VERMONT

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DELIVERED ELECTRONICALLY

July 25, 2018

Jackie Hughes, Esq.
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186

RE: GMCB Docket no. 009-18rr

Dear Ms. Hughes:

The Board has requested that BCBSVT provide responses to the following questions, each of which were raised at hearing, no later than July 31, 2018:

1. Does the filing include any reductions or offsets in costs related to the reduced side effects of new oncology drugs?
2. What percentage of the out-of-state provider rate changes are attributable to Dartmouth Hitchcock?
3. Provide any documents or testimony that BCBSVT provided to the legislature regarding the delay of the individual mandate until 2020.

In addition, I will be issuing a revised scheduling order today which amends the date on which legal memoranda will be due. Note that the Board has recessed, but not adjourned the hearing, and will adjourn on a future date pending receipt and review of all pertinent materials. The Board has not at this time chosen to extend the decision due date, but may choose to do so once it has had an opportunity to review the requested materials.

Regards,

/s/ Judy Henkin
Hearing Officer

cc: Kaili Kuiper, Esq.
Eric Schultheis, Esq.
Jay Angoff, Esq.
Agatha Kessler
Sebastian Arduengo, Esq.

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association

July 27, 2018

Ms. Judy Henkin
Hearing Officer
Green Mountain Care Board

Subject: Your 07/25/2018 Questions re: Blue Cross and Blue Shield of Vermont 2019 Vermont Individual and Small Group Rate Filing (SERFF Tracking #: BCVT-131497882)

Dear Ms. Henkin:

In response to your July 25, 2018 requests in follow up to questions raised at hearing in the above matter, here are *your questions* and our answers:

1. *Does the filing include any reductions or offsets in costs related to the reduced side effects of new oncology drugs?*
   We did not include a specific line item for the introduction of new oncology drugs beyond those utilized in the experience period. There were a number of new oncology medications approved for use in 2017. Both the 2017 utilization of these new oncology medications and any reduced side effects associated with their use are reflected in the experience and in the medical and/or pharmacy trends. Therefore, inasmuch as these new medications led to reductions in other costs, those cost savings are fully reflected in our filing.

2. *What percentage of the out-of-state provider rate changes are attributable to Dartmouth Hitchcock?*
   We understand this question to refer to the percentage of the total cost that is attributable to Dartmouth Hitchcock Medical Center (DMHC) in the "Other facilities and providers" category – as opposed to the "Vermont facilities and providers impacted by GMCB's Hospital Budget Review" category – within our unit cost trend build-up, rather than seeking specific information about the rate change at DMHC.

   Please note that the "Other facilities and providers" category also includes ancillary services along with the significant majority of physician contracts within the state of Vermont, the exception being UVMMC physicians.

   During 2017, DMHC comprised 29.6 percent of the "Other facilities and providers" category of claims. This same 29.6 percent is therefore the DHMC weight in the build-up of unit cost trend within this category.

3. *Provide any documents or testimony that BCBSVT provided to the legislature regarding the delay of the individual mandate until 2020.*
   BCBSVT provided a pre-hearing response to this question in response 11a of our July 10, 2018 response to Josh Hammerquist (page 281 of the binder). To further elaborate, BCBSVT testified that the impact of the individual mandate penalty repeal in Vermont was

expected to be more modest than estimates of ten percent nationally[1]. The most recent IRS statistics of income data from 2015 were also shared[2]. This demonstrated that, even before the penalty was repealed, a great many individuals were making the choice to forego health insurance coverage and instead pay a federal penalty.

Additionally, we provide the following information in response to Board Member Lunge's open questions regarding whether the historical approach to federal preemption and the rights of states to regulate AHPs have been impacted or changed under the final federal AHP rule.

The final federal rule confirms in several places that the federal approach to preemption has not changed under the rule with one caveat explained below. For example, the preamble to the final rule states: "Additionally, the Department explains elsewhere in this preamble that the final rule does not change existing ERISA preemption rules that authorize broad State insurance regulation of AHPs, either through the health insurance issuers through which they purchase coverage or directly in the case of the self-insured AHPs." 83 FR 28925. Similar language can be found with respect to rating (under ERISA section 514, States maintain significant authority to impose additional rating rules on insured AHPs through regulation of the underlying insurance policies obtained by AHPs to fund the benefits they provide, and may also impose similar requirements for self-insured AHPs.) 83 FR 28928. Section B.7 of the preamble explains ERISA Preemption and State Regulation of AHPs in more detail, 80 FR 28936 -7. The final rule preamble does make reference to several of the existing limitations on state regulation at 28943 wherein it states: "[Self-funded AHPs] sometimes may avoid the potentially significant cost to comply with state rules that apply to large group issuers, including for example premium taxes, benefit mandates, market conduct rules, and solvency standards. Under this final rule, however, States retain authority to extend such rules to self-insured AHPs and AHPs will be subject to ERISA requirements that demand sound financial management."

The rule does, however, provide "a potential future mechanism for preempting state insurance laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the important policy goals advanced by this final rule. But, as noted in the Proposed Rule, doing so at this time lies outside of the scope of this proceeding." 80 FR 28937. We take that to mean that if state AHP laws are so draconian as to appear to be actively undermining the AHP market completely, DOL reserves the right to claim that a law is preempted.

Of important note, guaranteed issue rules will apply to the market for Association Health Plans for carriers authorized to participate therein. Also, in consideration of the later effective date for self-insured AHPs, it is our understanding that the DFR emergency rule will only deal with fully insured AHPs.

Finally, in response to Chair Mullin's question regarding "additional protections" BCBSVT may be afforded under the law, we note that there are no special rules applicable to nonprofit hospital and medical services corporations under Vermont law that could serve as stand-ins for an adequate level of surplus. Like every other entity domiciled and offering insurance in Vermont, the Department of Financial Regulation is charged with the fundamental consumer

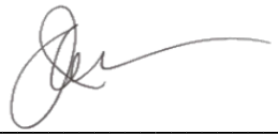
[1] https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf

[2] 12,880 residents paid individual mandate penalties totaling $6,104,000. See https://www.irs.gov/pub/irs-soi/15in46vt.xlsx

protection of monitoring solvency and requiring adequate, entity-specific levels of surplus that can withstand unforeseen adverse events and that recognize the risks associated with the conduct of business by that entity.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,



Jacqueline A. Hughes
Blue Cross and Blue Shield of Vermont