STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Individual Market Rate Filing	))))	GMCB-005-21rr SERF No. BCVT-132829271
In re: Blue Cross Blue Shield Vermont 2022 Vermont ACA Market – Small Group Market Rate Filing	)))	GMCB-006-21rr SERF No. BCVT-132829562

RESPONSE OF BLUE CROSS TO JUNE 7, 2021 BOARD QUESTIONS

Blue Cross and Blue Shield of Vermont provides the following responses to the Board's June 7, 2021 questions:

Question 1

For each filing, specify the percentage of the proposed premium (not premium increase) and the projected PMPM claims expenditures associated with spending at hospitals under the budget review jurisdiction of the Green Mountain Care Board, broken down by inpatient, outpatient, and physician services.

Response

The table below shows the proportion of total premium and PMPM for hospitals under the budget review jurisdiction of the GMCB. Note that the table shows the percentages and PMPM as filed and does not reflect changes discussed during the review process.

Claims Category	Individual Market		Small Group Market	
	Percent of Premium	PMPM	Percent of Premium	PMPM
Inpatient Facility	8.4%	$59.28	10.2%	$61.17
Outpatient Facility	21.9%	$155.28	20.8%	$124.97
Medical Pharmaceuticals	9.3%	$66.21	8.0%	$48.01
Professional Services	5.5%	$39.16	5.7%	$34.40
Total for hospitals under the budget review jurisdiction of the GMCB	**45.2%**	**$319.92**	**44.7%**	**$268.56**

Question 2

Explain how BCBSVT expects the Transparency in Coverage final rule and the Hospital Price Transparency final rule to impact insurer/provider contracting, if at all.

Response

The transparency in coverage rule does not require public data reporting to begin until 2022 and thus will not affect insurer/provider contracting in a manner relevant to the proposed 2022 rates. *See* Transparency in Coverage, 85 FR 72158-01, 72176 (Nov. 12, 2020). It remains to be seen whether the rule will have an impact on insurer/provider contracting, but it couldn't possibly affect contracts prior to 2023.

The hospital price transparency rule (45 CFR § 180.10 *et seq*.) requires hospitals to provide publicly both a comprehensive machine-readable file with standard charges for all items and services and a display of shoppable services in a consumer-friendly format by January 1, 2021. *See* 45 C.F.R. § 180.40.

[redacted]

[redacted]

Question 3

For the most recent year for which data are available, specify the percentages of payments made by BCBSVT under each APM category below across its individual and small group plans. The categories below are described in more detail in the Health Care Payment Learning & Action Network's Alternative Payment Model Framework Final White Paper dated January 12, 2016, available at https://hcp-lan.org/workproducts/apm-whitepaper.pdf and are the subject of issuer reporting in the QIS Implementation Plan and Progress Report Form, OMB 0938-1286.

Category 1 – Fee for Service – No Link to Quality & Value _____%
Category 2 – Fee for Service – Link to Quality & Value _____%
Category 3 – APMs Built on Fee for Service Architecture
- **APMs with Upside Gainsharing _____%**
- **APMs with Upside Gainsharing/Downside Risk _____%**

Category 4 – Population-based Payment

- **Condition-Specific Population-Based Payment _____%**
- **Comprehensive Population-Based Payment _____%**

Response

The table below shows the percentages of claims for the ACA market (individual and small group) for calendar year 2020 by the APM Framework categories:

Category	Percentage
1. Fee for Service – no link to Quality % Value	50.2%
2A. Fee for Service – Link to Quality & Value – Foundational Payments for Infrastructure & Operations	0.1%
2B. Fee for Service – Link to Quality & Value – Pay for Reporting	0%
2C. Fee for Service – Link to Quality & Value – Rewards for Performance	0%
3A. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing	0%
3B. APMs Built on Fee-for-Service Architecture – APMs with Upside Gainsharing/Downside Risk	49.8%
4A. Population-Based Payment – Condition-Specific Population-Based Payment	0.0%
4B. Population-Based Payment – Comprehensive Population-Based Payment	0.0%

Question 4

Describe in detail BCBSVT's efforts and plans to increase the use of higher-value payment approaches and its efforts and plans to implement fixed prospective payments within its ACO program in Vermont.

Response

Blue Cross has worked to engage providers across its network in value-based reimbursement but has been met with significant caution from providers who have expressed concern about re-engineering financial workflows, challenges with their electronic medical record systems, and the disruptions of the pandemic. Our efforts have focused on working with our hospital partners, since most provide both professional and hospital-based services. This offers the opportunity for holistic

approaches to reimbursement. Our value-based contracting work is informed by the goals of the Triple AIM:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

While providers support the three tenets, there is an unwillingness to be paid less money – reducing the per capita cost of care – even in the context of value-based reimbursement. Additionally, value-based reimbursement has an associated level of risk that providers are reluctant to assume. We have or had some programs in place, with varying degrees of success with provider engagement and overall programmatic results.

As part of its participation in the ACO, Southwestern Vermont Medical Center has agreed to accept fixed payments. No other hospital has been willing, thus far, to follow suit.

Despite the significant uncertainty brought on by the pandemic and the reluctance of many providers to adopt the fixed payments, we made significant progress in 2021, adding 11 professional practices to the OneCare Vermont fixed payment program. In addition, to ensure that we continue to advance toward fulfilment of the APM goals, several Blue Cross senior leaders have joined the fixed prospective payments workgroup convened by the Agency of Human Services to help devise strategies to speed the transition to a fixed payment system that meets the needs of providers and our rate payers. We also continue to work directly with OneCare on strategies to advance fixed payments.

Question 5

Explain how BCBSVT defines and measures low value care and whether has [sic] it has estimated the amount of low value care provided in Vermont.

Response

Blue Cross defines low value care using the University of Michigan Center for Value-Based Insurance Design definition: "Services that provide little or no benefit to patients, have potential to cause harm, incur unnecessary cost to patients, or waste limited healthcare resources." We address low value care through medical policies, payment policies, and utilization management.

Although we work to assist providers and patients in reducing low value care, the critical moment for identifying low value care is typically at the time of treatment. That's because what is "low value" in one setting with one patient can be high value in another setting with a different patient. As a result, much of the low value care in the system needs to be addressed by providers when working with their patients.

We do not specifically estimate the total amount of low value care provided to Blue Cross members because a global low value care definition has not yet been fully standardized and accepted. *See* Eline F. de Vries et al., *Are low-value care measures up to the task? A systematic review of the literature*, BMC Health Serv. Res. 16, 405 (Aug. 2016), available here. To minimize low value care, Blue Cross focuses on policies and procedures that protect patient safety, prevent overtreatment, and support high quality, cost effective care. We also target specific areas where we have concerns for either persisting issues of low value care, or safety, such as the use of benzodiazepines in the elderly. Because low value care often can only be determined at the point of care, there is a balance between limiting low value care and interfering in the patient-provider relationship.

For the Board's reference, the two studies cited below address regional variations in low value care. Both indicate that the prevalence of low value care in Vermont is not as high as other parts of the country.

Research Consortium for Health Care Value Assessment, *Estimating State-Level Prevalence of Low-Value Care Services Among the Privately Insured, 2015* (January 2020), available here.

Allison H. Oakes et al., *Systemic overuse of health care in a commercially insured US population, 2010–2015*, BCM Health Services Research (May 2019), available here.

Question 6

Provide an update on CivicaRX and the timing of its introduction of generic drugs into the market. Explain whether the filing contains any assumptions related to CivicaRX.

Response

The precise timing of CivicaScript's introduction of generic drugs into this market is currently unknown. At its most recent board meeting, the leadership of CivicaScript gave an update on the construction of the new manufacturing facility in Petersburg, Virginia. Work has begun on the foundation of the building, and the vertical build is expected to begin this month. In addition to the production capacity of this facility, CivicaScript is contracting with existing generic drug manufacturers to have them use some of their excess capacity to produce drugs on behalf of CivicaScript. That contracting process has been ongoing. There have also

been negotiations with various retail pharmacies for distribution of the CivicaScript versions of these drugs. That distribution network will be bolstered by OptumRx's mail order pharmacy. In total, about 15 to 20 percent of our total volume is represented in those pharmacies. While the manufacturing capacity and distribution network are being finalized, there is not a specific launch date yet for the targeted drugs.

The filing does not contain assumptions related to the impact of CivicaScript. We will build the impact of CivicaScript into future projections once a launch date becomes clear.

Question 7

Explain whether the filing contains any assumptions related to the impact of ambulatory surgery centers and, if it does, describe in detail what those assumptions are and how they were calculated.

Response

Yes, the filing reflects the impact of the ambulatory surgery centers in both the experience period and the outpatient trend selection.

The Green Mountain Surgery Center (GMSC) opened in July 2019. Through April 2021, the GMSC has saved approximately $5 million in health care cost to Blue Cross members[1] by offering surgery at approximately half the cost of other facilities in the region. Of this total, approximately 20 percent, or $1.3 million, are for members in ACA products.

For the ACA markets, in 2020, Blue Cross achieved 52 percent savings for the surgeries performed at the GMSC. These savings, totaling $554,000, are included in our experience and reduce starting allowed charges by 0.2 percent.

These lower cost services are also reflected in the outpatient trend calculation and selection. The selected outpatient trend of 0.3 percent would have been 0.2 percent higher without the savings generated by the GMSC. This would in turn have generated a combined average rate increase 0.1 percent higher than filed.

[1] Including members insured with the Federal Employees Program and other Blue Cross plans.

Overall, GMSC lowered premiums by 0.3 percent, or approximately $0.8 million, for the ACA market in 2022.

It is important to note that there is an inherent cap to the savings generated by the GMSC given the limited scope of services they have been approved to provide.

Question 8

Specify the number of members directly enrolled in BCBSVT plans and describe in detail the efforts BCBSVT has made to date and will make prior to open enrollment to inform these individuals of the subsidies that may be available to them if they purchase a qualified health plan through Vermont Health Connect.

a. At the hearing, please be prepared to explain how many directly enrolled members have enrolled through Vermont Health Connect for the 2021 plan year.

Response

As of May 31, 2021, Blue Cross had 4,682 members (2,707 subscribers) directly enrolled in its plans.

Plan	Subscribers	Members
Catastrophic	108	110
Standard Bronze	92	150
Standard Bronze CDHP	99	164
Standard Bronze Integrated	55	87
Standard Gold	228	413
Standard Platinum	397	691
Standard Silver - Reflective	568	1005
Standard Silver CDHP - Reflective	148	268
Vermont Preferred Bronze	77	133
Vermont Preferred Gold	86	145
Vermont Preferred Silver - Reflective	165	283
Vermont Select Bronze CDHP	238	421
Vermont Select Gold CDHP	318	568
Vermont Select Silver CDHP - Reflective	128	244
Total	2,707	4,682

As of June 18, 2021, 226 subscribers had made the switch from directly enrolled to VHC enrolled.[2]

In March 2021, with the passage of the American Rescue Plan, we began collaborating with the Department of Vermont Health Access to ensure that Vermonters have access to current and timely information and decision-making tools.

At the time, we immediately recognized the importance of connecting Vermonters to this information and what it meant for their monthly expenses or for their tax rebates come spring of 2022.

We worked diligently to enable the Vermonters enrolled directly with us to transition to Vermont Health Connect and take full advantage of the premium tax credits available to them.

We communicated these changes in early April and last week through letters targeted at our direct enroll population. Both letters were reviewed and approved by DVHA.

In addition to the letters, we have developed a web resource[3] center to help find important answers and tools. On the site we provide answers to frequently asked questions as well as a self-serve tool designed to help people calculate their subsidies. We will also update our website as Vermont Health Connect's site is updated.

In addition to the targeted mailings, our team also made outbound phone calls to members to ensure that these communications were clear and appropriate. To further strengthen communications, we are also using search engine optimization to help consumers find information about subsidy eligibility. Furthermore, our in-house service and sales team is fully trained and ready to assist any consumer who calls into our call-center with information about how to research their eligibility for subsidies and guidance on how to enroll through Vermont Health Connect. As we work on open enrollment communications and advertising, we will continue to include information about subsidy eligibility.

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[2] Per weekly report provided by DVHA.

[3] https://www.bcbsvt.com/individual-and-family-health-insurance-plans/the-american-rescue-plan.

Once Vermont Health Connect is able to display the new subsidy values, we will continue to evolve our message about the importance of the American Rescue Plan and how Vermonters can take advantage of this savings. The channels we are considering at this time are social media, email marketing, and direct mail.

The number of transfers to-date has been low, but the expectation is that this will increase when Vermont Health Connect is fully operational.

Question 9

Provide support for BCBSVT's assumption that approximately 13.2% of households enrolled through Vermont Health Connect paid their premium by credit or debit card and explain whether the information BCBSVT received from Vermont Health Connect was broken down by carrier.

Response

On March 25, 2020, the Department of Vermont Health Access provided Blue Cross with the monthly counts of Blue Cross subscribers who had paid their premiums by credit or debit card in 2020. Blue Cross compared those counts to our total enrollment in the individual market to calculate the 13.2 percent figure.

Question 10

Explain whether there are any national benchmarks relating to recoveries from carrier fraud, waste, and abuse programs and how BCBSVT monitors or evaluates the effectiveness of its fraud, waste, and abuse program.

Response

Health insurers do not have national benchmarks for fraud, waste, and abuse (FWA) activities, as the degree of FWA varies substantially from state to state. For example, in the 2015 report to Congress from CMS, Vermont had the lowest Medicare overpayment to beneficiaries of all 50 states. *See* http://medicareintegrity.org/wp-content/uploads/2015/02/StateWastePerBeneficiaryFinal.docx.pdf

A commonly cited study in the Journal of the American Medical Association looking at waste in the US health care system found that waste accounts for

approximately 25 percent of the dollars spent within the health care system. It is crucial to understand that the definition of "waste" considered by this and other published studies is far broader than the "waste" that can or could be addressed within an insurance carrier's FWA program. Specifically, the JAMA study includes such categories as "administrative complexity" and "pricing failure" that are clearly well beyond the scope of an FWA program as contemplated by this question. Narrowing the definition of "waste" to include only the FWA domains specific to a commercial carrier's FWA programming yields a result of roughly 3 percent waste. *See* William H. Shrank, MD et al., *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, JAMA 2019; 322(15):1501-1509 (October 2019), available here.

Blue Cross follows the National Healthcare Anti-Fraud Association (NHCAA) recommended processes for ensuring a strong FWA program that contains the following components:

- Our anti-fraud plan, which includes all of the detection methods and controls we have in place to deter and identify FWA.
- Strong clear corporate commitment.
- Detection methods with strong data mining capabilities.
- Communication with regulatory and Medicare and Medicaid agencies.
- Documentation of recoveries, savings, avoided costs.
- Detailed policies and procedures.
- Ongoing training for FWA staff and annual training in FWA for all employees.
- Confidential fraud hotline and email available to members, providers, and employees.
- Ongoing monitoring and auditing.
- Provider termination policy.

The Blue Cross and Blue Shield Association provides support and guidance to the Blues plans nationally for best practices and standards for FWA detection and prevention. We also work closely with our state Medicaid program to share information about FWA activity in our marketplace.

Along with our in-house programs, we use a variety of vendors to evaluate and audit providers. These vendors employ sophisticated data analytics to discover FWA in claims data. These vendors often pay for their fees by retaining a portion of savings. Because the vendors work on a paid commission based on the savings for claims we agree should be adjusted, they are incentivized to find errors. Before

we take a recommendation from a vendor and take any action against a provider, we review each claim to make sure that the vendor's recommendation is in line with our medical policies, our clinical guidelines, and our provider and member contracts, and that the claim has reached final adjudication.

Our vendors use proprietary software that identifies specific outlier claims to audit. Our payment integrity division looks for trends in their findings and has performed more extensive audits to investigate and identify additional claims to perform recoveries and evaluate internal controls that may be needed to identify the FWA found, such as creating a new payment policy. Our payment integrity division is also developing new benchmarking and metrics.

We monitor the financial impact and savings of our vendors and these savings are reflected in our rate filings. Normally previous FWA activity flows naturally through the experience underlying our rate development, but because of the disruption over the past two calendar years—including the rollback of FWA activities in 2020 due to the pandemic and the cyberattack on UVMHN—we are making the aggressively optimistic assumption that FWA savings will return to 2018 levels, the peak of historical program savings.

Once a set of practitioners is audited, information about the audit, suggested best practices from us, and sanctions (if any) spread to other practitioners. These additional "audit aware" practitioners make an extra effort to ensure that billings are accurate and in compliance with BCBSVT payment policies. This lateral spread of best practices helps to keep the amount of FWA within Vermont lower that it might otherwise be.

While we continually enhance our programs through the use of data analytics, we also recognize the challenges inherent in aggressively pursuing additional fraud recoveries. New programs are often difficult to implement due to provider pushback.

Question 11

Page 50 of the actuarial memorandum contains a reconciliation of SHCE and GAAP accounting for 2020. Please provide the same information for 2018 and 2019.

Response

The Supplemental Health Care Exhibit (SHCE) is on a statutory accounting basis (as promulgated by the NAIC), while the administrative charges in this filing were developed based on GAAP accounting.

In the SHCE, administrative expenses are included in lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4. Line 1.5 also includes an allocation of federal income taxes that are not part of administrative expenses. Those must be excluded to reconcile to statutory basis administrative expenses. Statutory and GAAP accounting treat some expenses differently, mainly related to network fees and pension costs. The following chart demonstrates a reconciliation of the SCHE to GAAP base period administrative charges:

Individual and Small Group		**CY 2018**	**CY 2019**
SCHE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	$37,401,260	$26,846,448
Less taxes in SCHE 1.5 that are not admin [4]	B	($2,759,515)	($1,138,520)
Total administrative charges - STAT basis	C = A – B	$40,160,775	$27,984,968
Differences in STAT and GAAP treatment	D	($2,236,734)	($2,102,889)
Total administrative charges - GAAP basis	E = C + D	$37,924,041	$25,882,079

Question 12

In Section 2.1 of the actuarial memorandum, BCBSVT notes that its provider network includes "over 96 percent of the providers in Vermont." Describe what characterizes the 4% of providers not included in BCBSVT's provider network.

Response

The table below shows the top four provider specialties included in the 4 percent of providers not included in Blue Cross's EPO network

[4] Note that Blue Cross had an income tax benefit, or negative income tax expense, for 2018 and 2019.

Specialty	Percentage
General Practice Dentistry	1.0%
Ambulance Services	0.9%
Oral Surgery Dentist	0.6%
Psychologist	0.3%
All other specialties (less than 0.1% each)	1.1%
Total Non-Participating Providers	**3.9%**

Question 13

The Board is working to better understand the variability in reimbursements paid to hospitals. How long would it take BCBSVT to calculate the following and does it have any alternative approaches that could be done sooner?

For each Vermont general/community hospital and for Dartmouth-Hitchcock, the ratio of BCBSVT's inpatient reimbursement to Medicare's inpatient reimbursement, standardized by MS-DRG relative weights, and the ratio of BCBSVT's outpatient reimbursement to Medicare's outpatient reimbursement, standardized by APC relative weights.

Blue Cross responded to the above inquiry on June 11, 2021, and respectfully refers the Board to that response. Below, Blue Cross responds to the following question provided by the Board after the June 11 response:

The Green Mountain Care Board requests that when Blue Cross and Blue Shield of Vermont (BCBVT) responds to the Board's June 7 questions, it provide the information described in its June 11 response to question 13.

Response

Blue Cross can provide a comparison of Vermont hospitals and Mary Hitchcock Memorial Hospital in New Hampshire, looking at the relative costs between hospitals. This information is used to inform our contracting activities. As a reminder, there are significant limitations with the data, which do not show how a hospital's reimbursement compares to Medicare reimbursements. Looking at inpatient, outpatient, and professional services separately and in isolation could lead to incomplete or inaccurate conclusions.

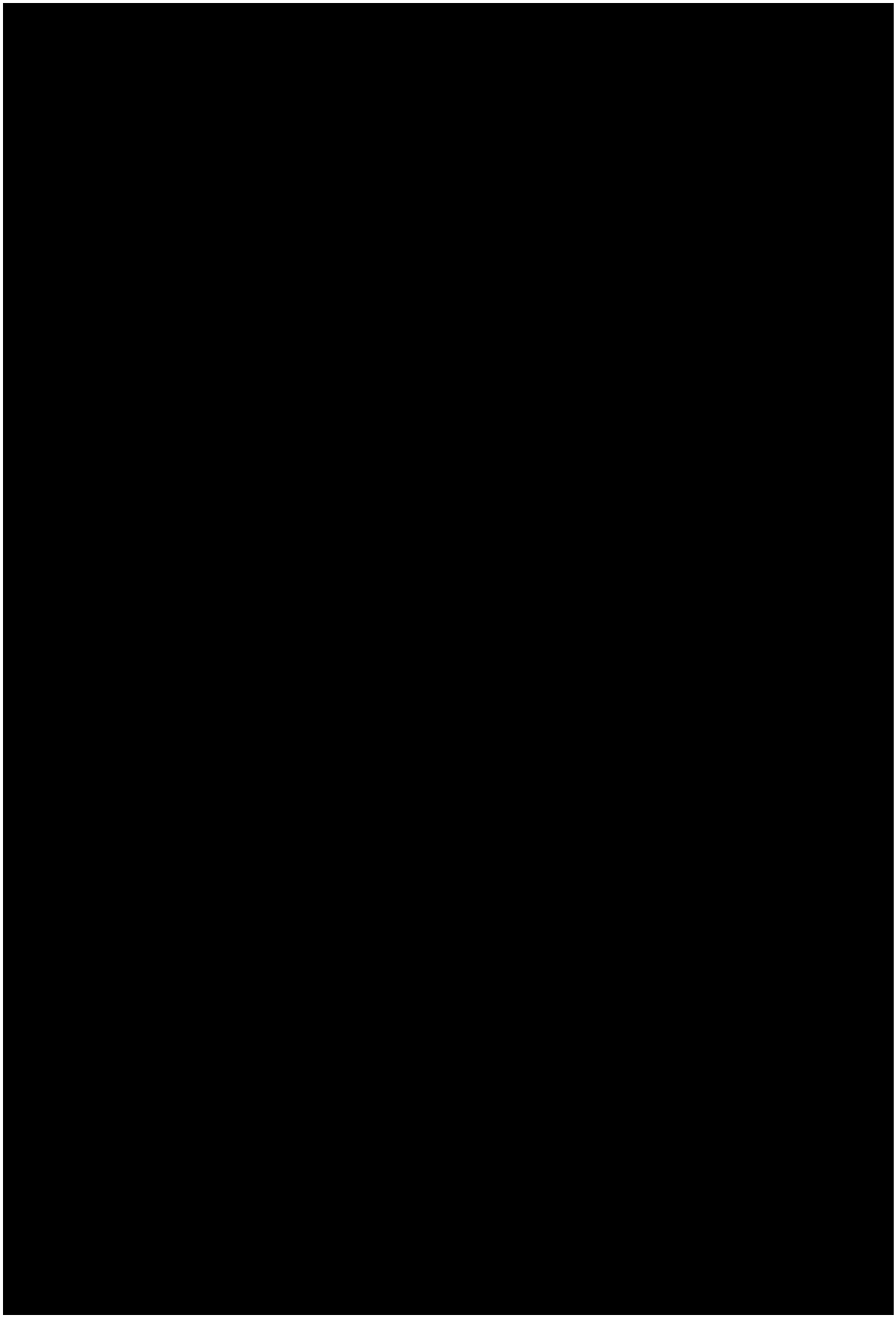
Challenges to using the data in a meaningful way include:

1. The relative comparisons do not account fully for the differences in the severity and scope of inpatient services provided at each hospital. There are material differences in what each hospital offers to its community. For example, while there are eight Critical Access Hospitals (CAH) in Vermont, they do not provide identical services and they offer services that are based, in part, on community needs. Further, as a tertiary academic medical center, UVMMC attracts a broader range of patients, including those with higher risks, that other hospitals in the state do not or cannot treat. Looking at one number does not allow for that nuanced view.

2. The relative comparisons do not account fully for the differences in the outpatient service mix at each hospital. While it is safe to assume that most hospitals offer many of the same outpatient services, e.g., radiology, laboratory/pathology, PT/OT, and surgical services, the weighting of those services varies materially by hospital. For example, one hospital's outpatient dollars may be derived almost exclusively from radiology and laboratory/pathology services, while another's top category may be surgical services. Again, one number does not fully capture these important differences.

3. The relative cost charts below do not incorporate professional costs. Professional costs will vary by facility particularly at the academic medical centers which have proprietary fee schedules. [redacted]

[redacted]



Dated: June 25, 2021

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that I have served the above Response on Michael Barber, Laura Beliveau, Thomas Crompton, and Christina McLaughlin of the Green Mountain Care Board; and Jay Angoff, Kaili Kuiper, and Eric Schultheis, counsel for the Office of the Health Care Advocate, by electronic mail, return receipt requested, on June 25, 2021.

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