BlueCross BlueShield of Vermont
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June 25, 2021

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

Subject: Your 06/19/2021 Questions re:
Blue Cross and Blue Shield of Vermont
2022 Vermont ACA Market - Individual and Small Group Rate Filings
(SERFF Tracking #: BCVT-132829562 and BCVT-132829271)

Dear Mr. Ruggeberg:

In response to your requests on behalf of the Office of the Health Care Advocate dated June 19, 2021, here are *your questions* and our answers:

1. *Provide the 2020 and projected 2021 claims data requested by the Office of the Health Care Advocate in question #1 of the proposed questions it submitted to the Board on June 7, 2021 and explain how these data compare to the projections BCBSVT provided the Board in connection with last year's individual and small group rate filing. In responding to this question, BCBSVT need not reproduce Appendix D of its COVID-19 Modeling Addendum.*

   For completeness of the record, the HCA request is repeated here:

   "Please update the tables in Appendix D: Breakout of Claims by Year of the COVID-19 Modeling Addendum submitted in connection with the 2021 VT Health Connect Rate Filing using 2020 actual data and 2021 projected data based on known or partially known data. In responding to the above question, please make sure to include the following:
   - Substitute, in the Projected Claims Table, the projected paid claims for 2020 of $339,991,579 with the actual paid claims for 2020;
   - Substitute, in the Projected Claims Table, the 2021 projected paid claims with the amount of claims BCBSVT currently projects for 2021, broken out by (1) actual paid claims for the months of 2021 for which such data are currently available, and (2) projected paid claims for the remainder of 2021."

   The response to L&E's inquiries dated June 21, 2021 provides an update to the COVID modeling performed as part of last year's individual and small group rate filing. Appendix H provides an update to the information presented as Appendix D of the July 14, 2020 modeling.

   The baseline claims have been updated in the June 1, 2021 modeling to include information underlying recent rate filings and to reflect current membership information. Notably, we used the 2022 ACA filing to project both 2020 and 2021 claims in the most recent modeling. A significant population shift observed in 2020 had not been anticipated by the 2021 filing, which had served as the baseline in previous modeling.

As a preliminary matter, we note that the modeling presented last summer in conjunction with the 2021 VISG rate filing defined a number of "second wave" scenarios wherein a wave was defined not by a prevalence of infection but by "the deferral of all non-[emergent] medical procedures." There was never a second deferral of non-emergent services in Vermont due to COVID-19. Therefore, even though the infection rate in Vermont peaked at the level of incidence underlying the "Boston Severity" scenario[1], the correct basis of comparison to actual results is the "No Second Wave" scenario.

The June 1, 2021 modeling incorporates more current data and was released after the widespread availability of vaccines. These updates have narrowed the range of possible future outcomes, which reduces the variance within the modeling results. In total, results remain consistent with the July 14, 2020 results, which showed a majority of results with a neutral to unfavorable two-year impact.

Specific costs are remarkably consistent from the midyear 2020 modeling to actual 2020 results and the updated 2021 modeling. Delayed claims in 2020 are somewhat higher than anticipated and returning care somewhat lower, both of which are attributable to the late October cyberattack at UVMHN. The cyberattack also had the effect of increasing returning care in 2021. Through March 2021 we estimate that approximately $1.0 million of care returning in 2021 is a result of the rescheduling of care deferred as a result of the UVMHN cyberattack.

Our updated 2021 projection includes a lower figure for direct costs and vaccine administration, the latter driven by vaccine administration at sites that are not submitting claims to Blue Cross. These are offset by an increase in "changes in demand," reflecting the observation that emergency room utilization has returned to historical norms contrary to our assumption in last summer's modeling that patients would continue to seek alternative sites of care after eschewing the emergency room during the lockdown. In the aggregate, the projected 2021 change from baseline of 2.7 percent is quite consistent with the 2.1 percent projected last summer. The observed 2020 result of a 2.5 percent decrease from baseline is extremely close to the 2.2 percent decrease projected last summer.

The table below provides a split view of 2021 modeling results for the ACA markets. First quarter direct cost and vaccination costs are actual claims.

Appendix H – ACA Markets 2021 Split			
	January – March	**April - December**	**2021 Total**
Direct Costs	$1,979,861	$1,081,592	$3,061,453
Vaccination Costs	$147,897	$965,556	$1,113,453
Delayed Claims	$0	$0	$0
Returning Claims	$1,311,788	$602,026	$1,913,814
Morbidity Impact Deferred Care	$56,278	$505,250	$561,528
Changes in Demand	-$39,546	$413,166	$373,620
Total	**$3,456,278**	**$3,567,590**	**$7,023,868**

[1] The average case rate per 100,000 in Vermont in January 2021 was 23.54. The average case rate per 100,000 for the Boston Hospital Referral Region (HRR) from March 22, 2020 through May 17, 2020 was 23.19. The case rate in the Burlington, VT HRR, which served as the basis of the Vermont scenarios, was 2.69 over the same period.

2. *Quantify the impact of BCBSVT's actual 2020 experience and current projection of 2021 experience on BCBSVT's RBC position and demonstrate how these actual and projected RBC impacts compare to the modeling that BCBSVT provided the Board in connection with last year's individual and small group rate filing on page 13 of its COVID Modeling Addendum.*

As noted above, it is most appropriate to compare the current modeling to the "No Second Wave" scenario of the 2020 modeling. The actual 2020 and current projection of 2021 based on the June 1, 2021 modeling is provided in the table below. The below table excludes Medicare Supplement since that line of business was not included in the July 14, 2020 modeling.

Modeled Average RBC Impact as of December 31,			
	2020	**2021**	**2020-2021 Total**
July 14, 2020	+35	-37	-2
June 1, 2021	+35	-39	-4

As shown above, the July 14, 2020 modeling very accurately projected 2020 results. The projection of 2021 results has changed only very slightly based on our latest modeling that includes actual data through March 2021.

3. *What was BCBSVT's total written premium in the Vermont individual and small group market (ACA Market) for 2020?*

Total written premium for the Vermont ACA market in 2020 was $318,920,553.

4. *On BCBSVT's total surplus, how much investment income did BCBSVT earn in 2020?*

In 2020, Blue Cross earned $3,160,477 in investment income.

5. *Quantify the proportion of BCBSVT's 2020 investment income allocable to ACA business in the same manner that BCBSVT used to calculate the target contribution to reserve described in Attachment C of the filings. Describe the allocation methodology used.*

The target contribution to reserve (CTR) is calculated using investment income allocated on the basis of capital requirements; that is, the contribution of each line of business toward the enterprise Authorized Control Level (ACL). The ACA market represents 55.76 percent of the capital requirements. Accordingly, $1,762,282 of the 2020 investment income would be allocable to ACA business on the basis of this methodology.

6. *Provide the numbers and percentages of cases of COVID-19 that BCBSVT has had to date and the costs of these cases for the plans covered by these filings.*

From February 2020 through June 22, 2021, 27 Blue Cross members enrolled in an ACA market plan had received inpatient treatment with a diagnosis of COVID-19, with allowed charges totaling $932,606. Additionally, 7,058 Blue Cross members enrolled in an ACA market plan had claims incurred in an outpatient setting related to a screening for COVID-19, with allowed charges totaling $3,269,372. Lastly, 22,076 Blue Cross members enrolled in an ACA market plan had claims for COVID-19 testing,

with allowed charges totaling $2,596,643 for 27,253 tests. Note that due to provider lag in reporting claims, the reported number of cases and treatment costs will likely increase as time passes.

7. *In BCBSVT's 2022 VT Health Connect Actuarial Memorandum at page 6, BCBSVT provides a table that lists its 2020 actual contribution to reserve as 5.2%. Explain how this 5.2% was calculated.*

The calculation of the 5.2% uses premium, claims and administrative expenses from our internal financial reporting, which is produced consistently with generally accepted accounting principles (GAAP). We adjust the raw totals for events that were incurred in other years in order to present an unpolluted view of actual 2020 results relative to expectations at the time of filing.

The 2020 reported premium of $317.7 million was adjusted for two items: (1) 2015 and 2016 risk corridor settlements were reported in 2020 in the amount of $10.1M; and (2) final 2019 risk adjustment was $2.4 million favorable relative to the estimate booked in December 31, 2019 financials. The adjusted 2020 premium is $305.2 million.

The 2020 reported claims of $250.7 million were adjusted for claims incurred in 2021 that were originally scheduled in 2020 but deferred due to the COVID-19 pandemic and UVMHN cyberattack. We adjusted the reported claims by the observed to date amount of $2.6 million for an adjusted total of $253.3 million.

No adjustments were made to the $36.0 million reported administrative expenses. The adjusted 2020 operating gain is $15.9 million, or 5.2 percent of adjusted premium.

8. *The table referenced in the preceding question also sets forth 2020 operating gains of $15,912,962 for the Vermont ACA market. What contribution to reserve would have produced an operating gain of $5 million? Of $3 million? Of $1 million?*

Performance for BCBSVT Vermont ACA Market for 2020 - Scenarios				
Scenario	**Filed Contribution to Reserve**	**Approved Contribution to Reserve[2]**	**Actual Contribution to Reserve**	**Operating gains/(losses) in millions**
Actual	1.5%	1.5%	5.2%	$15.9
$5M Gains	1.5%	-2.1%	1.7%	$5.0
$3M Gains	1.5%	-2.8%	1.0%	$3.0
$1M Gains	1.5%	-3.6%	0.3%	$1.0

[2] For the scenarios, these figures represent the CTR that would have been needed to produce the different requested operating gains scenarios.

9. Provide the cost accounting exercise that BCBSVT references at page 47 of its actuarial memorandum.

Blue Cross administrative expenses are tracked at a cost center level. Cost centers are assigned by department, division, or external fees, such as claims processing fees and federal or state fees. The Blue Cross actuarial and accounting teams determined a type of expense for each cost center: fully fixed, fully variable, or partially variable.

Fully fixed cost centers are expenses that do not vary based on the membership base. These services, such as legal services, provider relations and network management, facilities, some business technology expenses and some financial services (actuarial and underwriting for example), are needed regardless of whether membership grows or decline.

Fully variable cost centers are directly tied to enrollment or claims volume. These services, such as claims processing fees and customer service, are directly proportional to the number of members enrolled.

Finally, partially variable cost centers will fluctuate with enrollment changes but not directly proportionally to membership. For example, with membership growth, new employees are needed for variable cost centers. Those employees will increase some business technology expenses (e.g. desktop hardware, application licenses), but by a factor less than the membership increases since other costs (e.g. computer network infrastructure) are fixed. Other partially variable cost centers are dependent on the type of membership changes. For example, one new large self-funded group with 10,000 members will require new account management, benefit configuration, and reporting but only one new invoice, while 10,000 new ACA members will require additional invoicing but no new benefit configuration.

Total Enterprise Expenses for Year-to-Date November 2020 by Category (in millions)		
Fully Fixed	Core Business Technology	$15.41
	Corporate Infrastructure	$13.25
	Provider Services	$6.89
	External Affairs	$2.95
	Financial Risk Management	$2.06
	Federal and State Fees	$10.92
	FULLY FIXED	**$51.48**
Fully Variable	Claims Processing	$9.38
	Member Services	$7.52
	Vendor and Distribution Services	$6.65
	FULLY VARIABLE	**$23.55**
	SUBTOTAL (fully fixed and fully variable)	**$75.03**
	Fully Variable percentage of subtotal	**31.4%**
Partially Variable	Business Operations Technology	$13.26
	Financial Services	$6.47
	Client Services	$4.30
	PARTIALLY VARIABLE	**$24.03**
	GRAND TOTAL	**$99.06**

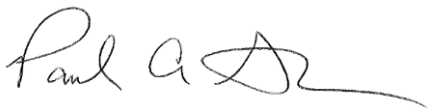
As shown in the table below, fully variable costs are 31.4 percent of the total of fully fixed and fully variable expenses. If the partially variable cost centers are split proportionally between fixed and variable, total variable costs would be 31.4 percent of the total.

To solidify our assumption, we looked at two examples of additional membership and quantified the specific impacts on the partially variable cost center. The first scenario, adding a large self-funded group with 10,000 members, results in variable expenses of 29.6 percent of the total. The second scenario, adding 10,000 new ACA market members, results in variable expenses of 25.3 percent of the total.

These results are all grouped around 30 percent. Because this value comports with observed staffing changes that have taken place with the addition of certain jumbo accounts in recent years, we conclude that 30 percent is the most appropriate estimate for the portion of total Blue Cross administrative expenses that vary directly with membership changes.

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

Sincerely,



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