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VIA ELECTRONIC MAIL

Michael Barber
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: **Blue Cross and Blue Shield of Vermont Small Group & Individual 2020 VHC Rate Filing (Docket no. GMCB-006-19rr); Non-Actuarial Questions #2**

Dear Mr. Barber,

Below please find BCBSVT's responses to the non-actuarial questions posed by the Board. As you mentioned in your letter posing the questions, this information is non-actuarial in nature; accordingly, these responses will not be filed in SERFF.

1. MLR Experience—Refer to Supplemental Health Care Exhibits (SHCEs) – Part 1, Line 7 (2015 – 2018):

The projected MLR for 2020 is 91.2%, slightly lower than 2019's projection of 91.8%. "Final Status" filings for 2015 – 2018 projected blended Individual/Small Group MLRs of 94.2%, 92.9%, 90.8%, and 92.5% respectively. However, the above-referenced SHCEs show actual MLRs for 2015 - 2018 of 87.1%, 92.5%, 94.2% and 97.5% respectively for Individual Coverage and 95.7%, 98%, 90.0%, and 93.2% respectively for Small Group Employer Coverage.

a. Separately for and by Individual Coverage and Small Group Employer Coverage, please summarize expected changes in Net Adjusted Premiums and Net Incurred Claims for 2020 and 2019 necessary to achieve the projected MLRs. Relative to reductions, if any, in Net Incurred Claims, please outline the approach for achieving the projected MLRs, especially for the Individual Coverage plans.

BCBSVT Response:
The projected MLR in each rate filing for the combined individual and small group risk pool is calculated in accordance with the ACA requirements from CMS. There is a CMS filing for reporting actual Medical Loss Ratios that is due by July 31 of the year

following each plan year. The actual MLR for the combined risk pool for years 2015, 2016 and 2017 were 92.0%, 92.6% and 93.1% respectively. As noted, projected MLRs in the filings for 2015, 2016 and 2017 were 94.2%, 92.9% and 90.8%. MLRs reported in the Supplemental Health Care Exhibit are necessarily reported in accordance with the NAIC requirements for that exhibit and are not the same as the calculation required by CMS for the combined risk pool. It is important to recognize that the unique, combined individual and small group market in Vermont makes it impossible to implement separate premium increases or claims reduction measures for individuals versus small groups. Financial results such as MLRs should be assessed on a combined individual and small group basis, reflecting the combined market. Because all corrective actions are necessarily identical for individuals and small groups, we do not distinguish between the two in this response.

Since the projected premium to be charged in any rate filing is the combination of expected claims costs plus the costs of paying the claims and administering the plans, the projected MLR for BCBSVT rate filings will consistently be within the 90-93% range. As such, this question highlights the inherent tension between affordability and access to care. In order to achieve a reasonable target MLR while minimizing premium increases, a necessary goal in a competitive market, a carrier must find ways to limit claims costs. All such limitations on claims by definition restrict access to care. The ideal solution is to restrict or eliminate unnecessary care or excessive provider reimbursements that will not impact network size. If these actions do not go far enough in limiting premium increases, harder choices need to be made regarding actions that will have a deleterious impact on access to care. This filing highlights a number of choices BCBSVT has made that will reduce claims costs without, in our judgment, unduly limiting access to care. Each of these initiatives could have been taken farther to produce even more premium savings through claims reduction, but BCBSVT determined that the resulting restriction in access to care would be too severe to warrant implementation. Please see the attached file, “Q1a chart.xlsx” for details.

Provider reimbursement, which also seeks to enhance affordability without unduly restricting access to care, will be addressed in our response to the second part of this question.

b. To rebalance the relationship between pressures for higher rates or reduced claims, how has your approach to provider reimbursement been affected?

BCBSVT Response: A critical goal of BCBSVT’s mission is ensuring that our members have access to the care they need at the best possible price. BCBSVT’s approach to provider payment supports this goal: first, ensuring that access to high quality care is not compromised; second, paying the lowest possible price for the services. To achieve these ends, BCBSVT negotiates with all hospitals in our local network and continuously adjusts community professional fee schedules. In both negotiated payment and fee schedule management, BCBSVT pushes provider payment as low as possible without

unduly limiting access. Even in the context of inadequate rates, BCBSVT is unable to compromise member access to needed care in favor of lower payments to providers because networks must be adequate pursuant to DFR Rule H-2009-03; further, provider payment must be sufficient to support a stable health care delivery system. BCBSVT believes strongly that it is paying providers as little as possible, without threatening member access to providers or threatening the stability of our health care system.

Additionally, as the GMCB has become more aggressive in the hospital budget review process, Vermont hospitals have consistently indicated that they are unwilling to remain in BCBSVT's network unless BCBSVT fully funds GMCB-approved increases to commercial rates.

2. Claim Adjustment Expenses and General and Administrative Expenses and Income from Uninsured Plans—Refer to SHCE-Part 1, Lines 8, 10, 12 and O2 (2015 – 2018):

For the above-referenced years, line O2 shows Covered Lives decreasing by 23% (from 26,942 in 2015 to 20,692 in 2018) for the Individual market and 16% (from 35,911 in 2015 to 30,227 in 2018) for the Small Group Employer market. During this same period, combined Claim Adjustment and G&A Expenses increased by 4.2% (from $11.99 million to $12.50 million) for the Individual market and 20.3% (from $12.8 million to $15.45 million) for the Small Group Employer market.

SHCEs for the same period show that Covered Lives for "Uninsured Plans" increased by 127% (from 49,063 to 111,407) while associated Claim Adjustment and G&A Expenses increased by only 23% (from $21.47 million to $26.39 million). Further, "Income from fees of uninsured plans" during this same period increased by 12% (from $31.6 million to $35.5 million). Such income is also allocated to expenses, such as federal taxes (Line 1.5) and "Improving Health Care Quality expenses" (Line 6.6). The "Notes" to BCBSVT's 2018 audited financial statement explain that "Under SAP . . . administrative fees received from ASC and ASO groups are recorded as an offset to administrative expenses".

a. Given the continued diminishment of "covered lives" in 2019 and 2020 in the Individual and Small Group markets and the apparent growth in the "uninsured market" as shown in SHCEs, why hasn't the offset to enterprise-wide administrative costs from fees paid by uninsured plans increased at a higher rate?

BCBSVT Response: Contrary to the premise of the question, BCBSVT has not experienced a 127% increase in "Uninsured Plans." As explained below, one large self-insured group customer moved from one type of self-insured arrangement to another type of self-insured arrangement; that is the figure cited in Question 2. The increase in fees collected is consistent with the overall increase in the self-insured market, which is about 8.5%.

BCBSVT's self-insured business includes two primary products: (1) Cost Plus, and (2) Administrative Services Only (ASO). In both products, the employer group is at risk for the claims expense; because BCBSVT is not taking risk on the claims, these are both uninsured products from BCBSVT's perspective. The principal difference between the two is that Cost Plus is sold with a "stop loss" component, under which BCBSVT charges the group a stop loss premium and accordingly credits the group for any high dollar claims above an agreed upon "attachment point." The specific terms of the stop loss agreements, including attachment points, vary by group, but the basic premise is the same. Because of the stop-loss premium, Cost Plus membership is reported in column 11 of the SHCE. ASO membership is reported in column 14. The fees for both are reported in column 14.

The actual membership contributing to the "Income from fees of uninsured plans" was 103,040 in 2015 (53,977 – Cost Plus; 49,063 – ASO) and 111,821 in 2018 (414 – Cost Plus; 111,407 – ASO), an increase of 8.5%, which drove the corresponding increase in fees collected. What BCBSVT has experienced during the timeframe from 2015 – 2018 is not substantial growth in the total "uninsured" market, but rather a significant migration of membership from Cost Plus products to ASO. Most notably, BCBSVT's largest self-funded group customer migrated from Cost Plus to ASO at the beginning of 2018. This is why the membership reported in column 11 of the SHCE has declined dramatically since 2015, and the membership in column 14 has increased by a similar amount.

3. Cost Shift

During the 2019 QHP hearing, a BCBSVT representative testified as follows: There is one other policy consideration I want to address and that's the cost shift. Because Medicare and Medicaid do not fully fund what they pay providers, in other words, provider costs are not fully funded by what Medicare and Medicaid pays them, those costs need to be shifted to private commercial payers. That includes individuals, small businesses and large groups. It's arguable that the large employers have the deep pockets that are necessary to bear the burden of the cost shift and continue to pay a substantial portion of the premium on behalf of their employees. It is arguable as to whether individuals and small groups who are paying these costs out of their pockets can or should also bear the burden of the cost shift.

a. Can BCBSVT provide an estimate of the burden on 2020 Individual and Small group premiums attributable to the Medicare and/or Medicaid cost shifts?

BCBSVT Response: Using reports published by the GMCB, we calculate that nearly 35 percent of commercial revenue at Vermont hospitals in 2018 could be attributed to the cost shift:

Total Revenue for all Vermont Hospitals[1]	$2,522,220,446
Percentage of Hospital Revenue that is Commercial[2]	55.8%
Total Commercial Revenue at Vermont Hospitals	$1,407,399,099
Total Vermont Hospital Cost Shift through 2018[3]	$490,885,653
Percentage of Commercial Spend Attributable to Cost Shift	34.9%

We then projected the results to 2020 by assuming that all commercial trend in excess of the All-Payer Model target of 3.5 percent is attributable to the cost shift. Put differently, we used total medical trend of 3.5 percent for Vermont hospitals and hospital-owned physicians rather than the assumed trend in the initial filing. The resulting calculation leads to a rate decrease of 16.8 percent from filed rates if the cost shift at Vermont hospitals were to be completely eliminated by 2020. Of course, the cost shift also exists for independent Vermont physicians, out-of-state providers, ancillary services and retail prescription drugs; however, the public data needed to estimate the rate impact of the additional cost shift for providers outside the purview of the GMCB is not available. If a cost shift similar to that for medical services in Vermont exists for all providers, for all benefits in- and out-of-state, the rate decrease for eliminating such a cost shift would be just over 30 percent.

b. What actions, analyses, testimony, etc. has BCBSVT engaged in related to mitigating the cost shift during the past year in anticipation of the 2020 Individual and Small Group filing?

BCBSVT Response: As the Board observed in its Annual Report for 2018, "[t]he cost shift occurs when hospitals and other health care providers charge higher prices for services paid by commercial insurance payers to make up for lower reimbursements from Medicare and Medicaid, and to cover the cost of health care services that are provided but not paid for (uncompensated care)." Green Mountain Care Board, Annual Report for 2018, at 12 (Jan. 15, 2019). The Annual Report also points out that, with one exception, the cost-shift to commercial payers has grown every year from FY08 through FY17. *Id.*

As the Board's description of the cost-shift recognizes, this dynamic results from the pricing decisions of hospitals and other providers, as they in turn react to the lower

[1] Fiscal Year 2018 Vermont Hospital Budgets: Year-End Actuals Reporting, https://gmcboard.vermont.gov/sites/gmcb/files/FY18%20Actuals%20Report-%20March%2021%20update.pdf, (last visited July 15, 2019)
[2] Vermont Community Hospitals System Trends, https://gmcboard.vermont.gov/sites/gmcb/files/Copy%20of%20H__One_Page_Hospital_Summary_REPEATING_updated_no_links.pdf, (last visited July 15, 2019)
[3] Summary of Fiscal Year 2018 Approved Hospital Budgets, https://gmcboard.vermont.gov/sites/gmcb/files/Summary%20of%20FY18%20Approved%20Budgets.pdf, (last visited July 15, 2019)

reimbursement rates they receive from Medicare and Medicaid. BCBSVT does not have the direct ability to influence providers' pricing decisions; that would require regulatory action, such as the rate-setting envisioned by 18 V.S.A. § 9376, or the ACO budget review framework enumerated in 18 V.S.A. § 9382. Nonetheless, while BCBSVT has no direct role in the decisions of state and federal authorities to set Medicare and Medicaid reimbursement rates, which generally underfund the health care goods and services in question, BCBSVT supports any efforts to increase these payments to levels that would mitigate the cost shift to commercial consumers

BCBSVT negotiates with providers in order to moderate their price increases, and thereby moderate the rate increases BCBSVT must then pass on to its policyholders. To the extent it is able to do so, those efforts work to mitigate the cost shift. However, its ability to do so is limited, given the reality that hospitals and providers rely on BCBSVT and other commercial payers to fund the shortfall between public-payer reimbursement and the corresponding health care goods and services.

4. Pharmacy—Refer to SHCE-Part 1, lines 2.2 and 2.3:

The data in the table below is from the referenced BCBSVT SHCE-Part 1 submission for 2015—2018. [See table in Board's July 8 letter]

a. In 2019 and for 2020, what expectations does BCBSVT have that the recent rate of rebate growth profiled below will continue?

BCBSVT Response: The significant growth in rebates in 2018 was due to the implementation of the ESI National Preferred Formulary (NPF), and was anticipated in the 2018 actuarial filing. Rebates also increased substantially in 2017 as BCBSVT worked with ESI to make a number of adjustments to the previous formulary intended to drive rebate improvement and bring the formulary closer in line with the NPF. These were "one time" savings opportunities. That said, while BCBSVT does not expect to make these same sorts of impactful formulary changes in 2019 and 2020, we will continue to work with our pharmacy benefit manager to maximize rebates. We reflect this work in our choice of a 10.6 percent trend on rebates from 2018 through 2020. Retail pharmacy initiatives to improve network pricing and maximize rebates decreased 2020 premiums by 0.9 percent.

Please contact me if you have any questions about the above.

Sincerely,

/s/ Michael Donofrio
Michael Donofrio

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Detailed response to Question 1a

Category	BCBSVT Action	Impact on: Affordability[1]	Impact on: Access to Care	Rejected Action	Impact on Access to Care
Pharmacy Contracting	BCBSVT has continued to work closely with its pharmacy benefit manager to improve network pricing and maximize rebates. This included moving to a more restrictive formulary in 2018 in order to enhance rebates.	-2.7%	Over a thousand members had their pharmacological treatment disrupted by the change in formulary, but BCBSVT was extremely proactive in communication efforts and member complaints were minimal.	A more draconian formulary could generate additional cost savings.	Member disruption could be significant.
Health Care Reform	BCBSVT continues to be a driver of health care reform efforts. BCBSVT is working closely with our network providers and OneCare Vermont to maximize our collaborative clinical reach focusing on reducing overall medical costs.	-1.2%	Clinical efforts through 2020 are designed to enhance access to care while eliminating unnecessary utilization, such as hospital readmissions and avoidable emergency room use.	Building more aggressive savings into premiums would reduce ACO targets and make it less likely that savings could be achieved.	Overly aggressive targets would likely impact the number of providers willing to join OCV's commercial network.
System Enhancements	Due to operating system enhancements, BCBSVT is now able to more rigorously enforce the requirement that members who are eligible for Medicare Part B should be enrolled in Part B such that their BCBSVT insurance is secondary to Medicare.	-0.6%	Members who are eligible for Part B but not enrolled will have to pay out of pocket for Medicare's share of services.	N/A	N/A
Lab Benefit Management	BCBSVT has entered into a shared savings arrangement with a lab benefit manager that combines a new fee schedule, a tighter contract governing the use of out of network laboratories by network providers, and a shared savings program.	-0.4%	More stringent management of out-of-network laboratories lead to some providers and patients switching to in-network labs.	BCBSVT is pursuing the next iteration of stricter network management, but does not expect to implement prior to 2021.	Care must be taken to ensure that members will not be left footing the bill when a provider writes a script for an non-network lab
Home Infusion Therapy	The Convenient Care program, which offers qualified patients the opportunity to have their infusion therapies done in the comfort of their homes by trained nurses, improves outcomes by reducing the risk of facility-borne infections.	-0.05%	Members have been slow to enroll in this program voluntarily, limiting the savings opportunity.	BCBSVT could consider making the Convenient Care program mandatory. The potential savings impact is approximately $50,000 per patient.	Infusion in a hospital setting would no longer be a covered benefit for patients not meeting certain clinical exception criteria.
Specialty Rx Utilization	In 2019, BCBSVT started requiring members to fill their prescriptions at a limited number of specialty pharmacies in its exclusive specialty pharmacy network.	-0.5%	Members cannot use specialty pharmacies that are not in the exclusive specialty network. Disruption was limited, and member complaints virtually nonexistent.	A carrier could indicate in its member materials the existence of a specialty pharmacy tier, thereby disincentivizing specialty users from enrolling in the plan.	Members would fear exorbitant out-of-pocket costs for their life-saving medications. BCBSVT would never consider this type of action.
Preventive Care	All BCBSVT VISG plans offer preventive care with zero cost sharing for the member. BCBSVT will continue to partner with OneCare Vermont focusing not only on increased access to primary care but appropriate follow up addressing gaps and transition in care.	+1.9%	In the case of preventive care, BCBSVT is aligned with the State in valuing improved access to care and improved quality of care over short-term improvements in affordability.	Ceasing programming to increase access to primary care would lead to immediate cost savings, improving short-term affordability.	While access would not necessarily be diminished, neither would it be enabled. Long-term affordability and quality of care would be compromised.

[1]Two-year rate impact from 2018 to 2020