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

BLUE CROSS'S RESPONSE TO
THE BOARD'S JULY 22 POST-HEARING QUESTIONS

Blue Cross and Blue Shield of Vermont provides the following responses to the Board's July 22, 2021 post-hearing questions:

Question 1

On page 4 of his supplemental pre-filed testimony (Ex. 21), Mr. Schultz calculated an average net premium decrease of at least 4.3% for BCBSVT members in the individual market if the Board approves the rates of both carriers as recommended by L&E. What would the average net premium change for BCBSVT members in the individual market be if the Board reduces both carriers' rates by 1.0%, 2.0%, and 3.0% more than L&E recommended? Explain why the results do or do not differ from the calculated -4.3%.

Response:

Preliminarily, we note that to the extent the Board is considering cutting MVP's rates below L&E's recommendations and then imposing parallel cuts on Blue Cross merely to maintain a certain relationship between the rates, that approach is neither warranted nor authorized by any applicable legal standard. If the Board is contemplating such a change to Blue Cross's proposed rates based on cuts to MVP's rates, we respectfully request that the Board advise the parties in all dockets of that fact and allow the parties to provide legal briefing and supplement the record as needed.

In addition, we note that any cut to the proposed rates that is not justified on its own merits under 8 V.S.A. § 4062 and GMCB Rule 2.000, § 2.301(b) would be arbitrary and contrary to law. By modeling the scenarios posited in Question 1, Blue Cross is not waiving any of the arguments discussed above.

Subject to the above, Blue Cross was able to model the proposed scenarios, as we demonstrate below.[1] It is critical to understand that examining average results fails to tell a complete story. Subsidies are calculated using a combination of the premium for the second lowest silver plan and each household income level. Under the ARPA, households cannot pay more than the following percentages of their income on the premium of the second lowest silver plan:

Income Brackets in ARPA			
Low end of FPL Range	High end of FPL Range	Low end of maximum premium contribution	High end of maximum premium contribution
0	150	0.0%	0.0%
150	200	0.0%	2.0%
200	250	2.0%	4.0%
250	300	4.0%	6.0%
300	400	6.0%	8.5%
400	Unlimited	8.5%	8.5%

For example, a single person making $45,080 has an income of 350 percent of the federal poverty level. This individual would therefore have a maximum premium contribution of 7.25 percent of the premium of the second-lowest Silver plan, or $272.36 per month. If enrolled in a Bronze plan, this member would see their net premium *increase* if gross premiums for all plans were reduced. The table below demonstrates the impact of a three percent reduction to gross premium for such an individual:

		L&E recommended rates	Reduction of 3% from L&E recommended rates
A	Second Lowest Silver Plan Premium	$759.61	$736.82
B	Maximum Premium Contribution	$272.36	$272.36
C	Subsidies (A - B)	$487.25	$464.46
D	Gross Premium (Standard Bronze)	$574.67	$557.43
	Net Premium (D - C)	**$87.42**	**$92.97**

[1] We note that the modeling presented in the prefiled testimony and at hearing did not contemplate reductions of equal percentages to both carriers.

In fact, if gross premiums in all plans are reduced below actuarially supported levels, all members with incomes between 300 and 800 percent of FPL enrolled in a Bronze plan (Blue Cross or MVP) will face a net premium increase as compared to approving rates as recommended by L&E.

The table below shows the impact of reducing gross premiums for all plans by three percent, organized by metal level and income level for the population enrolled with Blue Cross through Vermont Health Connect:

Metal Level	Impact of reducing all plans by 3%			Number of Blue Cross households impacted[2]		
	Income under 300% FPL	Income between 300% and 800% FPL	Income above 800% FPL	Income under 300% FPL	Income between 300% and 800% FPL	Income above 800% FPL
Platinum	Good	Good	Good	324	181	221
Gold	Neutral[3]	Neutral	Good	846	498	257
Silver	Neutral	Neutral	Good	3,017	410	67
Bronze	Neutral	Harmful	Good	1,076	615	248
Net annual premium savings for VHC members				$82,117	($8,377)	$315,459
Net annual premium savings for directly-enrolled members				N/A	N/A	$1,087,294
Net annual premium savings for all Blue Cross members				$82,117	($8,377)	$1,402,753

The Bronze plans have high out of pocket costs. Most members select them due to the low premium. Reducing premiums below actuarial recommendations for all plans would hurt the lower-income members facing the largest out-of-pocket spending and attempting to minimize their monthly premium, thereby making coverage less affordable for the members most in need.

The table below shows how the savings in gross premium dollars for the modeled reductions are distributed to the various ratepayers for each of the three scenarios requested:

[2] Based on the data provided by VHC and described in Paul Schultz's July 6, 2021 Prefiled Testimony.

[3] "Neutral" is defined as a change in net premium of less than two dollars per month.

Scenario	Gross Premium Saved	Government Subsidies Saved	Net Premium Saved: members above 800% FPL[4]	Net Premium Saved: members below 800% FPL
Reduction of **1%** from L&E recommended rates	$1,318,311	$826,119	$467,488	$24,703
Reduction of **2%** from L&E recommended rates	$2,636,622	$1,652,365	$935,010	$49,257
Reduction of **3%** from L&E recommended rates	$3,954,932	$2,478,440	$1,402,753	$73,739
Percentage of Savings		**62.7%[5]**	**35.4%**	**1.9%**

As demonstrated in the table above, nearly the entirety of the savings of the modeled rate reductions benefits the government and higher-income Vermonters. The average net premium reduction for Vermonters earning below $95,000 as a single individual or $265,000 as a family of four amounts to less than two cents of every dollar of the modeled rate reductions.

Rate reductions that are not actuarially supported must be funded through policyholder reserves. Impacts of depleting policyholder reserves include a reduced ability for Blue Cross to invest in programs that actually impact the cost, quality and access to care; jeopardizing solvency; and increasing the likelihood and magnitude of future rate increases.

The table below shows the net premium, defined as approved rates less federal and state subsidies, by metal level for the three scenarios requested. Note that for these scenarios, we assume that none of the currently direct enrolled members will receive subsidies in 2022.

[4] Including members of the Catastrophic Plan, who are not eligible for premium subsidies.

[5] This figure differs from the "roughly 80 cents on the dollar" to which Paul Schultz testified at hearing. In order to align with the -4.3 percent average net premium decrease cited in the question, we here assume that **no** members directly enrolled with Blue Cross are eligible for subsidies. Such an assumption is not realistic. We know that the distribution of savings is therefore even more skewed toward the government, while Blue Cross members will see average net premium decreases that are larger than those presented in the final table. Because we do not have income information for directly-enrolled members, we cannot estimate more precise results and accordingly demonstrate only the scenario that presents the minimum government savings and smallest average net premium decrease for Blue Cross policyholders.

	L&E Recommended Rates	Reduction of 1% from L&E Recommended Rates	Reduction of 2% from L&E Recommended Rates	Reduction of 3% from L&E Recommended Rates
VHC Platinum	1.7%	0.8%	0.0%	-0.9%
VHC Gold	-8.3%	-8.8%	-9.4%	-9.9%
VHC Silver	-40.4%	-40.6%	-40.8%	-41.0%
VHC Bronze	-16.0%	-16.1%	-16.3%	-16.4%
VHC Subtotal	**-15.7%**	**-16.2%**	**-16.7%**	**-17.1%**
Catastrophic	-9.7%	-10.6%	-11.5%	-12.4%
Direct Enroll	5.2%	4.2%	3.1%	2.1%
Total Blue Cross Individual	**-4.3%**	**-5.1%**	**-5.8%**	**-6.6%**

The impact of each scenario is not linear for each subscriber. For members not eligible for subsidies, the impact is one-to-one. For members eligible for subsidies, these rate reductions increase or only partially reduce net premiums while increasing the likelihood of an increase in net premium for 2023.

Reducing gross premiums in the individual market, even if done equally in both dockets, is regressive in that it overwhelmingly benefits government and higher-income ratepayers while harming lower-income Vermonters most actively seeking premium relief. Furthermore, it is an incredibly inefficient use of Blue Cross reserves in that it directs funds to the federal government that could instead be used to innovate and implement new programming that could bend the cost curve and improve affordability for all Vermonters.

We again urge the Board to approve individual gross premiums as recommended by L&E as a means of enhancing affordability in a progressive manner while allowing investment in the continued development and implementation of innovative solutions that bend the cost curve while improving quality and access to care.

Question 2

Provide additional detail regarding the program described in the first half of the second-to-last paragraph on page 5 of Exhibit 13.

Response:

Blue Cross has had a primary care provider (PCP) capitation program on its Managed Care contract since the early 1990s. Approximately [redacted] participate in the program. Participating providers receive monthly capitations, which vary by age, gender, and benefit, for members who selected them as their PCP. This program does not pay based on claim attribution. The list of codes (CPT-4) that are capitated is limited to certain primary care services:

Under this program, providers continue to submit claims and Blue Cross must continue to adjudicate claims in order to apply the appropriate cost sharing.

Question 3

Confirm that the 11 new professional practices referred to in the second paragraph on page 6 of Exhibit 13 are participating in OneCare Vermont's primary care capitation program.

Response:

The 11 new professional practices referred to in the second paragraph on page 6 of Exhibit 13 are independent providers now participating in Blue Cross's fixed prospective payment program with OneCare Vermont. In 2020, only one provider was participating in the program. To our knowledge, the fixed payment program is not referred to as a primary care capitation program.

Under the fixed payment program, Blue Cross pays OneCare Vermont a flat monthly PMPM for the ACA attributed lives and does not directly pay the provider for the claims for attributed members. Even though no fee-for-service payment is made, providers continue to submit claims because Blue Cross must continue to adjudicate these claims in order to apply the appropriate cost sharing and capture the data needed for the risk adjustment program. Detailed claims data are also necessary to assess any savings driven by the fixed prospective payment program and to ensure that future fixed prospective payments are set in a way that is fair to both providers and members. OneCare Vermont is responsible for distributing the funds to the providers. This program is not a fully capitated program. Blue Cross and OneCare reconcile the PMPM to the fee-for-service claims at the end of the plan year so that savings generated by this program can be returned to rate payers.

The OneCare Vermont primary care capitation program referred to in the question may refer to a program(s) administered by OneCare and developed and implemented by OneCare and the participating practices. Blue Cross does not have detailed information regarding such program(s).

Question 4

What percentage of total claims costs are for mental health services?

Response:

The portion of total medical allowed charges (including facility, pharmaceutical, and professional claims) for mental health and substance abuse (MHSA) services for ACA was 7.5% in 2019. The portion of MHSA services in 2020 was higher because very little MHSA care was deferred at the onset of the pandemic.

Our 2020 population health survey, assembled annually from claims as part of our NCQA certification, provides additional useful context regarding mental health needs. It shows that the percentage of our ACA population with co-occurring mental health diagnoses, meaning members with one or more chronic medical conditions and a mental health diagnosis, is 36% for 2- to 19-year-olds and 26% for those 20 years and older.

We know from research that only a portion of those with mental health conditions actually seek care for these conditions. As a result, it is likely that the co-occurring mental health diagnoses are substantially higher than our numbers listed here.[6] According to the National Alliance on Mental Illness, the average delay between onset of symptoms and the seeking of treatment for those symptoms is 11 years.[7]

We also know that individuals with mental health issues have more severe medical issues, and worse outcomes. A recent article in Social Science & Medicine shows significant direct and indirect effects of mental health on physical health and vice versa.[8] The study reports that indirect effects explain 10% of the effect of past mental health on physical health. There are stronger indirect effects for males (9.9%) and for older age groups in mental health (13.6%). Although the science behind the association of poor mental health and poor physical health is still young, the impacts can be clinically significant.

In summary, the increase in mental health issues as a result of the pandemic is likely to also exacerbate medical issues in this population going forward. In other words, what we are seeing now is only the tip of the mental health iceberg, and those mental health conditions are likely to impact both mental health claims and medical claims for years to come.

---

[6] *See, e.g.*,
https://www.mentalhealth.org.uk/statistics/mental-health-statistics-people-seeking-help
https://www.mhanational.org/mentalhealthfacts

[7] https://nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Mental-Health-Care-Matters-FINAL.pdf

[8] https://www.sciencedirect.com/science/article/pii/S0277953617306639?via%3Dihub

Question 5

Explain in more detail the 59-point reduction to RBC identified on page 6 of Exhibit 15. As part of the explanation, quantify the impact of the change in pension funded status in dollars.

Response:

Pension funded status impacts Blue Cross's RBC every year. That impact, every year, is the product of a calculation that takes into account the current value of pension fund assets *and* the current value of Blue Cross's pension liabilities. *See* Ex. 23, at 44-45. The impact for year-end 2020 was $47.8 million, which equaled a 222-point decrease in RBC.

The liabilities are the future obligation to pay benefits. The liability piece of the calculation is separate from the asset valuation. That is, even if pension assets remained stable, the pension funded status will still reduce RBC as liabilities increase. The liability calculation is based on a number of assumptions including current discount rates, which in turn depend on market interest rates. When interest rates drop, liabilities increase. No action taken by Blue Cross can affect that calculation.

An example illustrates this point: imagine two hypothetical companies with identical and very simple pension plans in 2020: five employees each, and each employee is entitled to a lump-sum payment of $100,000 in 2025. At year-end 2020, Company A has $350,000 in pension assets and Company B has $200,000 in pension assets. When these two plans are valued at year-end 2020, the liability calculation is the same, because each plan needs to have $500,000 on hand in 2025. At the end of 2020 the value of that liability is about $310,000, $390,000, or $475,000, if the discount rate is 10%, 5%, or 1%, respectively.

As this simplified example shows, the change in the discount rate affects the liability calculation for each plan in the same way, without regard to the asset valuation. Of course, Company A's overall pension funded status will be more favorable, because its assets are higher; but the impact of the difference between a 5% discount rate and a 1% discount rate is the same for each Company: an $85,000 increase in pension liability regardless of the asset value.

The figures that Blue Cross supplied on page 6 of Exhibit 15 are not as simple as the example above, because the plan is more complicated; there are other actuarial assumptions in play besides the discount rate; and there were other changes in asset value, including over $5 million in benefit payments. Ex. 23, at 45 (Note 12, Table 2, line f). The example above, however, illustrates why the liability calculation affects RBC but is unrelated to losses in pension assets.

Turning back to the specific numbers for 2021: again, the impact of the pension valuation at year-end 2020 was a decrease in surplus of $47.8 million, which equaled a total -222% impact on RBC. On page 6 of Exhibit 15, Blue Cross separated out the impact on RBC attributable to the Allianz losses from other aspects of the pension valuation, as follows:

- -163% is the portion of the total impact that was attributable to an estimated $35.2 million loss in pension assets attributable to the Allianz investment losses. Ex. 15, at 4.

On the financial statements, this figure is part of actual return on plan assets shown in footnote 12, table 2, line b. Ex. 23, at 45.

- -59% is the remaining overall impact of pension funding status on RBC, excluding the impact attributable to the Allianz losses. It can be further broken down as follows:

    - The actuarial valuation of the pension liability increased $6.5 million, which decreased RBC 30%. This calculation is shown in footnote 12, table 1, line 10, as the difference between the 2020 and 2019 valuations of the benefit obligation. Ex. 23, at 44.

    - Other changes in asset value, including benefits paid out by the plan during 2020, netted out as a $6.8 million decrease. This decreased RBC 31%. These changes, including the benefits paid, are shown in footnote 12, table 2. Ex. 23, at 45. Note, however, that table 2 shows Blue Cross's $15 million contributions to the plan, which is not part of the RBC impact.

    - The total net periodic benefit cost shown in footnote 12, table 4, line h, has a positive impact of $0.6 million or 2% RBC, which slightly offsets the liability calculation and other changes in asset value. Ex. 23, at 45.

Question 6

Explain in more detail the $15 million that BCBSVT added to the pension plan to meet ERISA requirements. How does this payment flow through BCBSVT's financial statements? How does it not impact RBC?

Response:

In 2020, Blue Cross first made an ordinary $2 million contribution to the pension plan. That amount was consistent with funding obligations in prior years and unrelated to the losses realized in March 2021. After the losses in pension assets, Blue Cross's pension actuaries calculated the funding contribution necessary to ensure that the 2020 year-end valuation met what's known as the 80% AFTAP funding level. If the plan's funded status falls below that level, the plan would have to implement certain restrictions on benefits. The amount required to achieve the 80% AFTAP funding level was $13 million, and Blue Cross contributed that amount to the plan just before the end of 2020. See Ex. 19, at 16. These two contributions together total the $15 million in footnote 12, table 2, line d of the financial statements. Ex. 23, at 45.

Under ERISA's funding rules, Blue Cross was not immediately required to replace the full amount that the pension fund lost in March 2020. But our RBC level must incorporate our overall long-term pension obligations, based on a current valuation of pension assets, expected future returns on assets and future pension liabilities. Our current RBC level and projections thus account for Blue Cross's likely future funding obligations.

A hypothetical example may help to illustrate the relationship between the RBC impact of pension funded status and specific contributions to the plan that impact cash flow. Suppose Blue Cross entered into a contract today that required it to pay out $10 million in 2022. That future payment obligation would immediately reduce Blue Cross's RBC level. In non-accounting terms, that $10 million is already spoken for, and thus not available to pay claims or otherwise offset future risks. Continuing with the hypothetical, when the $10 million payment is made in 2022, it appears on the financial statements and impacts cash flow, but it does not impact RBC again. The obligation to pay those funds was already accounted for.

The impact of the losses in pension assets is more complicated, but similar in that the impact to surplus happens when the liability is incurred. The $15 million contribution is recorded to a prepaid pension asset account that reflects the cumulative difference between aggregate net periodic pension costs (calculated annually) and aggregate cash contributions made to the pension plan. This is shown in footnote 12, table 3, line a(1) of the financial statements. The contribution impacts cash flow but does not get recorded against surplus, nor does it impact the income statement.

In sum, a specific contribution to the pension fund is a cash flow item that does not affect RBC. It is the overall pension funding obligation that affects RBC. Put another way, the fact that Blue Cross has been and will be obliged to make contributions to the pension fund impacts RBC. But the contributions themselves, at the time they are made, neither increase nor decrease RBC.

Dated: July 27, 2021

Respectfully submitted,

Stris & Maher LLP

/s/ Bridget Asay
Bridget Asay
28 Elm Street
Montpelier, VT 05602
Telephone: (802) 858-4285
basay@stris.com

/s/ Michael Donofrio
Michael Donofrio
28 Elm Street
Montpelier, VT 05602
Telephone: (802) 858-4465
mdonofrio@stris.com

Counsel for Blue Cross Blue Shield of Vermont

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 July 27, 2021.

/s/ Michael Donofrio
Michael Donofrio
Stris & Maher LLP
28 Elm Street
Montpelier, VT 05602
Telephone: (802) 858-4465
mdonofrio@stris.com