VERMONT

Green Mountain Care Board
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June 27, 2018

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

Re: Docket no. GMCB- 009-18rr, Non-Actuarial Questions #2

Dear Ms. Hughes,

Pursuant to its authority under 8 V.S.A § 4062 and 18 V.S.A. 9375(b)(6), the Board requests that BCBSVT provide the following information to assist with its review of the above-referenced filing. This information is non-actuarial in nature and therefore has not been requested through SERFF; however, the Board intends to also request, through L&E via SERFF, that BCBSVT provide additional actuarial information concerning this filing.

1. Explain how the company ensures that reimbursements to academic medical centers, community hospitals and individual providers reflect the actual costs of care, rather than site of service.

2. It was recently reported that as many as 70% of women with early stage breast cancer, the most commonly diagnosed cancer among women in Vermont, *see* http://www.healthvermont.gov/sites/default/files/documents/pdf/stat_DataBrief_BreastCancer_0.pdf, do not benefit from chemotherapy. *See* https://www.bmj.com/content/361/bmj.k2473.full. Has the insurer incorporated this finding, or other examples of potential overtreatment, in its patient or provider educational materials, policies, and/or provider reimbursement protocols? Please describe in detail, including the rate impact of adopting these policies or protocols.

3. Fully explain whether and how pricing information, including copayments and use of deductibles, is made available and readily accessible to members prior to deciding on elective surgeries or procedures.

4. Describe how the company utilizes specialty pharmacies and whether such use complies with 8 V.S.A. § 4089j.

5. Discuss fully whether the company has negotiated with providers and/or ACOs (other than OneCare, if the information is provided elsewhere in the filing), and the results of such negotiations, for limitations on annual reimbursement increases or for the use of alternative reimbursement methodologies, rather than fee-for-service reimbursement.

6. Describe the company's plans for consumer outreach and customer service relating to:

(a) defunding of the CSR program and creation of Reflective Silver Plans
(b) educating Vermonters on maintaining continuous coverage or enrolling in coverage as it relates to the individual mandate.

When providing the responses, please copy the question in the same numbered format as in this document, and provide your response immediately following. To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible, but no later than July 6, 2018. Note that the responses can be submitted separately and do not have to be submitted all at the same time. Thank you in advance for your cooperation.

Sincerely,

Agatha Kessler
Health Policy Director

cc: Kaili Kuiper, Esq.
Eric Schultheis, Esq.
Jay Angoff, Esq.
Judy Henkin, Esq.
Sebastian Arduengo, Esq.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

July 5, 2018

Agatha Kessler
Health Policy Director
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Docket No. GMCB-009-18rr, Non-Actuarial Questions #2

Dear Ms. Kessler:

Below we respond to the Green Mountain Care Board's (GMCB) June 27, 2018 questions to Blue Cross and Blue Shield of Vermont (BCBSVT). We have done our best to respond to the questions in the short time frame we were provided. We reiterate our concerns, previously expressed, about the timing and scope of the questions in this rate filing process. Providing high-quality responses to extremely broad health policy questions, some with questionable relevance to the rate filing statutory criteria, during a week where many people are on vacation, has been problematic. We would prefer to have some of these policy discussions outside the tight timelines of the rate review process.

1. **Explain how the company ensures that reimbursements to academic medical centers, community hospitals and individual providers reflect the actual cost of care, rather than site of service.**

BCBSVT has been a willing participant in transitioning to a system that does not compensate providers differently based on the site of service. BCBSVT has filed various reports with the GMCB on these activities. As part of those efforts, BCBSVT has reduced the academic medical center physician fee schedule and in aggregate there is currently only a 6-12% difference between the academic medical center and community fee schedule.

Regarding the inquiry about ensuring BCBSVT payments reflect actual provider costs associated with the delivery of care, BCBSVT relies on its provider partners to determine the provider cost required to deliver specific services and negotiate charges accordingly. However, it is also BCBSVT's understanding that there is much that is unknown about the actual cost associated with delivering different services, due to the complexity of the system. BCBSVT supports efforts to increase transparency in costs required to deliver services. It is our understanding that provider systems that have applied rigor to cost analyses for specific services have learned valuable lessons. *See,* Kaplan R and Porter M, *The Big Idea: How to Solve the Cost Crisis in Health Care,* HARVARD BUSINESS REVIEW, September 20, 2011; Gina Kolata, *What are a Hospital's Costs? Utah System Is Trying to Learn,* N.Y. TIMES, September 7, 2015; Morris, A

et al., *How a Tertiary Care Academic Endoscopy Center Used Time-Driven, Activity-Based Costing to Improve Value,* NEJM CATALYST, February 15, 2017.

However, BCBSVT does not have access to provider cost data and seems less well positioned within the system than the providers or the GMCB to examine the actual cost associated with any given service. Forcing providers to create and then provide BCBSVT with verifiable cost data and then asking BCBSVT to analyze it within the context of negotiated charges seems inefficient and unduly burdensome on the provider community. It is our understanding that some providers file cost data with Medicare, however, BCBSVT does not utilize this data in negotiations as we believe this information has significant limitations for BCBSVT purposes. Furthermore, as previously noted, hospitals currently take the position that the approved GMCB hospital rate increases set the floor in payment negotiations.[1]

Further, in the context of the generally understood theory that government programs do not cover the costs to provide care, private policyholders are expected to make up the difference. BCBSVT has provided information on the cost shift to fund Medicaid, Medicare and hospital bad debt and charity care. See BCBSVT Response to Agatha Kessler, Question 1 (page 5), dated June 28, 2018. Such response is incorporated herein as if fully set forth here. Given the burden of the cost shift, it is likely that payments to academic medical centers and community hospitals will never reflect the actual cost of care.

2. **It was recently reported that as many as 70% of women with early stage breast cancer, the most commonly diagnosed cancer among women in Vermont, *see* http://www.healthvermont.gov/sites/default/files/documents/pdf/stat_DataBrief_BreastCancer_0.pdf, do not benefit from chemotherapy. *See* https://www.bmj.com/content/361/bmj.k2473.full. Has the insurer incorporated this finding, or other examples of potential overtreatment, in its patient or provider educational materials, policies, and/or provider reimbursement protocols? Please describe in detail, including the rate impact of adopting these policies or protocols.**

BCBSVT uses evidence-based medicine to inform its medical policies when making member impact decisions. BCBSVT has a well-developed internal infrastructure which continuously monitors and modifies medical policies to reflect the latest treatment and scientific breakthroughs. This infrastructure draws on clinical expertise within the building, as well the local and national provider community. Additionally, through the Blue Cross and Blue Shield Association, BCBSVT has access to additional clinical data to inform its many medical policies.

The studies referred to are an evolution of existing knowledge on genetic testing to predict progression and risk in breast cancer. Since 2008, Oncotype Dx and similar tests have been medically necessary in specific clinical instances of breast cancer. Their use has evolved and the new study suggests that a subset of patients do not benefit from chemotherapy as noted. BCBSVT routinely communicates with our provider network on medical policy changes which are consistent with the evolving and current standard of care. This can be done through

[1] In an abundance of caution, we remind the GMCB that such rate increases relate only to the unit cost. Utilization of services appears outside the hospital budget process. As such, the unit cost increases are not an accurate proxy for the actual increased cost of services over a given budget year.

regular mailings and the BCBSVT provider portal. In addition, we routinely evolve our policies in partnership with our network providers to provide the safest, highest quality and most effective care.

Two recent examples illustrate this. The first was a transition to a non-invasive test for fibrosis in the liver as opposed to an invasive biopsy. BCBSVT instituted this policy in concert with our network specialists and went beyond many published guidelines to be at the cutting edge of appropriate and safe care, which was also more cost effective. A second example is the institution of coverage for a minimally invasive treatment for benign prostatic hypertrophy called a prostatic urethral lift. For some patients this is a safe, high quality and cost effective alternative to a large prostate surgery. Again, we worked with our network experts and moved beyond many of the current industry standard to cover this procedure because we see it as a better clinical alternative for our members, as well as being a more cost effective procedure.

Policy evolution such as this occurs through intensive literature research and continual evaluation of the evidence base to ensure that the service is safe and effective. As a part of this process, BCBSVT communicates with the provider community through multiple channels to alert them to these changes in policy and solicit feedback. The policies are thorough and provide the evidence base and education as to the utility of these services with all appropriate literature references. These policies receive direct network provider input which influence their direction.

BCBSVT is motivated to reduce excess and unnecessary care. As noted, BCBSVT provides members and providers with materials to encourage evidence based care. Any effectiveness of such outreach is embedded in the BCBSVT claims trends in the rate filing. However, we caution the GMCB to recognize that the system is not looking to the payer community to be overly aggressive in this arena. BCBSVT believes, as do most health system participants, that there is a great deal of waste in the system and that evidence based care provides many opportunities to improve quality and reduce costs. However, the elimination of that waste must come primarily from the provider community. No one – not providers, not members, not legislators, not health policy makers – appreciate a payer aggressively refusing to cover care based on clinical data, especially when that data is new. With the example the Board has provided, 70 percent of patients may not benefit, but 30 percent may. Providers must be primarily responsible to be informed of the risks of any treatment they may order and, in turn, to inform their patients of the risks, including effectiveness.

BCBSVT proactively works with providers that are seeking to reduce waste in the system. Shifting to an accountable care organization structure will facilitate that work. But when a payer denies care that a provider is recommending, both providers and members respond negatively. To the extent this results in appeals, additional resources are expended. Although BCBSVT strongly supports a more efficient health care system, we recommend clinical improvement come primarily from the provider community.

3. Fully explain whether and how pricing information, including copayments and use of deductibles, is made available and readily accessible to members prior to deciding on elective surgeries or procedures.

BCBSVT has an electronic tool that QHP members can use to determine how their benefits will adjudicate (as well as what different providers will charge). BCBSVT's Member Resource Center is a self-service web portal that encourages members to take a more proactive role in managing their health. Through the Member Resource Center, members can view personalized health information and benefits, change their PCP, request an ID card and make changes to demographic information. The Resource Center tracks and accumulates calendar year deductible amounts, and members can view claim status and claim summaries, and check Explanation of Benefits (EOBs). Members also have access to their HSA or HRA account information.

QHP members also have access to a suite of comprehensive online tools for health care information that includes a price and quality transparency tool. Using this tool, members can research projected actual costs of in-network medical services and supplies and compare the costs associated with physician services, hospital services, home health agencies, nursing homes, and prescription drugs. They can also find doctors who have earned National Committee for Quality Assurance Accreditation. BCBSVT's price and quality transparency tools provide cost and quality information for providers in the plan's local and national networks.

However, our Customer Service department also recommends that people call BCBSVT for the most complete information. Currently, even as we move toward payment reform, the charge for a given service will be based on the CPT codes chosen to bill the particular service. Although CPT coding rules appear straightforward, it can be difficult to predict how a particular provider's office anticipates coding a service. Additionally, a patient can be scheduled for one type of procedure, but due to unanticipated medical events, end up receiving a different procedure (with a different cost). BCBSVT Customer Service representatives are trained to walk members through this complex analysis and will contact a specific provider to help the member navigate this challenge. The health care system needs to be more transparent. But it is important for all health policy makers to understand the complexities associated with the CPT code driven billing system. Solutions will not be easy and will require a detailed understanding of the challenges.

Finally, we note that evidence is mixed as to whether price transparency tools will lead to patients choose less expensive options. *See, e.g.,* Desai, S et al., *Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, HEALTH AFFAIRS 36, No. 8 (2017); Mehrotra, A et al., *Consumers' and Providers' Responses to Public Cost Reports, and How to Raise the Likelihood of Achieving Desired Results*, HEALTH AFFAIRS 31, No. 4 (2012). Despite the availability of these tools for BCBVT policyholders, usage is extremely low. It appears that additional tools, besides access to cost data, may be necessary to incentivize people to choose less expensive care. BCBSVT has evaluated tools that might offer other incentives, but supports further discussion in this area with interested stakeholders.

4. Describe how the company utilizes specialty pharmacies and whether such use complies with 8 V.S.A. § 4089j.

Prior to the 2019 plan year, BCBSVT has allowed members to choose the specialty pharmacy of their choice within the BCBSVT network. However, prices vary widely and specialty drugs, while often miraculous, can be extremely expensive. Starting with the 2019 plan year, BCBSVT is employing the same strategy as MVP. Anticipated savings associated with this strategy of $1.3 million are included in the proposed rates. This cost control is due to the specialty pharmacy being willing to offer drugs at a higher discount in exchange for the higher volume associated with the exclusive arrangement. It is our understanding that MVP requires that members use a selected specialty pharmacy and has been doing so for some time. It does not appear that 8 V.S.A. § 4089j applies to specialty pharmacy, and BCBSVT's proposed approach is consistent with DFR approving MVP's strategy in the past.

5. Discuss fully whether the company has negotiated with providers and/or ACOs (other than OneCare, if the information is provided elsewhere in the filing), and the results of such negotiations, for limitations on annual reimbursement increases or for the use of alternative reimbursement methodologies, rather than fee-for-service reimbursement.

Documents filed with the GMCB cover the relevant details regarding OneCare. Subject to the general caveat that contract negotiations are confidential proprietary information that would put BCBSVT at a competitive disadvantage if known to our competitors, there are no other current ACO contracts in place with BCBSVT. We continue to work with other providers in the state, both to consider joining OneCare or to otherwise pursue payment reform. For more detail, please see BCBSVT Response to Agatha Kessler, Question 1 (starting at page 9), dated June 28, 2018.

6. Describe the company's plans for consumer outreach and customer service relating to:
(a) defunding of the CSR program and creation of Reflective Silver Plans
(b) educating Vermonters on maintaining continuous coverage or enrolling in coverage as it relates to the individual mandate.

Regarding Question 6(a), in addition to the following response, please see BCBSVT Response to Josh Hammerquist, Question 10(c), dated June 22, 2018. Regarding Question 6(b), in addition to the following response, please see BCBSVT Response to Josh Hammerquist, Question 6, dated June 21, 2018. As with every year, BCBSVT has spent a great deal of time encouraging people to maintain their coverage and stay enrolled with, or switch to, the appropriate BCBSVT product for them. This is the focus of our current Customer and Business Support Services. CBSS is a specialized team of customer service representatives that BCBSVT initially created to transition to Vermont Health Connect. CBSS, as with every year, has been honing its marketing message for the upcoming enrollment season. This year there will be more proactive customer outreach than in years past in light of the additional challenges.

Act 192, § 4 (2017, Adj. Session), specifically charges DVHA to engage in coordinated outreach efforts to educate Vermont residents about the importance of health insurance coverage and to assist Vermont residents by identifying coverage options for which they are eligible and with selecting and enrolling in coverage. We expect DVHA's outreach efforts to address the importance of maintaining coverage within the context of the current legal framework in Vermont.

However, BCBSVT is also working closely with DVHA, MVP and the Health Care Advocate to develop customer outreach themes and messaging. We believe that "silver loading" will be a difficult thing for customers to understand. It will be vital that regardless of where someone turns, they will hear the same words and overall message about the importance of understanding that they may need to proactively assess their enrollment choice this year. We anticipate that the messaging will be delivered in various media, including in writing, during phone calls, and on stakeholder websites, including the BCBSVT website.

We still anticipate a great deal of market confusion and have committed to doing additional customer outreach in January after analyzing people's choices and reaching out if such choices appear to be inconsistent with a customer's needs.

Finally, Act 192 created a Vermont individual mandate, but it is not effective until January 1, 2020 and the new law contains no penalties for noncompliance. The Legislature states its intent to adopt penalties in 2019 in § 2 of Act 192 as well as its intention that any such penalty will begin to be applied January 1, 2020. The Legislature has formed a working group to recommend provisions for the administration and enforcement of the individual mandate and to report its recommendations on or before November 1, 2018 and BCBSVT is actively participating on this workgroup. Messaging the importance of health insurance will be made more difficult with this gap, but will nonetheless be a priority.

We hope we have answered your questions.

Sincerely,

Rebecca C. Hughes for

Jacqueline A. Hughes, Esq.
Associate General Counsel