequately argue that its submission is consistent with the § 9371 factors, instead asserting that § 9371 is not a legal authority it certifies to and was not identified by the Board as applicable in its Rate Review Rule or hearing notices. BCBSVT Post-Hearing Memo, 2, n.2. BCBSVT thus concludes it would be improper to import the principles into the rate review process as a new set of criteria or legal obligations. *Id.* However, this is a statutory requirement, has been Vermont law for over a decade, and BCBSVT itself cites 18 V.S.A. § 9375—which, in turn, explicitly references § 9371—in its actuarial memorandum as a law to which it certifies compliance. BCBSVT Actuarial Memo, 3. BCBSVT cannot validly claim lack of notice.

BCBSVT further argues that § 9371 is a "statement of legislative intent" and only imposes legal duties on the Board. While that may be, there is insufficient evidence in the record allowing the Board to make the findings necessary to conclude that BCBSVT's submission is consistent with

the § 9371 principles.[29] BCBSVT bears the burden in these proceedings and has not provided the Board with a sufficient basis to conclude that BCBSVT's requests are consistent with, or not contrary to, applicable legal principles. Regardless, even if the Board were not to review BCBSVT's requests against the § 9371 principles—as BCBSVT acknowledges the Board must do—the result of this decision would be the same for the reasons set forth elsewhere in this Decision.[30]

## VII. Supplemental Orders

Below, we provide a brief rationale for the supplemental orders we issue in connection with this decision.

Risk Sharing Arrangement with UVMHN

To provide benefits and services at minimum cost under efficient and economical management, BCBSVT should seek to mitigate its risk as much as possible through provider contracting, not very high CTR requests. A risk-sharing arrangement with UVMHN based on a PMPM revenue cap could provide BCBSVT protection from overages like those it allegedly paid in FY 2022 and FY 2023 (approximately $28.3 million in total). *See* Findings, ¶¶ 92-93.

[redacted] Findings, ¶ 93. [redacted] *Id*. [redacted]

[29] For example, when asked whether BCBSVT's rates were a sustainable way to finance the healthcare system, Ms. Brisson-Lemieux stated: "I think there's probably better ways to finance the overall healthcare system," "I don't know that I can answer that question," and later that she did not "remember specifically reading about sustainability of the financing of healthcare of Vermont . . . ." Testimony of Martine Brisson-Lemieux Jul. 23 P.Tr. 259:15-261:18; *compare with* 18 V.S.A. § 9371(11) ("The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably."). Similarly, when asked whether BCBSVT considers whether hospitals "have unnecessary expenditures in their budgets that [BCBSVT's] rates contribute to paying for," Ms. Brisson-Lemieux testified "I don't think so." *Id.* 263:6-12; *compare with* 18 V.S.A. § 9371(10) ("Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes"). BCBSVT likewise provided insufficient evidence relating to §§ 9371(1) ("Systemic barriers, such as cost, must not prevent people from accessing necessary health care"), and 9371(2) ("Overall health care costs must be contained, and the growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.").

[30] It should be noted that the rate review criteria at 8 V.S.A. § 4062 overlap in many respects with the principles of health care reform. For example, the principles in §§ 9371(1) ("[s]ystemic barriers, such as cost, must not prevent people from accessing necessary health care") and 9371(2) ("[o]verall health care costs must be contained, and the growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care") clearly overlap with the requirement that the Board consider affordability and access in reviewing rates. Similarly, the principle in § 9371(11) ("[t]he financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably") overlaps with the requirement that the Board consider whether proposed rates are unjust or unfair.

[31] [redacted] Findings, ¶ 93.

Outlier Payment Reforms

The way BCBSVT pays outlier claims is not consistent with its duty to provide benefits and services at minimum cost under efficient and economical management. [redacted] *See* Findings, ¶¶ 96-97.

Revenue Neutrality

To provide benefits and services at minimum cost under efficient and economical management, BCBSVT must reject demands for "revenue neutrality." Negotiations may require a give and take, and we recognize that some flexibility may be required here, but the dynamic BCBSVT described is dysfunctional; it increases costs and prevents BCBSVT from the benefit of successfully addressing reimbursement-related problems (e.g., the [redacted] issues). *See* Findings, ¶¶ 94-95. The Board's regulation of hospital budgets provides no basis for demands for revenue neutrality.

Disparate Code-Level Increases

As stated above, to provide benefits and services at minimum cost under efficient and economical management, BCBSVT should seek to mitigate its risk as much as possible through provider contracting, not very high CTR requests. Allowing reimbursements at the code level to vary significantly increases the risk that costs will exceed expectations due to unexpected shifts in utilization. *See* Findings, ¶ 91. Regardless of whether we address this in the hospital budget process, BCBSVT should address it.

Paying Providers for Quality and Value

A key tenet of payment reform is that payments to providers should increasingly correlate to quality and value, including effective cost management. The additional money BCBSVT is paying into Vermont's health care delivery system should be generating value for its members (e.g., incentivizing good quality outcomes or financially penalizing poor outcomes, adequately reimbursing services with high impact on pop health and prevention). BCBSVT can and should do more in this area.

## Order

For the reasons discussed above, we modify and then approve BCBSVT's 2026 Individual and Small Group Rate Filings. Specifically, we order BCBSVT to (1) reduce the overall allowed medical utilization trend in each filing from 5.0% per year to 3.5% per year; (2) reduce the allowed non-specialty drug utilization trend in each filing from 4.5% per year to 3.3% per year; (3) reduce the individual premiums by 4.1% and the small group premiums by 3.3% to account for the impact of Act 55; (4) change the projected risk adjustment receivable in each filing to reflect the final market-wide figure announced by CMS; (5) use the Board's calculation of hospital budget submissions, excluding the impact of Act 55 (as shown in the table below), in its medical unit cost assumptions in each filing; (6) adjust the medical unit cost assumptions for CVMC in each filing by assuming that the Board will enforce half of CVMC's FY 2024 budget deviation through a reduction to the hospital's FY 2026

commercial rate cap; (7) reduce the CTR in the individual filing from 7.0% to 3.5%; and (8) reduce the CTR in the small group filing from 7.0% to 5.7%.

| Hospital | Request Excl. Act 55 |
|---|---|
| **Brattleboro Memorial Hospital** | 3.0% |
| **Central Vermont Medical Center** | 2.3% |
| **Copley Hospital** | 4.2% |
| **Gifford Medical Center** | 3.0% |
| **Grace Cottage Hospital** | 0.0% |
| **Mt. Ascutney Hospital & Health Ctr** | 3.0% |
| **North Country Hospital** | 0.5% |
| **Northeastern VT Regional Hospital** | 3.0% composite; 3.3% IP/OP, 0.0% Phys |
| **Northwestern Medical Center** | 2.6% composite; 3.0% IP/OP, 0.0% Phys |
| **Porter Medical Center** | 2.7% |
| **Rutland Regional Medical Center** | 1.5% composite; 2.3% IP/OP, 0.0% Phys |
| **Southwestern VT Medical Center** | 7.8% |
| **Springfield Hospital** | 3.0% |
| **The University of Vermont Medical Center** | -0.8% |

With the modifications above, we expect that the overall average rate increase for individual plans will be reduced from 23.5% to 9.6% and the overall average rate increase for small group plans will be reduced from 13.5% to 4.4%.

**SO ORDERED.**

Dated: August 22, 2025, at Montpelier, Vermont

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

GREEN MOUNTAIN CARE BOARD OF VERMONT

**Walsh, dissenting.**

I recognize and respect the reasoning that led my colleagues to the decision they reached. Their judgment reflects a sincere concern for maintaining insurer solvency, protecting access to care, and avoiding sudden disruptions that could destabilize Vermont's health care system. I know they, too, are concerned about affordability. Where I differ is in how we weigh those concerns against the equally pressing statutory requirement that rates be affordable, and against the responsibilities that come with nonprofit stewardship. Furthermore, I see affordability as the core that stabilizes a healthcare system. When people cannot afford to use a healthcare system, they delay or avoid care as much as possible, only seeking help in the most dire situations, which tend to be the most urgent and costly. Our hospitals

will provide that care, but will not be fully reimbursed for it because the injured or sick person cannot afford to pay. Simply put, an unaffordable system can never be sustainable.

I respectfully dissent.

s/ Thom Walsh )

Filed: August 22, 2025

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: Tara.Bredice@vermont.gov).*

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

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

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| In re: | Blue Cross and Blue Shield of Vermont 2026 Individual Market Rate Filing | ) ) ) ) | GMCB-004-25rr<br><br>SERFF No. BCVT-134524605 |
| In re: | Blue Cross and Blue Shield of Vermont 2026 Small Group Market Rate Filing | ) ) ) ) | GMCB-005-25rr<br><br>SERFF No.: BCVT-134524673 |

**SUPPLEMENTAL ORDERS**

1. BCBSVT is encouraged to negotiate a risk-sharing arrangement with UMVHN based on a PMPM revenue cap for services provided to BCBSVT QHP members at UVMHN facilities in 2026. BCBSVT should seek to negotiate a model that will provide it with substantial protection from the risk of revenues exceeding the cap. No later than February 15, 2026, BCBSVT shall submit a report to the Board describing how it has complied with this order and the outcome of its negotiations.

2. BCBSVT shall make the following changes to its inpatient DRG payment methodology:

   a. BCBSVT shall increase the low outlier threshold so that, at minimum, it is possible for 100% of DRGs to hit the low outlier threshold;

   b. BCBSVT shall reduce the high outlier threshold and adjust the high outlier payment methodology to more closely resemble Medicare's methodology.

BCBSVT shall submit a report to the Board on or before February 15, 2026, describing how it has complied with this order.

3. BCBSVT shall not permit a Vermont hospital to be held harmless for all or any portion of a negotiated reimbursement reduction or negotiated change in payment methodology (e.g., reformed outlier provisions), or from a claim edit, claim recoupment, or similar payment integrity or fraud, waste, and abuse activity, unless BCBSVT has first determined that doing so is consistent with its obligation to provide benefits and services at minimum cost under efficient and economical management. BCBSVT shall keep a record of all such determinations. In the event a Vermont hospital asserts that it has a right or entitlement to a particular rate or revenue in connection with the Board's hospital budget orders, BCBSVT shall promptly notify the Board and assist the Board in resolving the matter.

4. BCBSVT shall not permit its rate of reimbursement to a Vermont hospital for any specific code to increase in FY 2026 by more than the commercial rate cap approved by the Board for that hospital unless BCBSVT first determines that doing so is consistent with its obligation to

provide benefits and services at minimum cost under efficient and economical management. BCBSVT shall keep a record of all such determinations. BCBSVT shall submit a report to the Board on or before February 15, 2026, describing how it has complied with this order.

5. BCBSVT shall make substantial progress in increasing the value generated by its provider reimbursements, for example by incentivizing desirable outcomes, disincentivizing undesirable outcomes, promoting effective cost management, and sustaining access to essential services. BCBSVT shall submit a report to the Board on or before May 1, 2026, describing how it has complied with this order.

**SO ORDERED.**

Dated: August 22, 2025, at Montpelier, Vermont

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| s/ Owen Foster, Chair | ) | |
| | ) | GREEN MOUNTAIN CARE BOARD OF VERMONT |
| s/ Jessica Holmes | ) | |
| | ) | |
| s/ David Murman | ) | |

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