STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: BlueCross and BlueShield Vermont	)	
3rd Quarter 2018 Large Group Rating Program Filing	)	GMCB-003-18rr
	)	
In re: The Vermont Health Plan	)	
3rd Quarter 2018 Large Group Rating Program Filing	)	GMCB-004-18rr

OFFICE OF THE HEALTH CARE ADVOCATE MEMORANDUM IN LIEU OF HEARING

We thank the Green Mountain Care Board (Board) for the opportunity to respond to the Blue Cross Blue Shield of Vermont (BCBSVT) 3rd Quarter 2018 Large Group Rating Program Filing and The Vermont Health Plan (TVHP) 3rd Quarter 2019 Large Group Rating Program Filing (collectively, Filings). We also thank the Board for its commitment to containing health care costs and making quality health care accessible for Vermonters. In this memorandum, we use "BCBSVT" to refer to BCBSVT and TVHP collectively because TVHP is a wholly-owned subsidiary of BCBSVT.

The Office of the Health Care Advocate (HCA) submits the following Memorandum in Lieu of Hearing in opposition to BCBSVT's proposed 11.2% rate increase. BCBSVT failed to meet its burden of proof to justify the proposed rate. Further, the Filings are not affordable because they (a) fail to adequately demonstrate system cost containment efforts and (b) unreasonably exacerbate the health insurance affordability crisis experienced by Vermonters. Therefore, BCBSVT's proposed rate fails to conform to the applicable statutory standard for health insurance rate changes and should be modified downward.

We respectfully ask the Board to reduce the total proposed premium by, at a minimum, one percent. Such Board action will hopefully motivate BCBSVT to submit filings that minimally address the relevant statutory criteria while simultaneously encouraging meaningful participation in Vermont's efforts to contain cost, provide quality medical care, and ensure an accessible and affordable health care system.

We also ask the Board to define carrier rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria in future filings. Regulated entities will only pay lip service to cost containment and affordability until the Board mandates new processes and holds the regulated entities accountable to conform to the applicable statutory and/or regulatory standards.

Lastly, we note that the proposed 11.2% will apply in the second year of Vermont's all-payer model (APM) agreement. The Board endorsed this agreement as an "opportunity to move forward towards a more efficient health care system that rewards quality care and positive health outcomes."[1] Further, in that agreement, the Board noted that continuing health system cost growth will place "unsustainable financial burdens on Vermonters and their families…" and it will "cripple [Vermont's] economy."[2] The Board must apply its regulatory oversight to ensure carriers are doing everything they can to lower costs while maintaining quality care and access to care if the Board wishes for Vermont to meet the APM targets. A downward reduction of the proposed premium and the imposition of filing standards that track the statutory rate criteria would advance the Board's stated goal.

Before proceeding to the substantive sections of this memorandum, we first detail the applicable standard of review and the procedural history of the Filings.

STANDARD OF REVIEW

The insurer bears the burden of justifying the requested rate change when filing a rate request.[3] Neither the Board nor the HCA must present an alternative rate scheme to remedy a deficient proposed rate. Absent an adequate justification for the proposed rate, the rate scheme, or an element thereof, should be disproved or the Board may, in its discretion, modify the proposed rate or rate element.[4]

When "deciding whether to approve, modify, or disapprove each rate request," the Board is charged to "determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[5] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[6]

[1] GMCB Decision, In re Vermont All-Payer Accountable Care Organization Model Agreement (Oct. 26, 2016) at 11.
[2] Id. at 1.
[3] GMCB Rule 2.104(c).
[4] See e.g., GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to reserve based on the insurer failing to meet "its burden for the requested increase…")
[5] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207 (Vt. 2016).
[6] 18 V.S.A. §9375(b)(6).

Procedural History

On March 19, 2018, the Board posted the Filings on its website. The Fillings request an average rate increase of 11.2%.[7] This increase would impact 14,200 Vermonters.[8]

On March 22, 2018, the HCA filed notices of appearance to represent the public's interests.[9]

On May 14, 2018, Lewis & Ellis (L&E), the actuarial firm retained by the Board, submitted actuarial recommendations related to the Filings. L&E's recommendations, consistent with its charge and expertise, relate only to the actuarial soundness of the proposed rate and not the broader and complex set of statutorily-defined factors that the Board is charged to weigh when reviewing proposed rate changes.[10]

On May 15, 2018, the Vermont Department of Financial Regulation (DFR) submitted a solvency opinion regarding the Filings. DFR "does not expect the proposed rate will have a significant impact on [its] overall assessment of BCBSVT."[11] DFR references that BCBSVT is currently at or near the low end its RBC target.[12] We note, however, that BCBSVT's stated RBC target of 500% to 700% is substantially above both the 200% RBC level that triggers DFR oversight and the minimum RBC of 375% to avoid triggering monitoring by the BlueCross BlueShield Association.[13]

ARGUMENT

BCBSVT HAS FAILED TO MEET ITS STATUTORILY DEFINED BURDEN OF PROOF BECAUSE THE FILINGS ONLY ADDRESS WHETHER THE PROPOSED RATE IS ACTUARIALLY JUSTIFIED.

BCBSVT has failed to offer any evidence other than an actuarial justification for the proposed rate. BCBSVT chose such a course of action despite (1) clear statutory language that actuarial justification is only a subset of the factors that the Board is charged to consider when evaluating proposed rates and

[7] GMCB-003-18rr, SERFF Filing.
[8] GMCB-003-18rr, Lewis & Ellis Actuarial Opinion at 1; GMCB-004-18rr, Lewis & Ellis Actuarial Opinion at 1.
[9] GMCB-003-18rr, HCA Notice of Appearance; GMCB-004-18rr, HCA Notice of Appearance.
[10] GMCB Rule 2.301(b); GMCB Rule 2.401; In re MVP Health Insurance Company, 155 A. 3d 1207; 18 V.S.A. §9375(b)(6); see also, 8 V.S.A. §4062(a)(3).
[11] GMCB-003-18rr, May 15, 2018, Department of Financial Regulation Solvency Opinion at 3; GMCB-004-18rr, May 15, 2018, Department of Financial Regulation Solvency Opinion at 3.
[12] Id. at 1.
[13] Consumers Union, How Much is too Much: Have Nonprofit BlueCross and BlueShield Plans Amassed Excessive Amounts of Surplus? (July 2010), available at http://consumersunion.org/wp-content/uploads/2013/02/prescriptionforchange.org-surplus_report.pdf; Vermont Legislative Joint Fiscal Office, Issue Brief: Surplus and Risk-Based Capital for Health Insurance Companies (Sept. 2017).

(2) the unambiguous rule that BCBSVT bears the burden of proof to justify the proposed rate. Absent an adequate justification for the proposed rate by the insurer, the rate scheme, or an element thereof, must be modified by the Board.[14]

The legislature mandated that the Board review a proposed rate in terms of the rate's system impact, actuarial soundness, and impact on Vermonters. As stated above in the Standard of Review section, the legislature charged the Board to "determine whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, is not unjust, unfair, inequitable, misleading, or contrary to law, and is not excessive, inadequate, or unfairly discriminatory."[15] The Board must also take into consideration "changes in health care delivery, changes in payment methods and amounts …" and other issues at its discretion.[16] We recognize the difficulty of executing that charge. Regardless, the proper execution of the charge lies at the heart of Vermont's future.

Here, BCBSVT failed to adequately address multiple factors that the Board must evaluate when reviewing a proposed rate. Although BCBSVT has, in the past, only offered actuarial justification for proposed rates, such past practices do not negate the underlying statutory and regulatory frameworks that set out the factors and burden of proof that a carrier proposing a rate change must meet.

Further, BCBSVT's practice of only offering actuarial justification for the rates attempts to direct the Board's rate review towards a narrow subset of factors that best justify the proposed rate. The Vermont Supreme Court, however, has made clear that affordability and other non-actuarial factors that take into account health system function and the needs of Vermonters are mandated components of the Board's rate review.[17]

1. BCBSVT Failed to Adequately Address System Cost Reduction Efforts or the Financial Burden on Vermonter's of the Proposed Rate Increase

The legislature charged the Board to "determine whether a proposed rate is affordable…"[18] In cases such as this where there is no statutory or regulatory definition of a term and the statute deals with a specialized subject, the meaning ascribed to the term should be that meaning which is used in the

[14] See e.g., GMCB-016-14rr, Decision at 4 (disapproving an insurer's proposed administrative costs and contribution to reserve based on the insurer failing to meet "its burden for the requested increase…")
[15] Id.; GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3).
[16] 18 V.S.A. §9375(b)(6).
[17] See, In re MVP Health Insurance Company, 155 A. 3d at 1214.
[18] GMCB Rule 2.301(b); GMCB Rule 2.401; see also, 8 V.S.A. §4062(a)(3); In re MVP Health Insurance Company, 155 A. 3d 1207.

relevant technical field or policy community. [19] Here, the relevant policy community the Board should look to in ascribing meaning to the word "affordability" are similarly situated state actors.

We are aware of only one other state or jurisdiction that defines affordability in its health insurance rate review process, namely, Rhode Island.[20] In broad terms, Rhode Island applies a two-prong affordability test. The first prong of the affordability test is that a carrier must demonstrate that it is working to reduce health care costs by undertaking cost containment activities in line with health care system reform. [21] The second prong of the affordability test is that a carrier must demonstrate that lower-income consumers have "the ability … to pay for health insurance." Both prongs are necessary because carriers lack a financial incentive to reduce system costs or premiums. [22] Neither prong is sufficient because premium reductions absent system reform will risk carrier insolvency and absent system reform premiums will increase placing ever greater financial burdens on Vermonters. BCBSVT failed to adequately addresses either affordability prong.

a. BCBSVT is not engaging in adequate system cost reduction efforts.

In its actuarial memorandum, BCBSVT offers no evidence that the proposed rates are affordable in terms of implementing health care system reform. BCBSVT does not even discuss potential or early-stage health system reform efforts such as the implementation of cost containment measures or alternative payment methodologies that have the potential to reduce system costs in its original large group filing as it does in its 2019 BCBSVT Vermont Health Connect filing.[23]

As part of the filing review process, the HCA asked BCBSVT to explain how it is controlling costs for this book of business through alternative payment methodologies with or outside of OneCare Vermont. We asked for this explanation both because of the relevant statutory criteria for rate review

[19] E.g., William N. Eskridge, J., Philip P. Frickey, & Elizabeth Garret, Cases and Materials on Legislation: Statutes and the Creation of Public Policy (3d. ed. 2001).
[20] R.I. Gen, Laws § 42-14.5-2 (the Rhode Island legislature created a regulatory entity, the Office of the Health Insurance Commissioner (OHIC), with numerous charges including the review of proposed health insurance rates.); Office of the Health Insurance Commissioner Regulation 2 (Originally Effective December 15, 2006) at 14-16 (OHIC issued regulations defining the technical usage of the word "affordable."), available at http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf.
[21] Id. at 15 (activities examined under this prong include reform efforts such as improved primary care supply, reduced emergency room visit incidence, reduced re-hospitalization, and the "implementation of effective strategies by the health insurer to enhance the affordability of its products.").
[22] Marshall Allen, Why Your Health Insurer Doesn't Care About Your Big Bills, NPR (May 25, 2015) (describing how health insurance carriers lack incentives to reduce system costs), available at https://www.npr.org/sections/health-shots/2018/05/25/613685732/why-your-health-insurer-doesnt-care-about-your-big-bills,
[23] GMCB-009-18rr, BCBSVT Actuarial Memorandum at 22.

and the Board's policy statement that Act 48 "makes clear that health insurers, Medicaid, Medicare, and other payers should reimburse health care professionals with consistent payment methodologies that provide incentives to coordinate care and control cost growth."[24]

BCBSVT's response to our question was nonspecific and noncommittal.[25] BCBSVT stated vague plans to expand alternative payment programs and that it is "evaluating potential inclusion of BCBSVT's large group insured population for 2019" with OneCare.[26] BCBSVT also pointed out that approximately 50% of its contracts with network primary care providers include capitated payments. We note, however, that BCBSVT has stated that it sets its primary care capitated payments to be equal to the amount it would have spent under fee for service.[27] Although we explicitly asked BCBSVT about controlling costs, BCBSVT did not provide adequate information to evaluate whether any of the provider agreements it referenced in its response to our inquiry are designed to save money. Further, BCBSVT did not attempt to quantify current savings due to system reform efforts or to predict any specific cost savings in the future due to system reform efforts.

Because BCBSVT has offered insufficient evidence that they are making reasonable efforts to control costs for the population in this book of business, the Filings are, by definition, not affordable. In light of this fact, the Board must engage in the difficult task of balancing the carrier's needs against Vermonters need for health care cost containment and health care system reform. The result of this balancing should be a reduction of the proposed rates.

b. <u>BCBSVT failed to adequately demonstrate, or even minimally address, how the carrier has attempted to reduce the financial burden of the proposed rates on Vermonters.</u>

Affordability, as discussed above, contains a second component, namely, whether Vermonters can afford the premium charged. This second component is, as discussed above, a necessary but insufficient component of affordability meaning that an affordable rate must incorporate both insurer cost saving efforts and align with Vermonters' ability to purchase health insurance.

Many Vermonters, whether employers or employees, cannot afford the premium increase proposed in the Filings. We note that, for this book of business, an employee will likely pay a share of the

[24] GMCB Decision, <u>In re Vermont All-Payer Accountable Care Organization Model Agreement</u> at 2.
[25] GMCB 03-18rr, BCBSVT Response to Objection Letter #3 at 3 (Q4).
[26] <u>Id</u>. at 3 (Q4.b).
[27] GMCB 08-17rr, BCBSVT Vermont Health Connect 2018 Rate Filing, Hearing Transcript, Schultz Testimony at 80 (lines 4-24).

increased premium. In light of this fact, an observer might conclude that the primary burden of the proposed rate will be on Vermont employers.

Vermont employees will also significantly bear the burden of the proposed rate increase. Substantial evidence shows that employers view an employee's total compensation as a whole when setting wages. Thus, if the employer premium share increases, the employee's wage is offset by increased employer premium share.[28] Wage suppression due to premium growth likely also impacts employers in so far as they are unable to offer competitive a wage. Increases in the rates for these books of business thus have the dual effect of placing Vermont employers at a competitive disadvantage and creating an unsustainable financial burden for Vermont employees.

Although the Filings do not address the financial affordability of the proposed rate, we use a simple comparison of the historical premium rate growth for this book of business to real Vermont Gross Domestic Product (VTGDP) growth and real Vermont wage growth (VTWG) to demonstrate that the proposed rate is unaffordable for Vermonters.[29]

Rate growth for these books of business compared to VTGDP growth and VTWG demonstrate that the premiums have substantially outpaced Vermont's economic growth. Further, this comparison shows that health insurance premiums for these books of business have substantially outpaced the ability of individual Vermonters to afford them. The trend is clear, Vermonters are spending an ever larger percentage of their income for health insurance of the same or lesser benefit richness.[30]

BCBSVT's premium growth for this book of business has substantially outpaced the growth of Vermont's economy as measured by VTGDP growth. Between 2015 and 2017, BCBSVT's premium growth was 433% of real VTGDP growth.[31]

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[28] See e.g., Gary Burtless & Sveta Milusheva, Effects of Employer-Sponsored Health Insurance on Social Security Taxable Wage, Social Security Bulletin, 73(1), 83-107 (2013); Priyanka Anand, Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey, Health Economics, 26(12) (2017) (describing that a $1 increase in health care costs causes a larger than $1 decrease in total hourly compensation).

[29] We present real VTGDP growth and real VTWG, as opposed to nominal growth, because real growth is adjusted for differences in price levels (inflation) between time periods. Real VTGDP growth and real VTWG allow us to examine whether Vermonters' are actually better or worse off when making comparisons with premium increases across time periods.

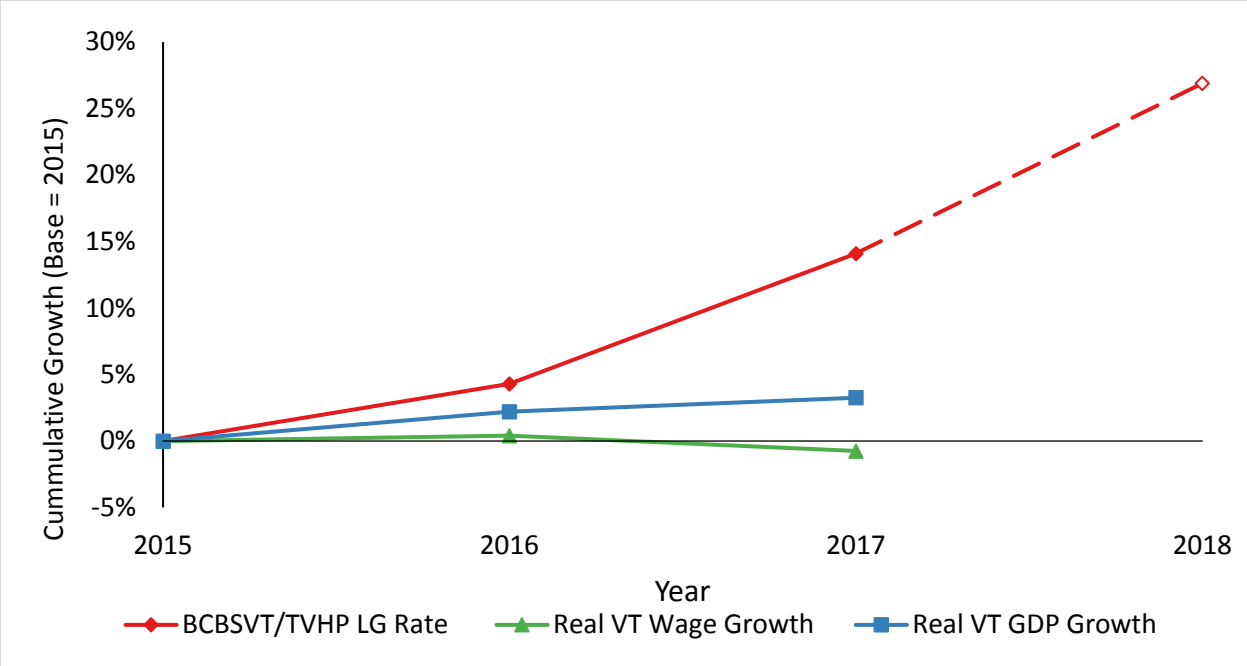
[30] Davis I. Auerbach & Arthur L. Kelermann, A Decade of Health Care Cost Growth has Wiped Out Real Income Gains for an Average US Family, Health Affairs, 30(9), 1630, (Sept. 2011), available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0585.

[31] 2015 to 2017 is the period starting with the first year that average rate increase for the book of business is available on the Board's website and ending at the most recent year for which VTGDP data is available. U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Vermont, retrieved from FRED, Federal Reserve Bank of St. Louis, available at https://fred.stlouisfed.org/series/VTNGSP; U.S. Bureau of Labor Statistics, Northeast Region CPI, Series ID: CUUR0100SA0. As discussed in note 21, we use real growth as opposed to nominal growth because real growth accounts for differences in price levels (inflation) between time periods. It was not possible to

BCBSVT's premium growth for this book of business also outpaced VTWG. Between 2015 and 2017, BCBSVT's premium growth was 14.1% compared to the real VTWG of -0.75%.[32]

The proposed rate increase would be less troubling if the historical trend of rate growth for this book of business was not increasing at an ever-faster rate. Indeed, between 2015 and 2018, assuming the rate increase in the Filings, the cumulative premium growth is a disturbing 26.88%.[33] Chart 1 presents the unsustainable trend of rate growth for this book of business compared to real VTGDP growth and VTWG.

Chart 1. Rate growth, real VTGDP growth, and VTWG.[34]



We note that the trend of premium outpacing VTGDP growth and VTWG has multiple possible effects. First, the growth of premium substitutes for wage increases as the total employee

calculate the carrier's real historical and proposed rate because inflation statistics for 2018 are not currently available. In light of this fact and a desire not to have a graph element represent both real (2016 and 2017) and nominal (2018) growth, we choose to present the carrier's nominal rate increase. We did, however, calculate the real rate growth for 2016 and 2017. The difference between the real and nominal rate growth from 2016 to 2017 was small and did not materially change the import of the comparison between rate growth, VTGDP growth, and VTWG.

[32] 2015 to 2017 is the period starting with the first year that average rate increase for the book of business is available on the Board's website and ending at the most recent year for which VTWG data is available. U.S. Bureau of Labor Statistic, Vermont Average Weekly Earnings (total private), SMU50000000500000011; U.S. Bureau of Labor Statistics, Northeast Region CPI, Series ID: CUUR0100SA0. Please refer to Note 23 for justification of decision to present real VTWG but nominal rate growth.

[33] GMCB-003-18rr, SERFF Filing.

[34] Id.; note 24; note 23; GMCB-004-17rr, Decision; GMCB-003-16rr, Decision.

compensation package increases even when wages remain flat due to rising premium. This essentially means that health insurance premium growth suppresses wage growth leaving Vermonters both paying more premium and having less money to purchase health insurance and other necessities. [35] Wage suppression due to premium growth also likely inhibits Vermont employers' ability to offer competitive wages.

Second, the increasing share of a household's income paid towards health insurance premium may influence a household's decision to not participate in the health insurance market. The result of such a decision undermines the risk pool and, if it happens at scale, leads to higher health insurance premiums for those remaining in the risk pool. Further, if a household chooses to forgo health insurance, this may increase the incidence and amount of bad debt that hospitals experience serving the uninsured. The incidence of bad debt may in turn increase the unit cost for health care services and increase the medical trend and further increase premium cost.

In the Filings, BCBSVT fails to offer any evidence that the proposed rate is affordable to Vermont policy holders and subscribers. In fact, federal government statistics unambiguously show that the rate growth has substantially outpaced Vermont domestic product and wage growth. Perhaps even more troubling, between to 2016 and 2017, with a base year of 2015, Vermont wage growth declined to a negative growth rate while the premium growth rates for this book of business have exponentially increased.

The proposed rate is not affordable to Vermonters as demonstrated by the unambiguous evidence presented in the above analysis. Therefore the Board should exercise its discretion to modify the rate downward.

CONCLUSION

BCBSVT has failed to meet its burden of proof for a rate increase because it has failed to adequately address the factors that the Board is charged to use when evaluating rate changes. These factors help advance the goals of the APM and ensure that health insurance rates are affordable for Vermonters. In fact, BCBSVT failed to even minimally address a substantial portion of the required statutory factors in the Filings that the Board is charged to weigh when evaluating a rate proposal.

[35] See, Burtless & Milusheva, supra note 28.

We respectfully ask the Board to define carrier rate filing guidance such that carriers are explicitly instructed to address the relevant statutory criteria. Regulated entities will only pay lip service to cost containment and affordability until the Board holds them to be accountable for their actions.

Further, we respectfully request that the Board reduce the total premium by, at a minimum, one percent based on an analysis of BCBSVT's failure to meet its burden of proof and on a balancing of the statutorily mandated factors the Board is charged with evaluating when exercising its authority related to rate modification.[36]

Dated at Montpelier, Vermont this 31st Day of May, 2018.

/s/ Eric Schultheis
Eric Schultheis, JD Ph.D.
Health Care Law and Policy Analyst
Office of the Health Care Advocate
Email: eschultheis@vtlegalaid.org

/s/ Kaili Kuiper
Kaili Kuiper, Esq.
Staff Attorney
Office of the Health Care Advocate
Email: kkuiper@vtlegalaid.org

[36] E.g., GMCB-03-15rr, Decision at 5 (reducing a proposed rate for a large group filing due to a carrier failing to meet its burden of proof; GMCB-04-17rr, Decision at 5 (reducing a proposed rate for a large group filing based on a balancing of the carriers' needs against the needs of Vermonters' for affordable rates).

CERTIFICATE OF SERVICE

I, Eric Schultheis, hereby certify that I have served the above Memorandum in Lieu of Hearing on Judith Henkin, Green Mountain Care Board General Counsel; Sebastian Arduengo, Green Mountain Care Board Staff Attorney; Agatha Kessler, Green Mountain Care Board Health Policy Director; and Jacqueline Hughes, Blue Cross Blue Shield of Vermont representative, by electronic mail, return receipt requested, this 31st day of May, 2018.

/s/ Eric Schultheis

Eric Schultheis, JD Ph.D.
Office of the Health Care Advocate
Montpelier, Vermont 05601
Email: eschultheis@vtlegalaid.org

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield Vermont 3Q 2018 Large Group Rating Program Filing	))	GMCB-03-18-rr
and	)	
In re: The Vermont Health Plan, LLC 3rd Q 2018 Large Group Rating Program Filing	))	GMCB-04-18-rr

Blue Cross and Blue Shield of Vermont's Reply Memorandum

While Blue Cross and Blue Shield of Vermont (BCBSVT) disagrees with the arguments put forth by the Health Care Advocate (HCA) in its May 31, 2018 Memorandum and believes that our filing speaks for itself, we address for the record a material inaccuracy in the HCA's characterization of our cost containment efforts for the Large Group insured line of business. We have repeatedly provided information to the Board on our robust cost containment programs within the specific context of rate filings as well as in other contexts, to many of which the HCA has been privy. We are doing excellent, timely, cost effective work and are pleased to reiterate the information in this Reply.

BCBSVT remains a leader in developing and deploying value based reimbursement programs moving providers from the traditional model to comprehensive, and at times risk-based, financial programs. Moreover, BCBSVT's care management programs have a long track record of success in containing costs while supporting our members so that they receive the most cost effective care at the right place, in the right amount and at the right time. We continually assess our value based reimbursement and care management programs and evolve them to improve their impact and maximize the value of our network providers and community resources.

I. Value Based Reimbursement

For years, BCBSVT arrangements with providers have included hospital diagnosis-related groups (DRGs) and per diem payments that provide consistent reimbursements for care and caps to the total cost of care. To ensure such payment limits do not compromise the quality of care, our integrated health and quality departments oversee and ensure that care is not being withheld. Moving from fee-for-service to value based reimbursement, BCBSVT continually collaborates with providers, and often State and Federal administrations, deploying value based programs

challenging BCBSVT and network providers to improve quality and reduce the cost of care for our members. As the Board knows, BCBSVT has led all commercial providers in the state as the only commercial payer for outpatient case rates (e.g. colonoscopy standard rates), and as the first payer reimbursing for Medication Assisted Treatment (Hub) programs.

Our commitment to advancing payment and delivery system reforms through provider collaboration remains focused on a varied set of initiatives from ACO contracts to condition-specific programs. Through a number of value-based programs with providers, we continue to focus on providing better care to our members, improving access if needed, and controlling medical spend. On behalf of our members and groups, BCBSVT has collaborated with network providers to implement the following programs that are currently extended to the Large Group insured line of business.

A. Mental Health/Substance Abuse-Focused Programs (FIT and SBIRT; Hub and Spoke)

- SBIRT
- FIT
- Hub and Spoke
- Other programs

See Appendix A for a high level descriptions of SBIRT, FIT and Hub and Spoke programs; Appendix B for Summary of SBIRT, FIT and Blueprint Participation and Costs; Appendix C for FIT Program Results

B. Accountable Care Organizations, Episode of Care and Case Rate Pilots

Meanwhile, BCBSVT has led all commercial providers in the state being the only commercial payer participating with Vermont's ACOs. While this program does not currently extend to insured Large Groups, we are currently in discussions with OneCare Vermont regarding the potential expansion of the program to include the Large Group insured line of business. We are also looking to expand the episode of care and case rate pilots to insured Large Groups as well. See Appendix D for a Description of ACO Program and Pilots; See Appendix E for Summary of Participation and Costs for ACO and Pilots.

- ACO Shared Savings/Shared Risk Program
- Episode of Care Knee or Hip Replacement Pilot
- Outpatient Case Rate Pilot

II. Care Management

Care Management is the overarching umbrella for all cost containment programs within the clinical departments of BCBSVT. This includes utilization management programs within pharmacy, advanced imaging, medical services, chronic condition disease management (prevalent and rare), and focused case management for complex and catastrophic cases. More detail on the following care management programs (whose results are reflected in our filings) are described in Appendix F.

- Utilization Management
  - Pharmacy
  - Radiology Appropriate Use Program
  - Integrated Medical and MH/SA Utilization Management Programs
- Chronic Condition Disease Management
  - Prevalent Chronic Condition management
  - Rare condition disease and case management
- Case Management
  - Whole person integrated medical and mental health substance abuse high utilization and high cost case management program
  - Better Beginnings perinatal support and care management program
  - End of Life program

Prescription drug programs alone saved nearly $2 million for Large Group insured customers in 2017. The medical programs contributed an additional $2 million of savings for Large Group insured customers through appropriate utilization. The impact of these programs are implicitly included in both the base claims data and the calculation of utilization trend. Much of the utilization increase is in preventive visits and appropriate care.

Our assessment of the drivers of potentially unnecessary utilization increases have led us to examine treatment patterns in ER and outpatient procedures, specialty pharmacy and more specifically in the areas of musculoskeletal disease, medical specialty pharmacy infusion site of care, cardiovascular disease, GI endoscopy as well as mental health and substance abuse.

As the Board knows, it takes several budget cycles to build and implement new utilization management programs, and for these programs to have an impact on care delivery. Programs are currently in development to mitigate ER use (utilization in Vermont is well above regional benchmarks) and outpatient surgical/facility procedures. We have recently expanded several programs listed below. See Appendix G for more detail on Prior Programs Expansions.

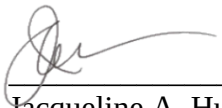
- Specialty pharmacy
- Cardiovascular Disease
- Mental Health and Substance Abuse
- Emergency Room Use including Telehealth
- Case and Disease Management

Far from "paying lip service to cost containment and affordability," as the HCA tries to suggest, BCBSVT continues to pursue our vision of a transformed healthcare system in which every Vermonter has health care coverage, and receives timely, effective, affordable care. We remain a leader in developing and deploying value based reimbursement programs while continually evolving our care management programs to contain costs while supporting our members so that they receive the most cost effective care at the right place, in the right amount and at the right time.

All of these value based reimbursement and care management programs are reflected in our premiums in two ways: they reduce the experience base on which the manual rate, as well as actual group-specific experience, is based; and they limit health care cost and utilization trend. We project trend rates forward using historic experience, so we are effectively assuming that all of these programs will continue to dampen future trend just as they have dampened past experience. Without these programs, current premiums for Large Groups would be significantly higher.

BCBSVT has fully justified and supported the rate factors before the Board as evidenced by the recommendations of the Board's own actuarial consultant and the Commissioner of Department of Financial Regulation's solvency opinion. There is no evidence in the record that would justify reducing the requested rates especially in view of the oversights made by L&E on utilization trend and pharmacy trend. Therefore, BCBSVT asks that the Board approve the filing, without modification.

Dated at Berlin, Vermont, this 5th day of June, 2018.



Jacqueline A. Hughes
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186
Tel. (802) 371-3619

APPENDIX A

Mental Health/Substance Abuse-Focused Programs (FIT and SBIRT; Hub and Spoke)

- **SBIRT**: BCBSVT is the only commercial payer collaborating with the Vermont Department of Health to expand the number of providers trained and utilizing SBIRT, a federally funded treatment method. We support the required training of these providers and reimburse for such services, which is increasing access to evaluation by our members. Additionally, we track the outcome of the program in collaboration with the State. Today, these practices impact the lives of 5,000 members.
- **FIT**: The FIT program is a SAMHSA-recognized best practice using real-time feedback from clients to better inform the process of therapy. FIT is proven to reduce drop-out rates and improve client satisfaction and outcomes while reducing unnecessary treatment. We provided training to 110 clinicians who took part in the two-day workshop. From this group, 70 clinicians were recruited into the first phase of implementation. The implementation phase included consultation groups, data collection on outcomes, and participation in a learning collaborative to reinforce accomplishments. Currently, these 70 clinicians care for 1,114 of our members. Following the initial phase of data collection, we continue to evaluate new reimbursement mechanisms that can support and expand the program. Providers who participated in our FIT program have three to four fewer visits per patient and significantly reduced patient emergency room usage. See Appendix C for Summary Chart.
- **Hub and Spoke**: We are the first health plan to fully engage with the State of Vermont's Hub and Spoke system of care treating opioid addiction. The program reimburses providers a monthly bundled rate—requiring only one co-payment from members—reducing previous barriers to care. The programs allow the VCC and us to integrate mental health, social, and medical services into one program. Clinicians and our care coordinators focus on the connections between detoxification, initiation of treatment with Suboxone, and referral to primary care for ongoing treatment. The results are positive for members regarding readmission rates and use of non-planned emergency department services.
- **Other programs**: Not resting on our successes, BCBSVT is currently collaborating with network providers on a number of other programs that will be assessed during their pilot stage for rollout to the Large Group insured line of business. These take time to do right.

APPENDIX B – SBIRT, FIT, Blueprint Summary Chart.

Program	Year	BCBSVT Members	Impacted Providers	Overall cost of care associated the program	% of Total BCBSVT Medical Cost	% of Membership (BCBSVT Members)
FIT	2016	1336	61	$913,811	0.09%	0.76%
	2017	1665	71	$1,122,488	0.10%	0.93%
SBIRT	2016	46	45	$2,318	0.00%	0.03%
	2017	31	45	$949	0.00%	0.02%
Blueprint	2016	118785	1033	$8,617,296	0.82%	67.27%
	2017	115908	923	$8,618,644	0.79%	64.95%

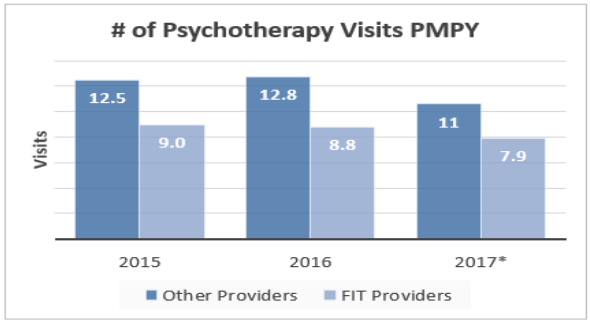
APPENDIX C Feedback Informed Treatment (FIT) Program Results

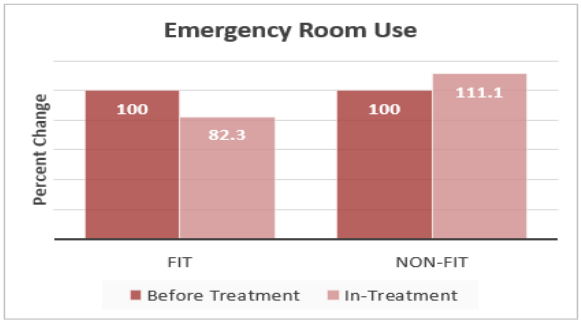
Blue Cross and Blue Shield Programs Are Designed to Reduce Barriers to Routine Evidence-Based Practice

Feedback Informed Treatment (FIT)

OBSERVATIONS

- Providers using the FIT program have 3-4 fewer visits per patient
- Providers using the FIT program show impact on reducing emergency room use





2017* - January-September

BlueCross BlueShield of Vermont

Appendix D ACO Program and Pilot Descriptions

1. ACO Shared Savings/Shared Risk Program

BCBSVT continues to be a key stakeholder in Vermont's healthcare reform initiatives. As the only commercial payer participating in Vermont's ACO shared savings pilot, we work closely with the ACOs and Green Mountain Care Board, establishing the framework necessary to move providers to risk-based contracts. In 2018, we implemented the state's first commercial ACO shared risk contract with OneCare Vermont covering approximately 21,000 BCBSVT lives.

Moving from a shared savings contract to a risk-based ACO contract for the first time provides the financial alignment between premiums paid by BCSBVT members and employers and medical care reimbursement. Our contract with OneCare requires shared risk for any medical cost in excess of the expected cost of the care for its population. Sharing of risk provides a new forum for BCSBVT and OneCare to work together, focusing not only on ensuring high-quality care but on the core components driving increased cost of medical care.

As providers accept risk and share in savings, they engage more in managing the risk, resulting in new community-based care coordination programs, continuous review of utilization of services, and deployment of condition-specific pilots. In our collaboration with OneCare, we remain the subject matter expert in data exchange, actuarial modeling, and group-level analytics. In exchange, we receive clinical data enhancing reporting and analytics capability. More importantly we expand our ability to provide community-level care coordination leveraging the expertise of our care coordinators and provider-based care coordinators.

2. Episode of Care Knee or Hip Replacement Pilot

In the third year of our episode of care knee or hip replacement pilot with UVMMC, self-insured groups experienced savings averaging $2,000 per case. With demonstrated savings and continued increase in orthopedic spend, we are approaching other facilities besides UVMMC to expand the pilot model. We expect to link future bundle rates to outcomes performance and outreach/care coordination with community providers.

3. Outpatient Case Rate Pilot

BCBSVT and Northwestern Medical Center collaborated to develop the first outpatient procedure case rate focusing on colonoscopies. Together, we modeled and developed the first colonoscopy case rate program in Vermont, directly addressing the need for consistent pricing for high-volume services and linkage to outcome results. In addition to being a standard rate for facility services, our organizations agreed to a lower cost for the procedure and redirect a portion of the money to preventive and wellness services. Assuming the pilot meets expectations, we will deploy this program to additional facilities in 2019 and 2020 and expand the number of case rate services.

APPENDIX E Summary of Participation and Costs for ACO Program and Pilots

Program	Year	BCBS VT Members	Impacted Providers	Overall cost of care associated the program	% of Total BCBSVT Medical Cost	% of Membership (BCBSVT Members)
ACO	2017	37871	1057	$141,526,379	13.02%	21.22%
	2018 projected	21000	603	$98,643,081	9.08%	11.77%
Episode of Care Pilot	2017	13	3	$513,316	0.05%	0.01%
Northwestern Case Rate (projected 2018)	2018 projected	568	4	$710,000.00	0.07%	0.32%

APPENDIX F Care Management Programs

a. Utilization Management

Pharmacy:

i. Step therapy encouraging appropriate use of generics and formulary therapies.
ii. Quantity limits encouraging regular follow-up with prescribing providers and adherence with care.
iii. Prior authorizations using industry standard appropriate use criteria guiding members towards more well proven therapies before the use of emerging and potentially less effective and not well proven therapies.
iv. RationalMed pharmacy safety program which makes use of integrated medical and pharmacy claim data to provide drug-drug and drug-condition interaction warning to pharmacists prior to a drug being dispensed.
v. Specialty Pharmacy Care Value programs which provide reimbursement for failed starts and indication based pricing models to help to contain the cost of specialty medications.
vi. Opportunities exist for clients to "lock in" to one specialty pharmacy to reduce cost and/or elect a "home infusion" program to move the site of care from outpatient facility to home based therapy for a portion of patients receiving specialty medication infusions.

Radiology Appropriate Use Program:

i. Prior Approval utilization management program for advanced and cardiology imaging which directs care to the most appropriate technologies for a given patient using industry standard appropriate use criteria.

Integrated Medical and MH/SA Utilization Management Programs:

i. Using >200 industry standard appropriate use medical policies to guide medical management to the most effective care plan for an individual through prior approval program (includes advanced and emerging procedures, outpatient surgery, sleep medicine, DME, out-of-network access and others
ii. Working with medial facilities help to guide patients through transitions in care from inpatient to outpatient settings, as well as alternate sites of care for mental health and substance abuse such as partial hospitalizations, to ensure appropriate and safe discharge plans and to avoid readmissions
iii. Manage medical pharmacy utilization within outpatient offices and facilities using industry standard pharmacy policies.

b. Chronic Condition Disease Management
- Prevalent Chronic Condition management program – disease education, self-management and care plan adherence support for members with common chronic diseases such as diabetes and asthma.
- Rare condition disease and case management working with Accordant Health Care a national case management vendor with subject matter expertise in rare disease.

c. Case Management
- Whole person integrated medical and mental health substance abuse high utilization and high cost case management program using retrospective and predictive identification working closely with our providers and community support systems.
  i. Includes complex and catastrophic conditions such as cancer care, multiple chronic diseases with complications, advanced and complex musculoskeletal care and recovery s/p catastrophic events such as trauma.
  ii. Focuses specifically on addressing social determinants of health and removing barriers to patient/member adherence to treatment plans, such as financial, social, psychosocial and health system related barriers
- Better Beginnings perinatal support and care management program.
- End of Life program – care management for patients receiving palliative or hospice care.

APPENDIX G Prior Programs Expansions

a) Specialty pharmacy
- We are focused, with our PBM, on the best price points available in the market and reduction of the impact of price inflation of specialty drugs
- We have instituted innovative indication based pricing for certain classes of specialty drugs, again with our PBM ESI, to leverage pricing by clinical utility with the pharmaceutical companies
- We obtain credits for "failed starts" or specialty medications which members discontinue due to side effects or complications. For example 50% of members starting a multiple sclerosis medication discontinue it within the first few months of use.

- We have a full time pharmacist who travels the state and "details" our network providers on new programs, adverse prescribing trends and clinically appropriate alternatives to higher cost pharmaceuticals. This detailing initiative has been well received by our network providers.

b) Cardiovascular Disease
   - We are working with our members to improve engagement with our disease management programs and our cardiac rehab program which have proven value to modulate adverse utilization.

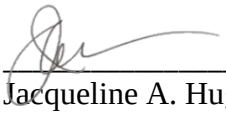
c) Mental Health and Substance Abuse
   - Through our partnership with Brattleboro Retreat, Vermont Collaborative Care, we have integrated a whole person approach to our case and utilization management programs through integrated resources which include focused clinical expertise in the areas of mental health and substance abuse. Through this and components of the program, we have significantly driven down inpatient and ER utilization and increased outpatient ongoing care with a mental health and substance abuse provider. As noted above, we support the state Hub and Spoke program through innovative care management and payment programs as well as eliminating benefit based barriers to care for our members. We will continue to expand this work.

d) Emergency Room Use
   - Member education through our "Know Before You Go" campaign providing examples of alternative sites of care for less complex acute conditions such as primary care urgent visits, urgent care visits and telemedicine.
   - Roll out of our Telehealth for minor acute care issues through the American Well program filling the access gaps that many of our members face in seeing their primary care providers when they need care for urgent issues.
   - 2019 Implementation of new technologies providing real time notification of admission, transfers and discharge information enabling timely care management support for members who either frequently utilize the ER or utilize it for potentially avoidable visits where an alternate site of care may be more appropriate.

e) Case and Disease Management
   - Implementation of a new mobile care management app which extends the opportunity for communication and engagement with our members meeting their needs through multiple channels.
   - After one-on-one engagement, this provides the capability for asynchronous communication such as texting as well as broad disease education resources and customized materials to our members whenever and wherever they need it.
   - This will expand the efficiency and reach of our staff without the need to expand personnel while improving the effectiveness of our care management interventions.

CERTIFICATE OF SERVICE

I hereby certify that a copy of this Reply Memorandum of Law has been duly served upon Judith Henkin, General Counsel to the Green Mountain Care Board, and Kaili Kuiper and Eric Schultheis, Office of Vermont Health Advocate, by electronic mail, return receipt requested, this 5th day of June, 2018.



Jacqueline A. Hughes, Esq.
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601-0186
Tel. (802) 371-3619