

June 21, 2024

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

**Subject: Your 06/14/2024 Questions re:  
Blue Cross and Blue Shield of Vermont  
2025 Vermont QHP Market Filings  
(SERFF Tracking #: BCVT-134091560, BCVT-134096633)**

Dear Mr. Rugeberg:

In response to your requests dated June 14, 2024, here are *your questions* and our answers:

1. *Since the filing was submitted, L&E has used information from both carriers to project final 2023 risk adjustment transfers. What is the rating impact of this updated projection?*

The table below shows the estimated risk adjustment transfers included in the rate filings and the projected final transfers from L&E, along with the impact to the Blue Cross VT filed rates.

	Risk Adjustment Transfer for 2025 (Receivables)		Average Rate Increases	
	Individual (incl. Catastrophic)	Small Group	Individual (incl. Catastrophic)	Small Group
Estimated Final 2023 - as filed	-\$8,954,199	-\$8,406,450	16.4%	19.1%
Estimated Final 2023 - from L&E	-\$10,032,304	-\$8,949,399	15.9%	18.8%

2. *For each month from January 2019 through March 2024, please provide the total allowed costs, member months, and any normalization factors appropriate to normalize for changes in unit costs, population age factors, and induced utilization.*

See attached tab Q2 in *Responses to Blue Cross VT 2025 QHP Rate Filing - Inquiry 2.xlsx* for the monthly allowed costs and normalization factors for medical claims. Claims included in this table are uncapped but exclude OTC COVID tests, which are no longer covered. Claims included are paid through May 2024, completed using Blue Cross VT monthly reserving models.

3. *Please provide the following values split by metal tier and by members who were and were not part of Medicaid redeterminations: Total Unique Members, Total Member Months, Average PLRS, Average Age, Average Allowed PMPM.*

The table below shows the member count, member months, average PLRS, average age, and average allowed PMPM by requested population.

		Total Unique members	Total Member Months	Average Risk Score PMPM	Average Age	Average Allowed PMPM
Part of Medicaid Redetermination	Platinum					
	Gold					
	Silver					
	Bronze					
	Catastrophic					
Not part of Medicaid Redetermination	Platinum					
	Gold					
	Silver					
	Bronze					
	Catastrophic					
Total Individual Market		25,731	234,963	1.286	44.29	\$905.79

The average risk score PMPM in the table above was calculated using the final 2023 risk adjustment results and are aligned with information in the RATEE report provided in our prior responses. The allowed PMPMs exclude all claims for members with over \$500,000, which is consistent with how we developed line 1+b<sub>7</sub> on Exhibit 5-IND<sup>1</sup>.

4. *The filing indicates that BCBSVT assumed all members will use in-network, non-OTC sources to purchase hearing aids, and did not adjust the source data for the availability of OTC hearing aids. Members are assumed to buy the more expensive hearing aids "in order to have their benefits apply." Does this assume that members would make such a decision even if they have yet to satisfy their deductible, and would potentially pay far less out of pocket for an OTC hearing aid than one via an in-network provider?*

In the development of the projected cost of the hearing aid benefit, we did not adjust the expected utilization for members choosing to buy a non-covered OTC device rather than a covered device.

5. *Provide actual hearing aid claims experience from 1Q2024.*

The table below shows the actual hearing aid claims experience for claims incurred January 2024 to April 2024, paid through June 11, 2024. We did not apply completion factors to these claims.

Month	Total Allowed for Hearing Aids	Total Number of Hearing Aids	Allowed PMPM	Units per 1,000	Average Cost per Unit
January 2024	\$12,087.45		\$0.27		
February 2024	\$20,000.00		\$0.44		
March 2024	\$21,250.00		\$0.47		
April 2024	\$31,684.00		\$0.70		

<sup>1</sup> Note that the label on exhibit 2B incorrectly stated "exc. All claims from members over \$1M" and should have been "over \$500,000".

6. *Explain the decision to assume that all Silver members with 77% CSR and lower respond rationally to the availability of lower premium Gold plans, given that these members would often already benefit from transitioning to Bronze plans, but have remained in Silver.*

Blue Cross VT does not have income information for subscribers. We also do not have information about the size of their household, the numbers of dependents that are not covered by Blue Cross VT, or their personal income tax situation. All Blue Cross VT has for information are the CSR levels and the amount of subsidies, if the subscriber elected to receive the advance premium tax credit (APTC) instead of waiting until completing their tax return to receive the premium tax credit. Members who choose to wait to receive their premium tax credit appear to have no subsidies in the data we receive from VHC. With all these unknowns around members’ personal situations, it is not possible for Blue Cross VT to know or understand the complete story behind any given member’s plan choice.

It is possible that members who would already benefit from transitioning to bronze plans prefer the lower cost shares of silver CSR plans.

At the time of filing, based on our rates alone, members in CSR 77% and CSR 73% would be able to purchase both gold and bronze plans at \$0 premium after subsidies, making gold plans the obvious choice. When selecting the assumption that all silver members with 70% CSR would move to gold plans, we considered all the possible options. However, assuming a portion of these members would remained in silver versus moving to gold would have also required us to decide the proportion of members who would make that choice. We opted for simplicity, as we do not have enough data to precisely know which plan members will select, and assumed that they would purchase gold plans.

It is important to note that any changes in membership distribution will impact many factors in the rate development, including the impact of changes in benefit factor, the selection factor, and normalization of induced utilization.

7. *We note that the projected cost for high-cost claimants excluded from the reinsurance agreement is about \$300k higher in 2025 than in 2023. Explain how this projected cost was developed.*

It is unclear where the \$300k quoted in the question references but we understand that the intent of the question is to reconcile exhibit 5 lines a<sub>3</sub> and e<sub>5</sub>.

Individual Market

In the individual market, there is one member excluded from the reinsurance agreement in 2024

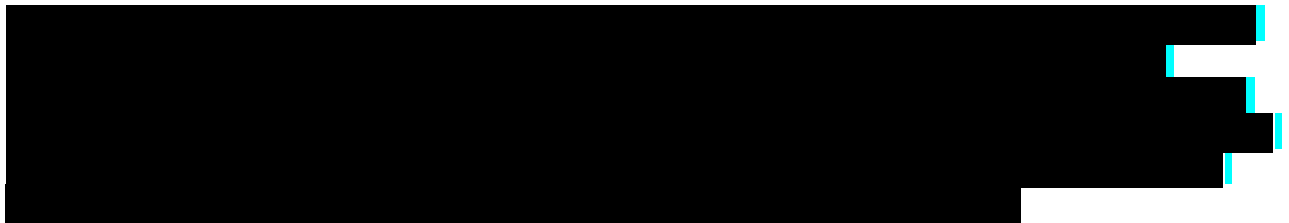
Allowed charges for drugs not included in the Blue Cross VT reinsurance agreement	\$1,598,269
Experience Member Months	234,963
Excluded PMPM from Experience (Exhibit 5-IND, line a3)	\$6.80

Total allowed charges for member excluded from Blue Cross VT reinsurance agreement	\$1,605,854
Claims above the \$1 million limit	\$605,854
Portion covered by HCRP (60%)	\$363,512
Portion covered by Blue Cross VT	= \$1,598,264 - \$363,512 = \$1,234,756
Projected Member Months	277,968
Projected Cost of high claimants (Exhibit 5-IND, line e5)	\$4.44

Small Group Market

In the small group market, there are two members excluded from the reinsurance agreement in 2024.

Allowed charges for drugs not included in the Blue Cross VT reinsurance agreement	\$1,926,302
Experience Member Months	263,429
Excluded PMPM from Experience (Exhibit 5-IND, line a3)	\$7.31



Total allowed charges for members excluded from Blue Cross VT reinsurance agreement	\$3,309,322
Claims above the \$1 million limit	\$1,309,322
Portion covered by HCRP (60%)	\$785,593
Portion covered by Blue Cross VT	= \$3,309,332 - \$785,593 = \$2,523,729
Projected Member Months	264,219
Projected Cost of high claimants (Exhibit 5-IND, line e5)	\$9.55

8. *In the case of both facility claims and non-MH professional claims, normalized 2023 utilization was almost exactly at the level of 2021 utilization. Additionally, in both cases, the actuarial memorandum notes that 2023 claims are artificially elevated. Further explain the reasoning behind assuming the increases from 2022 to 2023 are part of a trend that will continue for 2 years into the future.*

We expect positive future trends in both categories for the following reasons:

- Although the normalized utilization is similar between the years, almost all 36-month measures, which compare 2023 to 2021, suggest positive trends.
- In 2021, we saw the return of care deferred during the pandemic, the return of care deferred during the UVMHN cyberattack, and very robust utilization in October – December. We also noted some areas of care had not returned to their pre-pandemic levels. In prior filings, we benchmarked services against their “normal” pre-pandemic level. For the reasons outlined above, 2021 was a very anomalous year so we do not find the increase in utilization from 2022 to 2023 to be attributable to claims returning to their “normal” levels and view the alignment in utilization between 2021 and 2023 to be coincidental.
- The components of utilization have changed. Between 2021 and 2023, acute admissions have increased, while non-acute admissions have decreased. Outpatient and professional laboratory services have decreased, while the intensity of outpatient services and number of primary and specialty care services have increased. We do not consider a flat utilization trend is reasonable since the underlying service mix and drivers of trend are different, even if the composite total is similar.

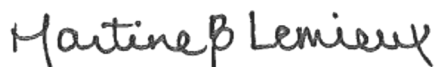
- As shown in our response to question 2 above, emerging 2024 experience is not showing any signs of slowdown in trend. The table below shows the year-ending March PMPM (normalized for cost, population changes, induced utilization, and working days) by type of claim using the same data used to populate our answer to question 2.

	<b>Facility</b>	<b>Professional</b>	<b>MHSA</b>	<b>MedRx</b>	<b>Total</b>
YE Mar 2022	\$455.83	\$163.92	\$19.48	\$57.39	\$696.62
YE Mar 2023	\$468.89	\$165.87	\$20.10	\$61.69	\$716.55
YE Mar 2024	\$484.37	\$171.97	\$21.77	\$66.72	\$744.83
YE Mar 2023 / YE Mar 2022	2.9%	1.2%	3.2%	7.5%	2.9%
YE Mar 2024 / YE Mar 2023	3.3%	3.7%	8.3%	8.2%	3.9%

- Vermont hospitals were approved on average higher net patient revenue budget than unit cost increases<sup>2</sup> and the only way to achieve that is through higher utilization (either with more services or with higher intensity of services). Early FY 2024 reporting further illustrates high utilization, as UVMHC’s April year-to-date reporting shows their FY 2024 Net Patient Revenue is 2.5 percent above budget<sup>3</sup>.
- For facility trends, we recognized that 2023 trends were slightly elevated with selecting a trend of 3.0 percent, which is lower than the most recent year-over-year trend of 3.9 percent. For non-MHSUD professional trend, we also selected a utilization trend slightly below the most recent year-over-year, although to a lesser degree than on facility.

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

Sincerely,



Martine B. Lemieux, F.S.A., M.A.A.A.  
Chief Actuary

<sup>2</sup>

[https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20ESTABLISHES%20FY24%20HOSPITAL%20BUDGETS%20BALANCING%20AFFORDABILITY%20AND%20SUSTAINABILITY\\_09.15.2023.pdf](https://gmcboard.vermont.gov/sites/gmcb/files/documents/GMCB%20ESTABLISHES%20FY24%20HOSPITAL%20BUDGETS%20BALANCING%20AFFORDABILITY%20AND%20SUSTAINABILITY_09.15.2023.pdf)

<sup>3</sup> [https://gmcboard.vermont.gov/sites/gmcb/files/documents/B24\\_UVMHC\\_April\\_Actual\\_submitted.pdf](https://gmcboard.vermont.gov/sites/gmcb/files/documents/B24_UVMHC_April_Actual_submitted.pdf)

