VERMONT

Green Mountain Care Board
144 State Street
Montpelier, VT 05602

802-828-2177
www.gmcboard.vermont.gov

June 15, 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
2019 Vermont Individual and Small Group Rate Filing
SERFF Tracking #: BCVT-131497882

Dear Ms. Hughes,

As you are aware, the Office of the Health Care Advocate (HCA), representing the interests of the public, may submit suggested questions to the Board, which the Board can in turn, in its discretion, forward to its actuaries. 8 V.S.A. § 4062(c)(3); GMCB Rule 2.00, § 2.02. In the interest of efficiency and in contrast to prior years, we have asked that the HCA segregate its suggested questions into two categories—actuarial and non-actuarial—the latter of which follow. (The actuarial questions will be submitted through SERFF.)

1. Please provide support, to the extent it exists, that the rates BCBSVT is proposing are affordable.
2. Please provide support, to the extent it exists, that the rates BCBSVT is proposing promote quality care.
3. Please provide support, to the extent it exists, that the rates BCBSVT is proposing promote access to health care.
4. Please provide support, to the extent it exists, that the rates BCBSVT is proposing are not unjust, unfair, inequitable, or misleading.
5. BCBSVT states, in its Actuarial Memorandum at page 6, that "rate mitigation" is reducing rates. Please provide support and outline how BCBSVT assured that the savings programs did not reduce benefits or otherwise limit access to healthcare. If the savings programs did reduce benefits or otherwise limit access to healthcare, please explain how BCBSVT determined that the "rate mitigation" was appropriate.
6. Please outline your approach to promoting primary care services, specifically:
    a. Please outline the key statistics you track and the results over the past five years, including:
        i. Percent of claims for primary care;
        ii. Percent of members who do not obtain a preventative medical visit in a given year.
    b. Please identify how BCBSVT uses its payment policies and contracting ability to advance primary care initiatives;

c. Please provide any marketing plans related to the promotion of primary care services (mass media, member outreach).

7. Please list the amount of bonus or "other compensation" for each of BCBSVT's ten highest compensated employees by employee role for the most recent annual period, using the most current compensation data available to BCBSVT.

8. BCBSVT states, in its Actuarial Memorandum, that it is passing 100 percent of federal income tax savings to consumers. Please provide additional detail, specifically:

    a. The total amount of alternative minimum tax (AMT) credits accumulated by BCBSVT since 1987;

    b. The amount of federal income tax BCBSVT has paid in each of the most recent years beginning with 2014.

9. Please describe any unforeseen adverse events that have impacted BCBSVT's ability to pay claims over the last ten years, and the amount by which any such event caused BCBSVT's surplus to decline.

10. Please outline how the 2018 Rx contracting initiative compared to assumptions in the past year's rate filing. What are BCBSVT's intended uses for any extra surplus generated in 2018?

11. Please explain the financial management program for BCBSVT's assets backing BCBSVT's surplus and reserves. Some areas to include in the response are:

    a. BCBSVT's asset allocation strategy and how BCBSVT arrived at that strategy;

    b. How much BCBSVT pays for the financial management services and to what service provider those payments are made;

    c. Actual and expected investment returns for each of the past 5 years;

    d. Performance benchmarks for the financial management services. Please provide benchmarks, if any, that BCBSVT has used to evaluate the financial management program;

    e. Executive variable compensation tied to asset performance.

When providing the responses, please copy the question in the same numbered format as in this document, and provide the response immediately following. Note that the responses can be submitted separately and do not have to be submitted all at the same time. 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 June 25, 2018. Thank you in advance for your cooperation.

Sincerely,

Agatha Kessler
Health Policy Director

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

BlueCross BlueShield of Vermont

June 28, 2018

Ms. Agatha Kessler
Health Policy Director
Green Mountain Care Board

Subject: Your 06/15/2018 Questions re: Blue Cross and Blue Shield of Vermont 2019 Vermont Individual and Small Group Rate Filing (SERFF Tracking #: BCVT-131497882)

Dear Ms. Kessler:

In response to your requests on behalf of the Office of the Health Care Advocate dated June 15, 2018, here are *your questions* and our answers:

1. *Please provide support, to the extent it exists, that the rates BCBSVT is proposing are affordable.*
2. *Please provide support, to the extent it exists, that the rates BCBSVT is proposing promote quality care.*
3. *Please provide support, to the extent it exists, that the rates BCBSVT is proposing promote access to health care.*

Within the construct of applicable state and federal law, BCBSVT's proposed rates are affordable, promote quality care, and promote access to health care.

The Health Care Advocate (HCA) poses these three standards as a series of independent inquiries in its questions 1, 2 and 3. Affordability, quality and access are interconnected and interdependent. The proposed rates reflect the lowest possible cost while also meeting the needs of qualified health plan (QHP) members for comprehensive benefits, access to high quality providers and services at the right time, in the right amount and in the right setting. Through a combination of focused medical cost management and administrative cost efficiencies, the 2019 rate increase is the lowest that BCBSVT has filed since the inception of the Affordable Care Act, and it is less than half the national average of all health plans that have filed 2019 rates to date. We also recognize that the work that regulators, policy makers and advocates did to protect Vermonters eligible for cost sharing reductions and to preserve affordability for them despite the elimination of funding for these subsidies by the Trump administration.

All of the stakeholders in Vermont's health care system, including BCBSVT, have collectively advocated for expansive coverage and benefits; broad consumer protections; a wide array of choices; and investments in innovative programs and health care reform initiatives. The proposed rates also reflect costs associated with these policy and regulatory choices. BCBSVT's proposed rates reflect the choices Vermont has made that emphasize quality and access to care, and have resulted in extremely high rankings of comparative

health measures among states. All stakeholders share a sense of pride in these outcomes which reflect our values as Vermonters.

Over the years, the state and federal governments have incrementally introduced numerous access and quality of care requirements. While individually, these legislative, regulatory and administrative requirements may not have a significant impact on affordability -- cumulatively, they have contributed to higher health care costs. These access and quality mandates, and their associated costs, are mandates that must be offered by the two insurers offering QHPs in Vermont.

The three interrelated standards of affordability, quality and access are evidence of the Vermont Legislature's commitment to the "triple aim." The goals of Vermont's health care reform efforts are to improve health, improve patient care and reduce the cost of health care. 2011, Act No. 48. Similarly, the Green Mountain Care Board (GMCB) has repeatedly confirmed that it, too, is "guided in its work and in its decision-making by the triple aim of improving access and quality, while containing health care costs."[1] These three objectives are meant to work together as an integrated whole to achieve a better health care system. BCBSVT shares these objectives and they are consistent with our vision of "a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care" Our mission of outstanding member experiences and responsible cost management are also aligned with the triple aim. One of the challenges we all face in pursuing the triple aim is that pursuing one objective at the expense of one or both of the others can lead to less than optimal results for the health care system as well as the individual consumers using health services.

I. Impact of Vermont Regulatory and Policy Decisions on Quality, Access and Affordability

Vermont policymakers and regulators frequently make decisions that impact the health care system. Often when decisions are made that increase access and quality, there are associated costs that impact affordability. We summarize below recent examples of policy choices that impact access, quality and the cost of QHP premiums and out-of-pocket expenses. BCBSVT QHP members enjoy both the benefits and the unintended consequences of these policy decisions. The list below is meant to illustrate both the dilemma faced when trying to strike the right balance between cost, quality and access, and is not meant to judge or criticize the specific the policy choices. Act 48 charged the GMCB with designing its regulatory agenda to promote access to quality care while lowering system costs. The results of some of the Board's efforts directly affect insurance rates and are among the various inputs to the rates.

- One of the largest inputs—about 40 percent—to the medical trend included in the proposed rates are payments to Vermont and out-of-state hospitals. GMCB has tried to dampen Vermont hospital budget trends but has not been wholly successful. Approved increases to Vermont hospitals on average were 2.7 percent, 2.2 percent, 3.5

[1] GMCB 2016 Annual Report, p. 3. http://gmcboard.vermont.gov/sites/gmcb/files/documents/2016%20Annual%20Report%20Final%20with%20Cover%20letter.pdf; see also, See, e.g., GMCB 2011 Annual Report, page 4; http://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB-2012_Annual%20Report.pdf (accessed June 22, 2018); GMCB 2012 Annual Report, cover page; http://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB_AnnualRpt2013.pdf

percent, 3.92 percent and 3.0 percent over the last five years; while those for the state's largest hospital's budget representing about 50 percent of the total hospital spending, were 4.4 percent, 2.7 percent, 3.6 percent, 4.1 and 3.39 percent over the same period. (These approved increases do not include additional hospital budget allowances for investments in health care reform efforts that hospitals were permitted in addition to their budget increases.)

- Despite the modest approved budget increase amounts, several Vermont hospitals had significant "excess" revenues in the last three years over and above the GMCB approved increase and well above the GMCB's permitted 0.5 percent "variance."
- Hospitals with "excess" revenues totaling approximately $60 million, $68 million and $44 million[2] over-budget were not required to fully refund or lower their rates for the portion attributable to commercially insured Vermonters. This year one hospital was authorized to retain $30 million of excess revenue to build a new mental health facility and, in 2016, this same hospital was authorized to invest $ 15 million for housing, rather than earmark a pro rata portion of its excess revenues for commercial rate reduction. While these are admirable and much needed investments, the resources were largely obtained from commercially insured Vermonters' premiums.
- In contrast, the GMCB approved a different hospital's proposal to return its excess revenue by reducing its commercial rates immediately in 2016 which reduction was reflected in 2017 QHP rates proposed by BCBSVT during that year's QHP rate process. The experience with this second approach shows that, not only was such an approach possible, but that had a similar approach been used with all hospitals with overages the proposed QHP rates would have immediately reflected the pro rata commercial payer credit for some $153 million in excess revenues (over the GMCB allowances) in 2017, 2018 and 2019 QHP rates. In 2018, UVMMC and Porter Hospital were authorized to rebase their FY 2019 budget submissions embedding their higher FY 2017 actual results, a further implicit increase that will impact 2019 QHP rates.[3]
- Hospitals have testified before the GMCB that they categorically refuse to negotiate reimbursement rates with payers because the GMCB has approved their commercial rate increases—the GMCB decision is "gospel."[4] BCBSVT is required by Vermont law to meet robust geo-access and wait time standards, essentially requiring prompt, *local* access to primary (including mental health) care and immediate access to most emergency care in every county of Vermont as well as specialty services, trauma and certain tertiary level care within set travel and wait times. While these geo and wait time access standards are appropriate, they limit BCBSVT leverage because the option of excluding any Vermont hospital from the BCBSVT network for refusal to negotiate is eliminated.

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[2] See, http://gmcboard.vermont.gov/sites/gmcb/files/files/meetings/presentations/A15_Individual_Hospital_Review_4_7_16.pdf, page 2; http://gmcboard.vermont.gov/sites/gmcb/files/files/meetings/presentations/Actual%202016%20Plans%20for%20March%2030%20GMCB.pdf, page 6; http://gmcboard.vermont.gov/sites/gmcb/files/Pat%20Jones%20-%202017%20Enforcement%20April%204%20GMCB.pdf, page 5. At least one hospital was permitted to write off a significant part of its overage above the FY 2017 $44 million figure.

[3] http://gmcboard.vermont.gov/sites/gmcb/files/APPROVED%20minutes%203.28.2018%20Board%20meeting.pdf

[4] GMCB Hearing February 28, 2018, testimony of UVMMC

- GMCB selected from among various plan options available under federal law to define Vermont's essential health benefits (EHB). Within the plan options, the GMCB also made numerous choices among the EHB components which necessarily involved selecting a benefit package that the Board believed promoted QHP-enrollees' access to affordable, quality health benefits. GMCB approves the standard QHP product designs each year and DVHA selects the standard and non-standard QHP products that may be offered. QHP issuers can propose non-standard plans but the benefits are essentially the same as all of the standard plans with different cost sharing structures. The benefits of each plan must meet the metal level federal Actuarial Value (AV) within strict deviation corridors and which is determined using the federal AV calculator. The HCA has stated its preference that the highest possible AV for each metal level for each plan should be the state's goal. The higher the AV, however, the higher the premium because the member out-of-pocket is reduced.
- State payment reform efforts are in early development phases in Vermont. BCBSVT is the only commercial health plan to participate in Vermont's only ACO. BCBSVT is partnering and investing in this effort recognizing that the success of this model depends on wide provider participation and achieving scale in order to provide future savings for the benefit of our members, and Vermonters, while improving quality and access.
- The Department of Vermont Health Access rejects the introduction of silver plans with simpler product designs because they are *less expensive plans*, i.e., lower cost plans. DVHA explained that their rationale for denying lower cost plans was that these lower priced plans would mean lower subsidies because the amount of available federal and state subsidy is determined by the cost of the second lowest silver plan and these new plans would have been the second lowest silver plan on which subsidy amounts would have been determined. The state's decision to reject these plans, which the state reasoned was to the benefit of subsidized members, made the choice of the lower cost plans unavailable for the many thousands of unsubsidized QHP members, who comprise three-quarters of all enrollees. These less expensive, simpler plans were also unavailable to subsidized members. These members were left to buy more expensive and therefore, less affordable, silver plans with the exception of the very lowest cost silver plan in the market. In 2017, a non-subsidized family would have paid *$2520 less* that year by purchasing this lower cost option instead of the next more expensive silver plan.
- Vermont imposes a number of taxes, fees and assessments that directly contribute to the level of health insurance premiums in order to fund state programs including; Blueprint charges, the health care claims tax, and funding of the GMCB and the HCA in addition to the cost-shift created by underfunding Medicaid provider payments. Blueprint payments are now approximately $8.7 million per year and BCBSVT is the major contributor to this state-run program, now over a decade old, to coordinate care for Vermonters with chronic conditions. This program is only funded by health insurance carriers offering fully insured plans and the increasing costs are shared by a shrinking pool of members. The health care claims tax is based on claims amounts and rises as health care claims costs rise. This is a two-part tax, a 0.8 percent assessment, about $4.5 million a year, paid into the State Health Care Resources Fund to fund Medicaid and an additional 0.199 percent, about $1.1 million a year, to support the state health care IT initiative (VITL).

- Vermont has chosen to continue to require pure community rating of QHPs even though federal law permits a 3:1 rating ratio based on age. This policy choice has led to higher premium rates for younger, healthier Vermonters (at a point in their lives when their incomes tend to be lower compared with those Vermonters nearing age 65) than if age rating were allowed. Younger enrollees effectively subsidize older enrollees because of this policy choice. Vermont also chose to prohibit a rate differential for smokers though federal law permits a 1.5:1 rating ratio. This choice means higher rates for non-smokers than would be with a rate deviation for tobacco use. Lastly, Vermont is one of two states that has chosen to define and regulate product tiers. This choice has resulted in higher rates for individuals without children when compared to families with children.
- BCBSVT along with other regulated entities funds the GMCB budget. The charge is anticipated to be $1.238 million for 2019. Some of these funds pay for the support of the Office of the Health Care Advocate and VPQHC.
- Vermont underfunds Medicaid provider payments, which, along with Medicare, and free and reduced care at hospitals, means that the underfunded costs are shifted to the commercially insured marketplace. The GMCB studies and reports annually on the estimated cost shift which has grown from $393 million in 2014[5] to almost $491 million in 2017,[6] an increase of about 25 percent over four years. In 2018, the cost shift was expected to increase by an additional 5.9 percent.[7] As of 2014, the ACA's Medicaid expansion had greatly expanded the number of Medicaid enrollees with some 23.3 percent of state residents enrolled. While Medicare, which is also responsible for some of the cost shift albeit a smaller amount, accounts for 18.4 percent of state residents.[8]
- State mandates for health benefits, access to certain providers, , eligibility for certain individuals and groups, and caps and limits on member charges all contribute to the rising cost of health plans that would be less in their absence. Many Vermonters benefit from the expanded coverage and options provided, but at a premium cost to others who may not utilize these types of services and perhaps would make a different choice about balancing the amount of coverage with the level of health insurance premiums. Recent examples of mandated expansions include:
    - Services of athletic trainers, naturopaths, and chiropractors, among others;
    - There is a requirement that insurers hold members who use out-of-network emergency services harmless from balance billing by those out-of-network providers. This consumer protection has been abused by air ambulance providers nationally that refuse to contract with commercial payers, charging

[5] See GMCB January 15, 2015 Annual Report, page 5; http://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB_2015_AnnualRpt_Web.pdf (accessed June 22, 2018).
[6] See GMCB January 15, 2018 Annual Report, page 11; http://gmcboard.vermont.gov/sites/gmcb/files/2017%20GMCB%20Annual%20Report%20-%201%2016%202018%20FINAL.pdf (accessed June 22, 2018).
[7] 2017 GMCB Annual Report, page 11.
[8] Published this 2014 enrollment report in 2016, it is the latest available report on the GMCB website. http://gmcboard.vermont.gov/sites/gmcb/files/files/resources/reports/2014_Enrollment_report_and_Priv_Health_Ins_lines_of_business_Final.pdf (accessed June 28, 2018)

many multiples of in-network rates and taking advantage of members at a most vulnerable time or during a catastrophic event;

- This year, Vermont legislators chose to require 2019 silver and bronze health plans to treat chiropractors the same as primary care providers with respect to copays. The new law is expected to increase utilization as well as premiums while diluting the focus and importance of primary care services. A similar expansion for physical therapists is mandated for 2020 silver and bronze plans.
- Vermont requires health insurance coverage of no cost share vasectomies; no cost share breast ultrasounds that would have previously been subject to cost share; and twelve months of contraceptives at one time; while also allowing pregnant women to enroll in coverage at any time and 60 days free coverage to a member's newborn. These preventive and practical benefits, which are universally intended to improve quality of life and long-term system-wide savings, result in higher premiums.
- Vermont has the only Exchange with out-of-pocket prescription drug cap levels equivalent to the annual minimum federal HSA deductible amount. This cap necessarily means that premiums are higher due to more prescription drug cost being included in plan premiums rather than borne by the individual member. Until the Vermont Legislature affirmatively addressed the issue, the cap also made bronze QHP plans ineligible for treatment as HSA compatible plans under the federal AV calculator.
- Over the years, Vermont has adopted many other mandated benefits, mandated providers and mandated eligibility that add to the cost of coverage. The cumulative cost of all mandates are included in the filing.

Despite the negative impact that some of the policy choices detailed above have had in terms of overall health care costs and affordability, at 3.7 percent, Vermont's uninsured rate is the second lowest in the nation. Despite the choices described above that add to cost, Vermont is #2 among the fifty states.[9]

Administrative expenses, the one component of premiums over which BCBSVT has direct control, are some of the lowest among health insurers nationally. BCBSVT actively manages its budget and continuously seeks efficiencies in order to provide the highest levels of customer service, efficient plan management, and effective health programs at the lowest possible cost. BCBSVT makes choices that improve access and quality for members while also responsibly managing costs. These efforts are an important part of the services offered as well as the value proposition for consumers. These initiatives include: meeting and maintaining national accreditation standards; providing award-winning customer service; collaborating with the state to provide seamless enrollment and management of the products offered through Vermont Health Connect; advancing new payment models to emphasize quality and measurable care standards, offering complex case management; and managing and negotiating the best possible prices for pharmaceuticals. As the only Vermont-based non-profit health insurance provider in Vermont, BCBSVT works in collaboration with stakeholders on solutions that benefit all members. BCBSVT supports community health and wellness programs, promotes best practices for employer-based health care initiatives, collaborates with the state in protecting the QHP marketplace, partners with providers to offer innovative

[9] http://www.governing.com/topics/health-human-services/gov-uninsured-rate-census-2016-states.html; accessed June 28, 2018).

treatment approaches, and works with all stakeholders in the health care system to improve quality, access and affordability for all Vermonters.

- BCBSVT is currently the only health plan in Vermont that has Health Plan Accreditation from the National Committee on Quality Assurance (NCQA)[10] for its QHP products. An NCQA Health Plan Accreditation survey includes a detailed review of Plan performance in seven standards categories, and includes some must-pass elements. These elements include:
    - quality management and improvement, including provider contracting, member experience and coordination of care;
    - population health management, including wellness and prevention and complex case management;
    - network management, including availability of practitioners, accessibility of services, network adequacy and the provider directory;
    - utilization management, including clinical criteria for UM decisions, UM oversight by appropriate professionals such as doctors, nurses and board-certified consultants, timeliness of decisions, use of clinical information in benefit decision making, denial notices, appropriate handling of appeals (notices, policies for appeals and full and fair review of appeals), evaluation of new technology and pharmaceutical management;
    - credentialing and recredentialing, including credentials verification, ongoing monitoring and interventions;
    - members' rights and responsibilities, including policies and procedures for complaints and appeals and subscriber information;
    - member connections, including customer service, pharmacy benefit information and accurate health plan information

In addition to the review of standards, NCQA also scores 28 different Health Plan Effectiveness Data and Information Set (HEDIS) clinical measures and nine Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. These measures are nationally benchmarked, allowing BCBSVT to compare itself to other U.S. health plans and provides consumers with objective information about the quality of BCBSVT products and performance.

Accreditation is costly and resource intensive, but is a federal ACA requirement. Importantly for our members, it also holds us to high, measurable quality standards and performance. BCBSVT was awarded its first *QHP product accreditation* on March 31, 2013 in a stand-alone add-on survey which was then integrated with our other products on a full health plan survey in November 2014. NCQA awarded continued QHP product (a/k/a "marketplace") accreditation to BCBSVT on November 26, 2014. MVP has never had NCQA marketplace accreditation for its QHP products so it has avoided this federally mandated expense for five years.

Vermont was ranked number one in the country in 2017 on a range of performance metrics for access and affordability, prevention and treatment, avoidable hospital use and

[10] http://www.ncqa.org/Programs/Accreditation/Health-Plan-HP.aspx ;

cost, healthy lives and equity.[11] Vermont's rank has slipped to number four overall in 2018 with worsening[12] in the access and affordability and "disparity" (formerly equity) metrics.[13] Despite its number four overall rank, Vermont still ranked number one (best state in the nation) in three key disparity metrics: uninsured adults ages 19-64, uninsured children ages 0-18 and adults who went without care because of cost.

Vermont also was ranked third best state for employee health insurance contributions as a share of median income, meaning that Vermont employees share *less* of the burden of health insurance contributions than employees in 47 other states. Id. Moreover, Vermont's low income rank improved which means more Vermonters were eligible for private insurance rather than Medicaid. Id. BCBSVT is proud of the contributions it has made to improve the performance of the access and affordability metrics for its insured members. We continue work with providers and consumers to encourage age and gender appropriate preventive screenings, immunizations and other important, evidence-based care.

Moreover, BCBSVT maintains an award-winning customer service team as part of an organization that is committed to providing outstanding experiences to its members. BCBSVT's customer service team has been the highest ranked team among all Blue Cross and Blue Shield plans as measured by Member TouchPoint Measures (MTM) for five years. BCBSVT's customer service team was deemed the *Highest Performing Call Center in North America* by Service Quality Metrics (SQM) for the second year in a row among 250 small to mid-sized call centers that are monitored by SQM. SQM also awarded BCBSVT the Customer Service Representative of the Year, Best Practice Quality Assurance Program, Contact Center World Class Certification, Highest Employee Satisfaction in the Health Care division and Highest Omni Channel Satisfaction for its on-line member resource center. Whether it be obtaining emergency care internationally or guiding our members through the complex health system in Vermont and across the United States, our customer service team is performing at the highest possible level. This team is instrumental in helping our members' access timely, quality care at the lowest possible cost.

It is important to reiterate that rate filings reflect the rising expense of health care costs and utilization among other key factors which are measured independent of other economic measures. Medical trend continues to grow faster than inflation and wages but has stabilized as compared with the rate five to ten years ago.[14] The factors affecting the projected costs of medical services and pharmacy in 2019 include the rise in medical and pharmacy costs, rise in utilization, Vermont's aging population (with age rating prohibited), new government mandates, the year-over-year increase in taxes based on rising claim payments and the cost shift to fund the ever-growing Medicaid deficit.

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[11] Commonwealth Fund 2017 scorecard for Vermont. https://www.commonwealthfund.org/publications/fund-reports/2017/mar/aiming-higher-results-commonwealth-fund-scorecard-state-health ; accessed June 28, 2018.

[12] Vermont's worsening position is largely attributed to sub-metrics that do not apply to BCBSVT QHP members such as adult dental visits, Medicare beneficiaries receiving high risk drugs, admissions for ambulatory care for "dual eligibles" (persons on both Medicare and Medicaid); 30-day hospital readmissions for dual eligibles, and potentially avoidable emergency department visits for dual eligibles.

[13] Commonwealth Fund 2018 scorecard for Vermont. https://interactives.commonwealthfund.org/2018/state-scorecard/state/vermont ; accessed June 28, 2018.

[14] https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html; accessed June 28, 2018

Finally, there are many challenges BCBSVT faces when administering the QHPs as defined within the ACA. BCBSVT seeks to find the appropriate balance within the interdependent domains of affordability and promoting access to high quality health care.

Our approach includes the industry's broadest network of providers in Vermont and the United States providing access to care even in our most rural areas. We are in the minority of health plans nationally who has chosen not to limit our networks.[15] Health plans with more restrictive networks constitute 73 percent of the 2018 exchange market, up from 68 percent in 2017 and 54 percent in 2015. Id. Just 27 percent of plans in the 2018 marketplace offer broad physician networks. Id. In addition to access, robust networks have been proven to keep costs lower. We have also moved forward with telehealth both in partnership with our providers but also by bringing new resources into Vermont in order to fill gaps in care and improve access for our members. This goes beyond minor acute care visits to behavioral health, nutrition and lactation consultations supporting some of our most vulnerable members who previously had challenges accessing the care they need simply due to provider distribution and transportation barriers.

We are moving forward with innovative provider relationships which are value based with an emphasis on outcomes important to members. These range from innovative models with single practices to promote better access to care for our members with significant mental health needs to our partnership with the statewide ACO, OneCare. Many, but not all, of our QHP lives are attributed members of the ACO. This collaborative partnership around their care, which includes shared risk and ongoing work in the areas of care management, quality, analytics and non-specialty pharmacy, will help to control costs and ensure high quality care.

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 continuously 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.

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 continuously collaborates with providers, and often State and Federal administrators, deploying value based programs challenging BCBSVT and network providers to improve quality and reduce the cost of care for our members. BCBSVT has led the state as the only commercial payer implementing outpatient case rates, e.g., colonoscopy standard rates; and as the first payer reimbursing for Medication Assisted Treatment (Hub) programs.

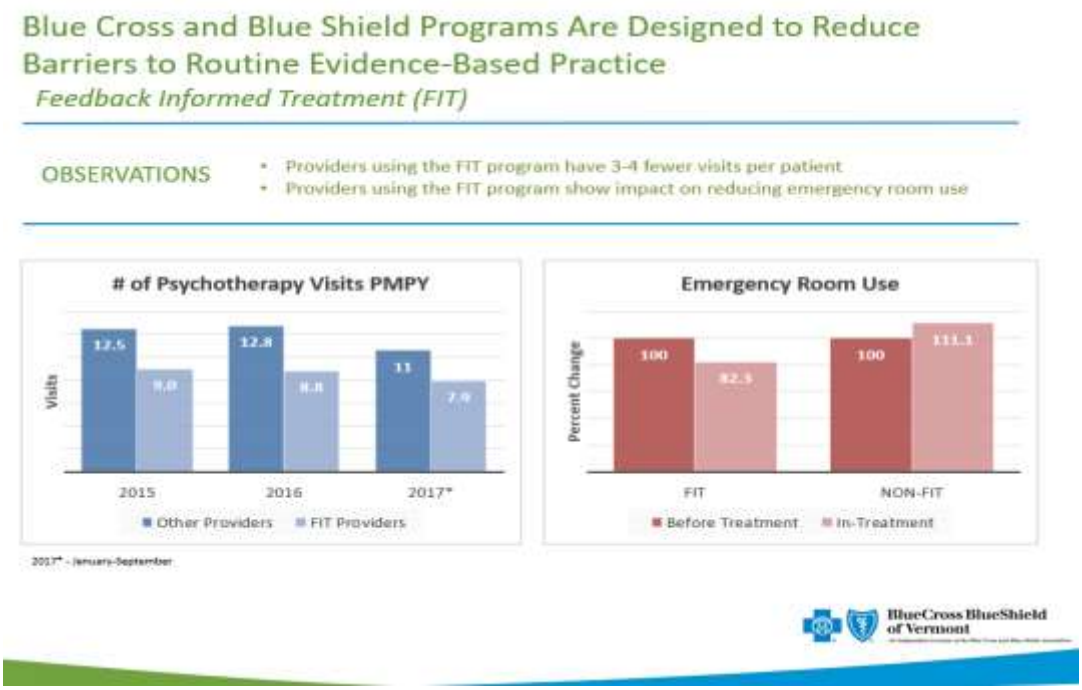
[15] http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1512054657_Avalere_2018_Exchange_Networks_Deductibles_Release.pdf; accessed June 28, 2018

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.

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%

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

- Screening, Brief Intervention and Referral to Treatment (SBIRT) Program: 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 across all our products lines.
- Feedback Informed Treatment (FIT): The FIT program is a Substance Abuse and Mental Health Services Administration (SAMHSA)-recognized best practice using real-time feedback from clients to better inform the process of therapy. FIT is proven to reduce therapy 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 across all our product lines. Following the initial phase of data collection, we continue to evaluate new reimbursement mechanisms that can support and expand the program. As shown below, providers who participated in our FIT program have three to four fewer visits per patient and reduced patient emergency room usage.



- 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 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 with lower 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 in the near future. Each of these initiatives take time to do right.

Accountable Care Organizations, Episode of Care and Case Rate Pilots

Meanwhile, BCBSVT has led all commercial providers in the state by being the only commercial payer participating with Vermont's ACO. We are currently in discussions with OneCare Vermont to continue the expansion of the program to include other market segments. We are also looking to expand the episode of care and case rate pilots to other market segments.

Program	Year	BCBSVT 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%
North-western Case Rate (projected 2018)	2018 projected	568	4	$710,000.00	0.07%	0.32%

ACO Shared Savings/Shared Risk Program

In 2018, we implemented the state's first commercial ACO shared risk contract with OneCare Vermont covering approximately 21,000 QHP 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.

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 bundled rates to outcomes performance and outreach/care coordination with community providers. This pilot is being expanded to serve QHP members.

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 to 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.

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. Examples of our programs (whose results are reflected in our proposed rates):

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.

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 more than 200 industry standard appropriate 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 medical 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 post-catastrophic trauma care.
     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.

BCBSVT clinical programs produced $50 million in savings in 2017 across BCBSVT's entire book of business. The cost savings 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 increase have led us to examine treatment patterns in outpatient facilities, i.e., emergency departments 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.

Cost management is a continuous focus of BCBSVT and it can take 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 emergency department use (utilization in Vermont is well above regional benchmarks) and outpatient surgical/facility procedures. We have recently expanded programs in:

a) Specialty pharmacy
   - We are focused, with Express Scripts (ESI), 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 ESI, to leverage pricing by clinical utility with the pharmaceutical companies.
- We obtain credits for "failed starts" or specialty medications which members dis-continue due to side effects or complications. For example, 50 percent 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 rehabilitation 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.
- In 2019, we will deploy 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 application 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.

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 rate 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 QHP plans would be 3.1 to 4.2 percent higher. We think our efforts have produced significant savings and we continually look to improve savings but not at the expense of access or quality.

Many providers vehemently and repeatedly object to having care supervised or managed in any way.[16] We don't adopt care management programs unless they are proven to save money without compromising the services our members need. Once implemented, we continually assess the continued value of all prior approval programs and make changes to improve their value or when practice models indicate a change is necessary or valuable. BCBSVT long ago moved away from 1990s style management strategies such as patient referrals and gatekeepers.

According to the National Academy of Medicine, $765 billion a year are lost in waste by the U.S. health care system. That is approximately 25% of the cost of health care per year. This is care and resources that does not improve the health of Vermonters. We seek to transform the health system so that all of our incentives are aligned towards improving the health of the population. Vermont as a state has only recently started this journey and health plans continue to play a part in promoting appropriate care pathways for our members through care management programs.

We note that the GMCB has not defined "affordable" or what it means to "promote quality of care or access to health care." The federal rule subjects single risk pool coverage to a reasonableness review if the rate increase is 15 percent or more. By this standard, rate increases of less than 15 percent are *per se* reasonable.[17] When the Department of Financial Regulation was responsible for reviewing rate filings in 2012 and 2013 and making recommendations to the GMCB on the whole rate filing, it applied the following measurable standards.

A. Affordable: A rate change (or trend factor change) is affordable, if:

1. The overall proposed increase is less than 10.0% higher than previously approved overall change; and

2. Following review, the rate or trend factor change is found to be actuarially justified.

3. A proposed rate or trend factor increase of ten percent or greater over the previously approved change is presumptively not affordable, unless,

[16] Vermont imposes the strictest turn-around time in the country on prior authorizations. This strict time frame is costly to administer, but was intended to lessen the burden on providers and members.

[17] 45 C.F.R. § 154.200 (a); HHS Notice of Benefit and Payment Parameters for 2019 Final Rule

following review, the Department finds that the proposed increase is actuarially justified and is necessary to sustain projected losses and necessary expenses for the class of business in question.

B. Promotes quality of care: The Department does not supervise providers. In the context of rate regulation, a rate or trend factor, whether new or a proposed change, promotes quality of care if the policy forms with which the rate or trend factor will be used have been filed with and approved by the Department. Department approval of the policy forms means that all health care benefits mandated by Vermont law have been provided.

C. Promotes access to health care: A rate or trend factor, whether new or a proposed change, promotes access to health care if it is affordable, as defined above, and if the policy forms with which the rate or trend factor will be associated provide consumers an opportunity to seek an independent review of adverse coverage determinations.

See, for example, Commissioner Donegan's 3rd Q2013 and 4th Q2013 Safety Net Rate Filing Recommendation, August 28, 2013, p. 3.

The proposed QHP filing meets both of these standards. The filing is less than 10 percent change for all but the on-exchange silver-loaded plans. The silver-loaded plans reflect the specific Vermont legislative policy objective[18] to maximize federal dollars that were lost when the federal Cost Sharing Reduction (CSR) payment program was abruptly ended in October 2018. The introduction of silver-loaded plans will prevent an otherwise indicated 1.9 percent increase on all plans to make up for the loss of CSR funding. The filing meets all relevant actuarial standards. The QHP forms are approved by DFR and contain all mandates and other requirements of Vermont law. BCBSVT provides an opportunity for independent review. Either the federal or the DFR standard provide measurable benchmarks to assess whether a proposed rate promotes access to quality care and is affordable, and the proposed rate filing meets the standards of both regulators.

In summary, BCBSVT is wholly engaged with the state policy makers, regulators, providers, community, and our members to provide QHP plans that promote quality and access at the most affordable level possible. The 2019 proposed rates reflect engagement and effort in improving every aspect of Vermont's health care system. BCBSVT has been extremely successful in its efforts to provide high quality plans that offer better health, better care and lower cost. The proposed rates are less than they would have been without BCBSVT efforts at cost-containment in all areas (provider negotiations, case management, pharmaceutical price management, regulatory solutions such as Silver-loading, contracting with the ACO, achieving administrative efficiencies). BCBSVT's proposed 2019 rates also reflect the realities of the policy choices made by all of the stakeholders in Vermont's health care system.

II. There Is No Conflict Between Solvency and Affordability

[18] See 2017, Act No. 88 (Adj. Sess.).

BCBSVT protects affordability by filing rates that protect solvency. Far from being in conflict, solvency is the most basic tenet of affordability. The Vermont Department of Financial Regulation (DFR) "considers the solvency of insurers to be the most fundamental aspect of consumer protection."

Solvency is a critical aspect of affordability from two perspectives. By financing the health care system, BCBSVT protects consumers by aggregating the cost of health care across the entire single risk pool, protecting individual members from what could be otherwise financially ruinous health care bills. For example, the health care for a premature baby who spends two months in the NICU costs approximately $700,000 – far more than the average family can afford. Similarly, health care for acute lymphoblastic leukemia with a relapse costs approximately $1,000,000. To cover the health costs of the NICU infant, BCBSVT must collect 1207 member months in premium.[19] These are unforeseen and unavoidable events that cost far more than the typical family can absorb. However, the cost of the monthly premium becomes much more "affordable" in the context of just such an unfortunate event.

Solvency is also a key component of affordability in that BCBSVT requires capital to continue to invest in innovative programs that can mitigate the cost of care and thereby ultimately reduce premiums for ratepayers. As discussed more fully above, examples of such innovations include value based payment programs to improve overall mental and physical health care quality. Often such programs require an initial investment that smaller independent providers are unable to make alone.[20]

There are additional parameters in place to ensure that filed rates are as affordable as possible given the services they finance.

The vast majority of premiums collected by BCBSVT go directly toward the financing of the health care system. Over 90% of premiums collected pay policyholders' medical and pharmacy claims costs. BCBSVT collects premiums and reimburses doctors, hospitals, pharmacies and other providers for the cost of providing clinically appropriate care to Vermonters. The entirety of this portion of the premium will be disbursed as payments to providers. There is significant actuarial rigor that goes into the projection of claims costs. If rates are neither excessive, nor inadequate, they are an accurate projection of costs, and have therefore been verified to be as affordable as possible *given the underlying cost of care*. Said slightly differently, adequate and not excessive rates are not unaffordable unless the care which the premium pays for is too comprehensive.

The balance of premiums that don't go directly to providers, go toward state and federal fees, assessments and taxes, BCBSVT administrative costs, and a small contribution to maintaining member reserves. Most of the fees and assessments are incurred because of health policy decisions made by state and federal governments, many of which support other health care investments. These costs are entirely out of BCBSVT's control. It is also important to recognize that many non-medical costs incurred by BCBSVT go to support statutory and regulatory obligations, most of which are in place to protect consumers and promote a stable health care financing system.

[19] This assumes the average 2019 PMPM of $580.

[20] As most people interested in health policy will observe, often these investments take a long time to reduce spend, decreases can appear inconsequential in the face of unrelated increases, and some investments don't ultimately reduce costs. However, the system benefits from having resources available to support innovation.

State and federal law require that no more than 20 percent of premiums goes to cover these types of costs. BCBSVT is proud to promote affordability by going well above and beyond these requirements: only 8.2 percent of premiums goes to cover these costs, nearly 60 percent less than the allowed amount, are for non-medical or non-pharmacy expenses. Nonetheless, BCBSVT continually strives to make these costs as low as possible, while not undermining the quality of service offered to customers or regulatory obligations. As previously noted, BCBSVT actively manages its budget and continuously seeks efficiencies in order to provide the highest levels of customer service, efficient plan management, and effective, quality health programs at the lowest possible cost. BCBSVT makes choices that improve access and quality for members, while also responsibly managing costs.

Additionally, BCBSVT includes only 1.6 percent of premium to cover the cost of bad debt, maintain surplus within the modest range required by DFR, fund initiatives that help to promote affordability by reducing the cost of care, and continue to pay claims should the cost of care turn out to be higher than anticipated in the actuarial projection. In fact, the entire margin would be consumed by a mere 1 percent increase in health care utilization trend above the level ordered by the GMCB. This level of margin is significantly lower than that realized by Vermont hospitals over the past several years. Further, it is clearly modest in light of BCBSVT realizing losses of nearly $19 million in the VISG line of business over the last three years. BCBSVT has not included any recovery of those losses within our modest contribution toward member reserves.

The GMCB has responded to a perceived conflict between affordability and solvency by routinely reducing rates below an actuarially justified level, thus depleting reserves. However, the rate review statutes were written in the context of implementing Green Mountain Care, the envisioned state-level single payer system. In that context, the gap between affordability and the actuarially projected cost of providing the care would be funded through Vermont general revenues or the decision would be made to reduce the comprehensiveness of the benefits available under Green Mountain Care. Without Green Mountain Care, when rates are cut below what is actuarially required, BCBSVT must fund the shortfall out of the pockets of future policyholders – a strategy that is unsustainable. The impact of year-over-year rate reductions on BCBSVT's solvency has been explored in our recent motion to reconsider the GMCB decision in dockets BCBSVT 3rd Q 2018 Large Group Rating Program, Docket 3-18-rr and TVHP 3rd Q 2018 Large Group Rating Program, Docket 4-18-rr. It is not a solution to use underfunding BCBSVT policyholder reserves as a means to control costs: if rates continue to be funded below actuarially adequate levels, it's not a matter of *if* BCBSVT goes out of business, but when.

Had the GMCB not cut rates below actuarially adequate levels for 2018, the current rate increase would be only 2.1 percent, due in large part to BCBSVT rate mitigation efforts (please see our response to Question 5 below). Rather than continuing to create a conflict between the consonant concepts of affordability and solvency, the GMCB must facilitate the continuation of the good work BCBSVT does in promoting affordability. This can only be accomplished through approving rates that are actuarially adequate, allowing BCBSVT the ability to make the investments in financial and human capital necessary to continue our good work in the areas of payment reform, quality improvement, and partnering with all the stakeholders in the state to pursue the ever elusive dream of meaningful health care reform.

4. *Please provide support, to the extent it exists, that the rates BCBSVT is proposing are not unjust, unfair, inequitable, or misleading.*

Please refer to the actuarial memorandum and actuarial certification as well as all BCBSVT answers to GMCB interrogatories and the forms previously approved by Department of Financial Regulation for support that the rates BCBSVT is proposing are not unjust, unfair, inequitable, or misleading.

5. *BCBSVT states, in its Actuarial Memorandum at page 6, that "rate mitigation" is reducing rates. Please provide support and outline how BCBSVT assured that the savings programs did not reduce benefits or otherwise limit access to healthcare. If the savings programs did reduce benefits or otherwise limit access to healthcare, please explain how BCBSVT determined that the "rate mitigation" was appropriate.*

The new savings programs referenced are focused on helping our members find the right care at the right place at the right time. The first of the three new programs referenced start with advancing our analytic capabilities to better identify members who are at increasing risk of an adverse health event before it happens and coordinating outreach and support either through our best in class care management programs, which are part of our unique payer-provider partnership with the Brattleboro Retreat providing single point of contact to teams of social workers, mental health professionals and nurses or through our providers and the ACO as well as our community partners such as the Blueprint for Health and the SASH program. We are currently initiating work flows to identify these members earlier in their care journey and coordinate with the ACO as appropriate. Our and industry experience suggest that care management is a cost effective intervention which controls costs and adverse utilization such as avoidable inpatient admissions and ER visits. This program does not reduce benefits or access but on the contrary increase both.
The second program references seeks to mitigate the issue of using claims data for clinical interventions for individual patients. Currently there is a routine 60-day delay between the event which generates the claim and our receipt of it. We often hear stories of members who say that if they had been provided care coordination and connection to health resources closer to the initial event they would have been able to avoid complications and achieved a better outcome. The addition of a real time admission, discharge and transfer notification system will mitigate this issue and allow us and our care partners to intervene in a more timely manner for our members in order to again increase access to appropriate care and therefore benefit and improve the health of our members.
Lastly we know that care management has a significant positive impact for our members. We have satisfaction rates higher than 96 percent and regularly receive glowing thanks and testimonials from those we have helped. However we have realized that we have not met the evolving communications preferences and needs of our members and are therefore expanding into the area of secure mobile care management. This communication method will still start with the all-important human relationship and engagement will not replace but rather extend the reach of our care management staff. This increase in access to our health support team will again increase and expand the benefit of care management to more of our members and increase their access to care.

6. *Please outline your approach to promoting primary care services, specifically:*
   a. *Please outline the key statistics you track and the results over the past five years, including:*

BCBSVT has a Health Value Improvement Committee (HVIC), designed to improve the value of the health care system for our members and customers through a focus on health outcomes, member safety, and efficient and effective care. Staff include representatives from integrated health, provider contracting, analytics, reimbursement and actuarial services. The committee tracks key measures of trend, utilization, quality, avoided cost, cost savings and member engagement through a management dashboard and an annual analysis of the qualified health plans. The key measures identify opportunities for program development, in addition to measuring program effectiveness and impact. Key measures are compared to local and national benchmarks to inform the committees work.

i. Percent of claims for primary care;

For this purpose, we have defined primary care health care services provided by Family Practitioners, Primary Care Internal Medicine, OBGYN Practitioners and Pediatric Practitioners. We also included health services provided be specialists trained for and skilled in first contact and continuing care for individuals including the above specialties as well as Nurse Practitioners, Primary Mental Health Services and services provided at FQHCs. Lastly we are mandated to cover primary care services provided by Naturopaths within their scope of practice.

We have discussed that care management services supporting primary care should be woven into the definition and propose including the costs of the Blueprint for Health and the Care Management payments to the ACO into the definition. Using the broadest definition to capture the true costs of all services directly by and in support of primary care practitioners is a better estimate of the overall investment in primary care.

The historical percent of medical claims for members in Commercial Individual and Small Groups lines of business that were for primary care are as follows:

Year	Percent of medical claims for primary care
2014	12.4%
2015	12.1%
2016	12.0%
2017	12.6%

ii. Percent of members who do not obtain a preventative medical visit in a given year.

Year	Percent of members did not have a preventive visit in a given year
2014	71.4%
2015	70.6%
2016	71.7%
2017	69.5%

b. *Please identify how BCBSVT uses its payment policies and contracting ability to advance primary care initiatives;*

BCBSVT provides significant support, both financially and through policy, to advance primary care activities. BCBSVT has a separate and distinct primary care fee schedule which reimburses Evaluation and Management services at a higher level than the plan's specialist fee schedule. BCBSVT's primary care fee schedule is evaluated on an annual basis to ensure continued competitiveness in the marketplace. In addition, BCBSVT contributes significant financial support to Vermont primary care through the BluePrint for Health (see 6.a.i).

BCBSVT payment polices also appropriately support primary care. BCBSVT encourages primary care physicians to see patients after regularly scheduled office hours and provides a higher level of reimbursement for such visits. This practice reduces visits to the emergency rooms and urgent care centers, supports the physician-patient relationship, and provides additional reimbursement to primary care.

BCBSVT also provides additional reimbursement to primary care practices who participate in the SBIRT program (Screening Brief Intervention and Referral to Treatment) to help fund early detection and intervention in substance dependence. BCBSVT is currently working to implement reimbursement for "spoke" services under Vermont's Hub and Spoke program. Those services are predominantly delivered in primary care settings.

c. *Please provide any marketing plans related to the promotion of primary care services (mass media, member outreach).*

BCBSVT communicates the importance of primary care services and the importance of maintaining a relationship with a PCP in both our Certificates of Coverage and in the Outlines of Coverage: "While members are not required to select a PCP, they are encouraged to do so to help with the care coordination."

BCBSVT's "Know Before You Go" campaign encourages members to understand the differences between PCP, Urgent Care, Telemedicine and ER visits. The purpose of this campaign was to educate members and drive them to the appropriate level of care. The last iteration of the campaign occurred in 2016 and 2017 and involved one-page slicks for providers' offices and an updated webpage (http://www.bcbsvt.com/member/know-before-you-go).

BCBSVT also sends a targeted member mailing (built on the Know Before You Go Appointment Prep Card http://www.bcbsvt.com/visitprep) to members who are eligible and due for annual well-visits, preventive screenings such as mammograms, annual monitoring of kidney function for members taking persistent medication (ACE/ARBs, or diuretics), diabetic testing (HbA1c, Eye-Exam, Attention for nephropathy)

7. *Please list the amount of bonus or "other compensation" for each of BCBSVT's ten highest compensated employees by employee role for the most recent annual period, using the most current compensation data available to BCBSVT.*

Attached is the 2017 Supplemental Compensation Exhibit for BCBSVT that is filed each year with the Vermont Department of Financial Regulation. As noted on page Supp 1.2, the amounts disclosed in column 4-Bonus reflect payments related to BCBSVT's pay for performance incentive program. They are not bonuses given on a discretionary basis, but rather they represent the portion of each employee's compensation that is withheld and payable annually upon achievement of pre-established performance metrics in the previous calendar year. The amounts reported in column 9-All Other Compensation include employer matching contributions under a defined contribution 401(k) plan, service awards, amounts paid for optional cash-in of combined time-off (CTO) balances, rewards paid under BCBSVT's employee wellness program, taxable group term life and other taxable fringe amounts as applicable.

8. *BCBSVT states, in its Actuarial Memorandum, that it is passing 100 percent of federal income tax savings to consumers. Please provide additional detail, specifically:*

Attachment C of the Actuarial Memorandum outlines the details of passing the benefit of the federal income tax savings on to consumers. It is repeated here for ease of reference (italics added) with two clarifications.

Tax Cuts and Jobs Act

The Tax Cuts and Jobs Act enacted in late 2017 is anticipated to have two specific impacts on BCBSVT's financials. First, beginning with the 2018 tax year, the BCBSVT legal entity will no longer be subject to federal income taxes (note that BCBSVT subsidiaries will continue to be taxable). *The savings resulting from the elimination of BCBSVT's annual federal tax obligation are being passed on directly to our customers via premium rates, and that is what has led us to reduce our long-term CTR requirement from 2.0 percent to 1.5 percent.*

The second expected impact results from the repeal of the corporate alternative minimum tax (AMT) in the new law. As a low to moderately capitalized Blue Plan, BCBSVT has been subject to federal income taxes at an AMT rate since 1987. AMT credits accumulated by BCBSVT since 1987 have become refundable under the law, and the total AMT credit balance is scheduled to be paid to BCBSVT over a four year period from 2019 through 2022, based on filed federal tax returns from 2018 through 2021. *Assuming the credits are refunded to BCBSVT in accordance with the provisions set out in the Tax Cuts and Jobs Act, these funds will also be used for the direct benefit of our customers as they are received from the IRS. The method(s) for returning the AMT credits to customers will be determined at that time, and may include lower premium rates than would otherwise have been necessary, replenishment of member surplus shortfalls, or other appropriate measures designed to protect and minimize the costs incurred by our members.*

Although the word "scheduled" was used in the original submission, the anticipated refund is in no way a certainty at this time. Further, the anticipated timing of the first portion of the refund in 2019 is actually late 2019, after BCBSVT's 2018 income tax return

filing has been filed and processed. BCBSVT will likely file its 2018 income tax return on or around September 15, 2019.

a. The total amount of alternative minimum tax (AMT) credits accumulated by BCBSVT since 1987;

The accumulated AMT credits are scheduled to be refunded over a four year period beginning, at the earliest, in late 2019 based on BCBSVT's 2018 filed federal tax return. Based on assumptions about sequestration and other factors (which assumptions may need to be revised if changes occur in the meantime), the AMT credits currently projected to be refunded to BCBSVT in the future are $16.6 million in late 2019; $7.9 million in 2020; $3.6 million in 2021 and $2.8 million in 2022. Assuming the AMT credits are refunded to BCBSVT in accordance with the provisions set out in the Tax Cuts and Jobs Act, these funds will be used to the direct benefit of our customers as they are received from the IRS. The method(s) for returning the AMT credits to customers will be determined at that time and may include lower premium rates than would otherwise have been necessary or replenishment of member surplus shortfalls (e.g. not charging the market for the late-2017 and 2018 CSR funding shortfall).

b. The amount of federal income tax BCBSVT has paid in each of the most recent years beginning with 2014;

Federal income tax paid (received) related to 2014, 2015, 2016 and 2017 is $4.8 million, $4.4 million, $(0.7) million and $0.3 million, respectively.

9. Please describe any unforeseen adverse events that have impacted BCBSVT's ability to pay claims over the last ten years, and the amount by which any such event caused BCBSVT's surplus to decline.

The financing of health care claims is accomplished through an actuarial pricing exercise that is completed some six to twelve months prior to the period in which claims are actually incurred, based on an annual experience period that begins at least 15 months prior to that. Necessarily, actual experience will differ from the actuarial projection. When claims experience is higher than projected, BCBSVT experiences a financial loss. There is no opportunity to adjust rates midstream, and BCBSVT does not recoup losses from prior years in subsequent rate requests. These losses are funded fully out of surplus.

Additionally, external forces sometimes arise that also cause financial losses. These, too, must be funded out of surplus.

The following list of unforeseen adverse events is certainly not comprehensive. They represent a cross-section of common causes of financial losses, from regulatory actions to claims costs that differed from the actuarial projections to actions BCBSVT has taken to see members through difficult changes. Each of these had an impact to surplus.

2018: In late 2017, the federal government defunded the Cost Share Reductions program. The GMCB denied BCBSVT's request to file amended 2018 QHP rates reflecting the defunding. BCBSVT will nonetheless honor promises made to Vermonters to continue to cover federal CSR benefits. These benefits, expected to total about **$6.7 million** through 2018, will be funded out of surplus.

2017: The GMCB made explicit cuts to utilization trend beyond those recommended by the Board's contracted actuary. This trend reduction did not manifest in actual claims, leading to a reduction in surplus of **$4.0 million**.

2016: Data issues at Vermont Health Connect led to significant downward membership restatement well after the close of the 2014 plan year. Because the 2016 QHP filing was submitted before the restatement took place, per member per month claims in the experience period were understated. The impact on 2016 financials was a loss of **$4.5 million**.

Full-year 2015 experience showed that actuarial values had been understated through the 2016 filing. Earlier experience had been inconclusive due to the significant market changes, including transitional plans being available through the early part of 2014. This unanticipated inadequacy in actuarial pricing had an impact of **$10.3 million** in 2016 alone.

Within the Large Group line of business, premature twins born in late 2016 required several months of NICU care. This single medical event, which was fully covered by BCBSVT, created a financial loss of nearly **$1 million**.

The GMCB made explicit cuts to CTR in the QHP filing and also reduced actuarial factors beyond those recommended by the Board's contracted actuary, leading to a reduction in surplus of **$4.5 million**.

2015: Actuarial projections can be particularly challenging in an environment of significant change or uncertainty. As one such example, QHP rating rules prohibit the recognition of selection – that is, members making financial choices that are best for them. However, 2014 experience showed that selection does have an impact on the actuarial value for each plan in that high-cost members tend to gravitate to richer plans, making the actuarial value of these plans even greater. This in turn leads to premium being understated in the absence of a balancing adjustment. BCBSVT added a 2 percent factor to the 2016 rate filing to reflect this impact. However, since the experience did not yet exist at the time of the 2015 rate filing, that filing did not include an adjustment factor. This understatement of premiums had an impact of approximately **$6.8 million** on 2015 QHP results.

2014: Due to issues with the rollout of Vermont Health Connect, BCBSVT chose to cover all prescriptions for Vermonters in January 2014 as a bridge to VHC enrollment. This free coverage was provided at a cost of **$0.2 million.**

The GMCB disapproved actuarially required rate increases for transitional plans that covered Vermonters for a portion of 2014, leading to a reduction in surplus of **$3.2 million.**

2013: After MVP dropped their Catamount members at the end of 2012, the members all shifted to BCBSVT as the payer of last resort. DFR disallowed a rate adjustment to reflect the higher risk of these members, leading to a financial loss of about **$1.6 million.**

TVHP filings in this time period were constructed based on assumptions regarding the outcome of negotiations with Vermont Managed Care on its Medical Expense Target (MET). The filing for 2013, the final year that VMC contracted with BCBSVT, assumed a 7 percent increase in the MET. Actual negotiations led to a 17.35 percent increase. The loss this generated impacted surplus by about **$5.3 million.**

We have restricted the time period to the most recent five years, and provided only a flavor of the types of unforeseen events that can arise rather than an exhaustive list of all circumstances that have led to financial losses over that time period.

A $1 million reduction in surplus is approximately 4 percentage points of Risk Based Capital (RBC). In the aggregate, this limited inventory of unforeseen adverse events reduced surplus by $48.1 million, or approximately 192 RBC percentage points.

10. Please outline how the 2018 Rx contracting initiative compared to assumptions in the past year's rate filing. What are BCBSVT's intended uses for any extra surplus generated in 2018?

BCBSVT is currently projecting a loss of up to $15 million on the QHP line of business for 2018 due to a combination of GMCB lowering premiums below the actuarially justified levels and not allowing BCBSVT to amend its 2018 rates for the defunding of the Federal Cost Share Reduction program, lower than projected enrollment, and medical and pharmacy utilization currently running higher than estimated. BCBSVT's ongoing work to achieve the best possible pharmacy discounts will serve to offset other unfavorable variances of actual to expected results.

At the time of the 2018 QHP rate filing, BCBSVT had was still negotiating the new contract with its pharmacy benefit manager. As part of the contracting process, BCBSVT was able to negotiate better than expected discounts. These new contract terms were reflected in the 2019 VISG (QHP) rate filing. Had the new terms been known at the time of the 2018 rate filing, the factor on line 1+c5 of exhibit 5 would have been 0.9909 instead of 0.9967. This change would have lowered rates by just over a half percent, amounting to an approximate $1.9 million favorable result vs. expected.

11. Please explain the financial management program for BCBSVT's assets backing BCBSVT's surplus and reserves. Some areas to include in the response are:
a. BCBSVT's asset allocation strategy and how BCBSVT arrived at that strategy;
b. How much BCBSVT pays for the financial management services and to what service provider those payments are made;
c. Actual and expected investment returns for each of the past 5 years;
d. Performance benchmarks for the financial management services. Please provide benchmarks, if any, that BCBSVT has used to evaluate the financial management program;
e. Executive variable compensation tied to asset performance.

BCBSVT's asset allocation strategy is based on the principle objective of achieving a stable level of current income to buffer experience in the underwriting cycle and the secondary objective of surplus growth. While BCBSVT aims to optimize the risk adjusted return on assets, this is constrained by the importance of stability and

minimizing risk to surplus and reserves (which is also consistent with Vermont law on insurer investments, 8 V.S.A. § § 3461 et. seq. and related regulations). The strategy requires ongoing balancing of regulatory and underwriting risk factors with investment risk in order to maintain a stable overall risk profile. The asset allocation strategy consists of investments that are oriented to safety of principal, liquidity, and income, such as money market funds and bonds, as well as investments that provide opportunities for growth, such as equities. Investments in asset classes such as alternatives and derivatives are not part of BCBSVT's current or historical allocation strategy.

BCBSVT obtains custody services from US Bank and Peoples United Bank for fees totaling $73,000 in 2017, investment advisory services from US Institutional for fees totaling $123,000 in 2017 and asset management services from Goldman Sachs Asset Management and Piermont Capital Management for 2017 fees totaling $274,000. Investment results are measured against relevant benchmarks for each asset class with actual total returns, net of fees, vs. benchmark monitored by BCBSVT's investment advisor, reviewed monthly by management and quarterly by the Finance Committee of BCBSVT Board.

Actual total return, net of fees vs. Benchmark for BCBSVT for each of the past 5 years:

	2013	2014	2015	2016	2017
Total BCBSVT Return, net of fees	3.33%	4.43%	0.66%	4.71%	6.29%
Benchmark (blended)	2.81%	4.56%	0.45%	4.93%	6.22%

No executive or employee compensation is tied to asset performance because, as noted, BCBSVT should not be incentivized to take undue risk with such assets.

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

Sincerely,

Ruth Greene
Vice President, Treasurer & Chief Financial Officer

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SUPPLEMENTAL COMPENSATION EXHIBIT

For the Year Ended DECEMBER 31, 2017
(To be filed by March 1)

PART 1 - INTERROGATORIES

1. Is the reporting insurer is a member of a group of insurers or other holding company system? Yes[X] No[ ]
   If yes, do the below amounts represent 1) total gross compensation paid to each individual by or on behalf of all companies that are part of the group: Yes[X] No[ ]
   or 2) allocation to each insurer: Yes[ ] No[X]

2. Did any person while an officer, director, or trustee of the reporting entity receive directly or indirectly, during the period covered by this statement any commission on the business transactions of the reporting entity? Yes[ ] No[X]

3. Except for retirement plans generally applicable to its staff employees, has the reporting entity any agreement with any person, other than contracts with its agents for the payment of commissions whereby it agrees that for any service rendered or to be rendered, that he/she shall receive directly or indirectly, any salary, compensation or emolument that will extend beyond a period of 12 months from the date of the agreement? Yes[X] No[ ]

PART 2 - OFFICERS AND EMPLOYEES COMPENSATION

1 Name and Principal Position	2 Year	3 Salary	4 Bonus	5 Stock Awards	6 Option Awards	7 Sign-on Payments	8 Severance Payments	9 All Other Compensation	10 Totals
1. Current Principal Executive Officer	2017	497,855	115,787					22,655	636,297
	2016	483,463	130,266					22,136	635,865
	2015	469,381	134,713					22,271	626,365
2. President of Affiliate - Cobalt Benefits Group	2017	275,078	114,694					75,855	465,627
	2016	267,126	107,869					74,551	449,546
	2015	259,346	101,891					74,537	435,774
3. Current Principal Financial Officer	2017	280,526	88,952					23,084	392,562
	2016	272,417	87,325					22,563	382,305
	2015	264,482	74,887					11,282	350,651
4. Vice President of Business Technology and Chief Information Officer	2017	266,990	94,868					15,530	377,388
	2016	259,038	94,656					10,850	364,544
	2015	247,280	64,589					10,856	322,725
5. Vice President and Chief Medical Officer	2017	250,000	39,855					21,896	311,751
	2016	236,784	33,166					10,688	280,638
	2015	226,999	2,764					8,608	238,371
6. Vice President of Consumer Services and Planning	2017	230,423	58,051					20,862	309,336
	2016	223,762	63,559					19,925	307,246
	2015	217,244	62,347					15,242	294,833
7. Vice President of Client Relations and External Affairs	2017	222,115	54,902					18,752	295,769
	2016	215,695	35,993					2,895	254,583
	2015								
8. Senior Medical Director	2017	241,889	5,102					11,342	258,333
	2016								
	2015								
9. Vice President and Chief Administrative Officer	2017	205,000	30,503					20,085	255,588
	2016								
	2015								
10. Chief Actuary	2017	217,566	26,366					9,870	253,802
	2016	211,229	30,050					9,654	250,933
	2015	204,909	29,083					8,859	242,851

PART 3 - DIRECTOR COMPENSATION

1 Name and Principal Position or Occupation and Company (if Outside Director)	Paid or Deferred for Services as Director 2 Direct Compensation	3 Stock Awards	4 Option Awards	5 Other	6 All Other Compensation Paid or Deferred	7 Totals
Board Chairperson	43,500					43,500
Board Member	32,700					32,700
Board Member	25,900					25,900
Board Member	25,750					25,750
Board Member	24,683					24,683
Board Member	22,900					22,900
Board Member	21,700					21,700
Board Member	20,450					20,450
Board Member	20,450					20,450
Board Member	20,050					20,050
Board Member	18,100					18,100
Board Member	16,150					16,150
Board Member	14,200					14,200

PART 3 - DIRECTOR COMPENSATION

1	Paid or Deferred for Services as Director				6	7
	2	3	4	5	All Other	
Name and Principal Position or Occupation and Company (if Outside Director)	Direct Compensation	Stock Awards	Option Awards	Other	Compensation Paid or Deferred	Totals
Board Member	8,250					8,250
Board Member	7,300					7,300
Board Member	7,050					7,050
Board Member	1,100					1,100

PART 4 NARRATIVE DESCRIPTION OF MATERIAL FACTORS

Provide a narrative description of any material factors necessary to gain an understanding of the information disclosed in the tables.

SUPPLEMENTAL COMPENSATION EXHIBIT (continued)

PART 4 - NARRATIVE DESCRIPTION OF MATERIAL FACTORS

Part 2: We have reported the compensation paid to the individual who serves as President of Cobalt Benefits Group, LLC ("Cobalt"). Cobalt bears the full cost of the compensation paid to its President. Cobalt is owned on a 50/50 basis by BCBSVT and Blue Cross and Blue Shield of Massachusetts ("BCBSMA"). It engages in the business of administering group benefit plans, for groups headquartered both inside and outside of Vermont. We have reported Cobalt's President's entire compensation, even though half of the cost of that compensation is effectively borne by BCBSMA.

The amounts disclosed in column 4-Bonus reflect payments related to BCBSVT's pay for performance incentive program. They are not bonuses given on a discretionary basis, but rather they represent the portion of each employee's compensation that is withheld and payable annually only upon achievement of pre-established performance metrics in the previous calendar year. The amounts reported in column 9-All Other Compensation include employer matching contributions under a defined contribution 401(k) plan, service awards, amounts paid for optional cash-in of combined time off (CTO) balances, rewards paid under BCBSVT's employee wellness program, taxable group term life, and other taxable fringe amounts as applicable. Not all employees receive payments in each of these categories every year. Additionally, the President of Cobalt receives an annual supplemental retirement benefit payment that is reported in column 9.

Two of the officers reported in Part 2 were eligible for benefits under a Supplemental Executive Retirement Program (SERP). Benefits under this program are not paid until after an officer retires from BCBSVT. The net periodic benefit cost incurred under the SERP program is accrued each year; these amounts are de minimus. There were no SERP payments made in 2017 to any of the individuals reported on this exhibit.

Part 3: Payment to Board members consists of annual retainers as well as meeting fees. There are different levels of retainer amounts for the Chair, Vice-Chair, committee chairs, and members.