

June 27, 2022

Kevin Rugeberg, FSA, MAAA  
Vice President & Consulting Actuary  
Lewis & Ellis, Inc.

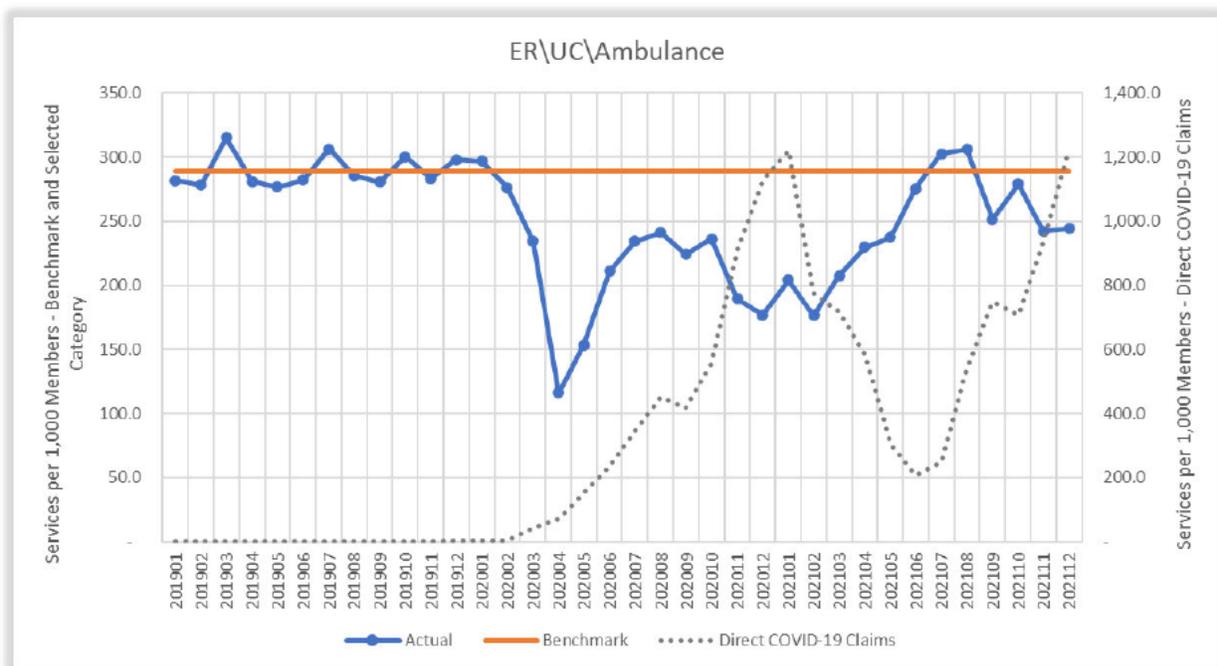
**Subject: Your 06/20/2022 Question re:  
Blue Cross and Blue Shield of Vermont  
2023 Vermont ACA Market - Individual and Small Group Rate Filings  
(SERFF Tracking #: BCVT-133243519 and BCVT-133243509)**

Dear Mr. Rugeberg:

In response to your requests dated June 20, 2022, here are *your questions* and our responses:

- While we recognize that an explicit adjustment is being made only to Emergency, Urgent Care, and Ambulance, this comes with an implicit adjustment of zero percent to all other claims (excluding influenza). We would expect that of all service categories, emergent care would be among the least sensitive to suppression from COVID-19. Explain why it is reasonable to assume that emergent care is more sensitive to COVID-19 than non-emergent care.*

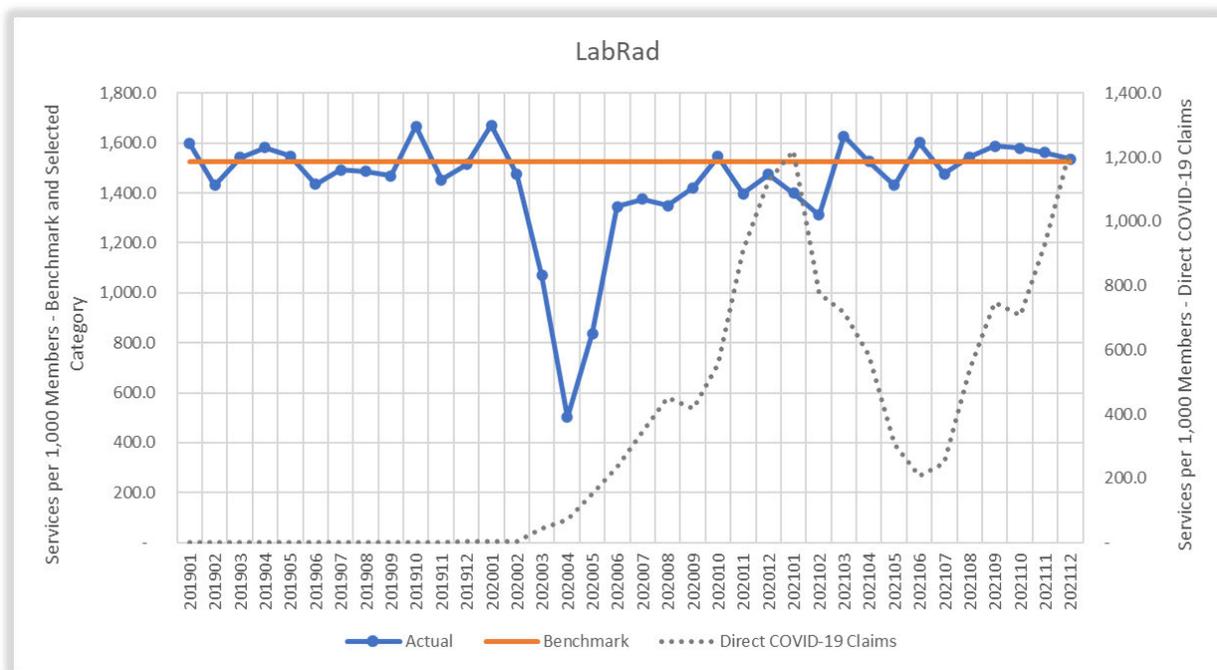
Emergent care is not necessarily more sensitive to the pandemic than non-emergent care. However, the data does clearly demonstrate that utilization of emergency room, urgent care and ambulance services shows a strong inverse relationship to the incidence of COVID-19 cases:



The sensitivity of emergency room, urgent care and ambulance services to COVID-19 stems from the avoidable use of these services when COVID-19 cases are low. Patients stopped using the emergency room for minor conditions during the pandemic. Whenever the COVID-19 caseload fell to lower levels, emergency room utilization returned to its typical level.

Furthermore, emergent care is free from the offsetting impact of returning services. If emergent care is foregone, it cannot be deferred to return when COVID-19 cases are less prevalent. While non-emergent care was similarly foregone during outbreaks of COVID-19, it could be rescheduled to be performed at a later date. This manifested in both the return of deferred services from prior periods (i.e., 2020) and the return of care that had been deferred within the calendar year. This latter phenomenon impacted seasonality but did not impact the overall rate of utilization for the calendar year.

By way of example, the below graph shows the ebb and flow of laboratory and radiology services throughout the pandemic. While many months were impacted by a high level of deferred services, others were impacted in the opposite direction by returning care. The net impact was very close to zero for calendar year 2021.



Other categories of services exhibited similar patterns. Our assumption, then, was not that non-emergent services were insensitive to suppression from COVID-19. Rather, our conclusion, informed by an examination of actual experience data, is that the net impact of COVID-generated deferred and returning care on the 2021 utilization of non-emergent services was not demonstrably different from zero. While the data analysis taken to a high level of precision suggested that a small additional upward adjustment may have been warranted, the impact was not sufficiently material to be definitive. We therefore chose to adjust only influenza along with emergency room, urgent care and ambulatory services.

2. We note a July 2021 report released by DFR<sup>1</sup> seemingly references BCBSVT predicting that 2021 claims in the Vermont Individual and Small group markets would be increased by approximately \$2.3 million for

<sup>1</sup> [https://dfr.vermont.gov/sites/finreg/files/doc\\_library/dfr-report-financial-impacts-covid-health-insurance.pdf](https://dfr.vermont.gov/sites/finreg/files/doc_library/dfr-report-financial-impacts-covid-health-insurance.pdf)

*“returning utilization” and “Other Changes in Demand for Services,” and have no impact from “reduced utilization.”*

*Please explain what new information led to the assumption in the 2023 rate filing that 2021 claims, aggregated across all service categories, were suppressed by COVID-19, given what appears to be a prediction from last year that those claims would be increased by COVID-19.*

At the time our 2021 COVID-19 modeling was produced, we did not anticipate the existence of additional variants and waves of COVID-19 infections after vaccines became broadly available. We expected that the return of care deferred during 2020 would overwhelm other lingering impacts of the pandemic. Instead, despite high rates of vaccinations, Vermont was hit hard by the COVID-19 variants in the 2021 (see the graphs in our response to Question 1). The additional waves of COVID infection led to further suppression of care across all service categories, as described above.

*3. Follow up from our responses to question 10 from the inquiries dated May 19 and questions 7 and 8 from the inquiries dated June 3.*

It came to our attention during our conference call of June 24 that considerable confusion remains regarding our responses to question 10 from your inquiries of May 19 and questions 7 and 8 from your inquiries dated June 3. There seems to be a misunderstanding of our methodologies for both experience period adjustments and the facility trend assumptions, the relationship between the two, and whether they together produce reasonable projections of facility claims.

Filing Methodology

When building the projected index rate, the first step is to ensure that the base experience used is reflective of the projection period. To achieve this, we exclude COVID claims and adjust for population changes. We also adjust for the impact of the pandemic on calendar year 2021 since actual 2021 data clearly shows that 2021 was dampened due to ongoing high levels of infections.

To adjust baseline experience, we analyzed three years of experience by service category. While most service categories were impacted in some way since March 2020, only emergency room, urgent care, ambulance services, influenza and pneumonia care were different in a statistically significant way from their pre-pandemic levels. All other categories were within a small range of the benchmark or offset by related categories. See the Q4 tab of *Responses to Blue Cross 2023 ACA Rate Filing Inquiry 5.xlsx*. We therefore adjusted only the base experience for the index rate for the impacts of the pandemic on those five services.

The trend analysis is a separate component of the projection of the index rate. Once we produce a baseline that accurately represents the projected population and a normal level of utilization, we must trend it forward to the projection period. We agree that the trend analysis should reflect the adjusted experience data. However, due to time constraints, we used unadjusted 2021 data for our trend analysis, verifying after the fact that analysis based on adjusted 2021 data produces similar results<sup>2</sup>.

---

<sup>2</sup> As disclosed in footnote 4 of our May 27 responses, we did not adjust the experience for the suppression of ER claims in 2021 as part of our trend analysis. Had we excluded ER claims from the statistical analysis, the regressions would have been 0.5 percent higher, and the relevant time series result would have been 0.3 percent higher. Our selection of 1.5 percent may therefore be slightly understated when considered in conjunction with the suppression of ER claims.

### First Objection

In your letter dated May 19, 2022, you stated that *“utilization trend was negative from 2018 to 2019, prior to the pandemic”* and implied that your expectation would be a continued downward trend through 2023.

While your observation is accurate, it is in no way indicative of an underlying negative facility trend. As noted in the 2022 filings and in our previous responses on this topic, calendar 2018 experience was a high outlier. Experience trend from 2017 to 2019 was positive (and, in fact, *higher* than our 2023 filing assumption). The observed negative trend from 2018 to 2019, therefore, was driven by a timing aberration and is not reflective of observed long-term trends. Since facility trends were positive prior to the pandemic and have been modestly positive even during the pandemic (excluding ER, urgent care and ambulance services, as discussed above), it is unreasonable to expect that 2023 facility utilization will fail to “rise above the 2019 level.”

### Second Objection

In your letter dated June 3, you suggested that our *“argument in support of positive utilization trend assumes a priori that positive trend will occur.”* This is demonstrably untrue. As we have discussed, the experience period adjustment was executed using an untrended benchmark and is independent from the trend analysis. While it is clear that it would be an actuarially sound methodology to have incorporated these base period adjustments into the data used for trend analysis, our trend analysis did not adjust base experience in any way. There was no a priori positive trend assumption in any of our analysis.

This specific objection appeared to be specifically in relation to the observations of modestly positive trend from 2019 to 2021 that we observed above and in our May 27 response. The objection is based on a premise that *“utilization trend observed was negative going into COVID.”* As explained above, this conclusion is demonstrably incorrect across all facility services. Nonetheless, the data in our response were not adjusted across all facility services; rather, we adjusted emergency room, urgent care and ambulance services to bring utilization for these services to its pre-pandemic level. Trend for these services—which are a small component of all facility services—was flat from 2019 until the pandemic began impacting utilization in March 2020.

### Third Objection

In your letter dated June 3, 2022, you stated that *“However, the regression analysis referenced includes Spring 2020 in the first half of the trend period. As such, the trends they report appear to be driven mostly by the return from low COVID utilization, rather than a long-term trend. For example, the “36-Month logistic Regression”, which returned 1.6%, returns instead 0.2% if the data from 2020 is excluded.”* Deferral of care caused claims in the second quarter of 2020 to be significantly dampened, while much of the second half of 2020 includes some amount of returning care. Calendar year 2021 continued to be affected by COVID-19 and saw several service categories remain dampened. Considering this, both 2020 and 2021 would require adjustments to remove the impact of the pandemic.

Removing both 2020 and 2021 has the impact of revisiting the trend analysis through 2019 that was used for the 2021 ACA filing. The approved trend in the 2021 filing was 1.1 percent. While this is modestly lower than our current assumption of 1.5 percent, a projection of trend from 2021 also includes an expectation of modest impacts from the replacement of COVID-19 services and patients with a more typical mix of patients and diagnoses<sup>3</sup>, along with the morbidity impact of deferred care.

---

<sup>3</sup> Note that services directly related to COVID-19 were removed from the trend analysis and, in fact, the premiums.

If 2020 is removed but 2021 retained, as your objection indicates, one must adjust the 2021 data for the impact of the pandemic on utilization. As demonstrated in our response to Question 1 here, certain services were dampened in 2021. After making a complete adjustment for the pandemic impact, the regression results excluding 2020 yield 0.9 percent. Once again, we find a result that comports with our current assumption upon recognizing anticipated utilization impacts unique to the post-pandemic period.

The 0.2 percent trend cited in this objection is a outlier and cannot be relied upon to project future trend.

Finally, in setting our trend assumptions we consider the reasonableness of component assumptions on projected results. After application of our base period adjustment and trend assumption, the resulting overall facility trend from our final pre-pandemic year (2019) to the projection period (2023) is 0.9 percent. Without exception, this figure is well aligned with every methodologically sound measure of observed facility trend that has been examined in our original work for the filing or in any analysis defined in your objections and our responses.

We are eager to resolve any remaining confusion or objections pertaining to our analysis of facility trend. We are available at any time this week for a follow-up conference call if additional clarification is needed.

4. *Follow up from our response to question 1 from the inquiry dated June 17.*

In our response to question 1 from your inquiry date June 17, we provided the results of our stochastic modeling of RBC. We are following up with the details of the model, along with a more complete description of the results here.

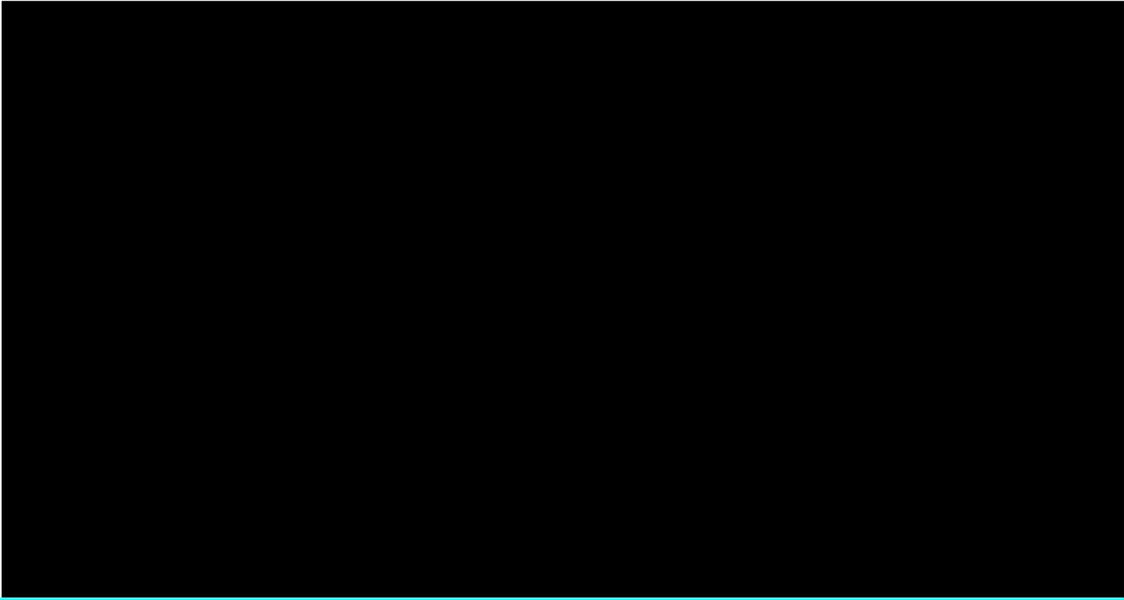
As a preliminary matter, we have identified a mechanical issue in the model related to the manner in which deficiency reserves were incorporated into the 2022 and 2023 calculations. The impact of the correction modestly narrowed the ranges for both 2022 and 2023 while increasing all 2023 results by 30 to 35 basis points.

[REDACTED]

Recognizing that RBC is materially influenced by a great many factors, Blue Cross has undertaken a more rigorous process for projecting future RBC levels. Restricting those projections to point estimates limits the amount of information provided and gives a false sense of certainty to the projection. We have therefore developed a stochastic model that is designed to identify the most likely *range* of RBC results. The model uses the following assumptions:

Category	Line of Business	Assumption/Range
2022 Membership	All Lines of Business	Based on actual year-to-date members extended through year-end based on historical seasonal patterns
2023 Membership	ACA Market	Average membership gain of 2.6% based on observed 2022 result, modeled lognormally with a mean of zero and standard deviation of 0.84% and 0.42% for the small group and individual markets, respectively.
	Medicare Supplement	Average membership gain of 1% based on 2021 and 2022 results, modeled on a normal distribution with standard deviation of 1%
	Vermont Blue Advantage	[REDACTED]
	Large Groups (insured and self-funded)	Flat from actual 2022
	FEP, Host, CBA	Flat from actual 2022
2022 Claims	ACA Market	Normally distributed with a mean equal to the 2022 forecast (in turn based on the 2022 rate order), adjusted for midyear hospital increases, and a standard deviation of 1.1% based on an assessment of annual claims deviation since inception
	Medicare Supplement	Normally distributed with a mean equal to the 2022 forecast (in turn based on the 2022 rate orders) and a standard deviation of 2.1% based on an assessment of annual claims deviation over the past thirteen years
	Vermont Blue Advantage	Congruent with expectations underlying recently submitted CMS bids; no variation
	Insured Large Group	Based on 2022 forecast updated for actual renewal rates
	FEP, Host, CBA, Part D	From 2022 forecast
2023 Claims	ACA Market	Normally distributed with a mean equal to the expected results in these dockets and a standard deviation of 1.1%
	Medicare Supplement	Normally distributed with a mean equal to the expected results in the draft 2023 rate filings and a standard deviation of 2.1%
	Vermont Blue Advantage	[REDACTED]
	Insured Large Group	Based on approved Q3 2022 filing
	FEP, Host, CBA, Part D	Held constant from 2022
Other Categories	Administrative Expenses	Assumed annual 4% growth from baseline of 2022 budget
	Administrative Revenue from Self-Funded groups	[REDACTED]
	Investment Returns	Based on input from our pension consultant, expected annual return of 3.85% modeled on beginning market value of \$180 million, varying with a standard deviation of 4.73%
	Pension	Based on input from our pension consultant, 2022 asset return normally distributed with a mean of 5.68% and standard deviation of 9.79% and 2023 asset return normally distributed with a mean of 6.10% and standard deviation of 11.44%; discount rate modeled based on an examination of historical experience using 50% reversion to a long-term mean of 4.1% with annual variability normally distributed at a standard deviation of 0.6%.

Each of the 10,000 scenarios selects a random variable within the defined range for each variable assumption, then assembles all components to calculate a projected year-end 2022 and 2023 RBC. The graphs below show the range of results for 2022 and 2023. Each dot represents the number of scenarios that produced a given RBC, and the orange lines reflect one standard deviation from the median.



	2022	2023
Median RBC	[Redacted]	[Redacted]
Probability greater than 590%	[Redacted]	[Redacted]
Probability greater than 745%	[Redacted]	[Redacted]





Year-end 2022 and Year-end 2023			RBC Impact		
			<-----Most Likely Range----->		
			-1 SD	Median	+1 SD
<b>Projected December 31, 2022 RBC ratio</b>					
Change in Insured Volume					
2022 Net Income					
<b>Vermont Blue Advantage</b>					
<i>Change in Insured Volume</i>					
<i>Operating Results</i>					
<i>Covariance</i>					
<b>Pension Impacts</b>					
<b>Investment Return</b>					
<b>All Other/Covariance</b>					
<b>Projected December 31, 2023 RBC ratio</b>					

We understand that your report is due within a week. We are available at any time for a follow-up conference call if further clarifications are needed.

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

Sincerely,

Paul Schultz, F.S.A., M.A.A.A.  
Chief Actuary