STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield of Vermont	)	
2018 Vermont Health Connect Rate Filing	)	
	)	GMCB-08-17-rr

SUGGESTED QUESTIONS FOR BLUE CROSS BLUE SHIELD OF VERMONT

Pursuant to Rule 2.000 §2.202(c), the Office of the Health Care Advocate respectfully submits to the Green Mountain Care Board the following suggested questions for Blue Cross Blue Shield of Vermont (BCBSVT) in regard to the above-captioned matter.

Questions related to variances from past rate filings and claims experience:

1. Pg 12 SERFF: You mention 2017 had a unit cost improvement of 0.5%. How did you validate that your unit cost tracking procedures in 2018 do not include the same level of conservatism?
2. Pg 12 SERFF: Please provide actual to expected (in prior year rate filings) results for 2013 to 2017:
    a. overall cost increase year to year.
    b. medical trend broken down by utilization and unit cost.
    c. pharmacy trend broken down by utilization and unit cost.
    d. population changes including overall size, aging, and family size.
3. Pg 13 SERFF: 1.6 Historical Financial Results - Please list any one-time issues or adjustments to the 2016 financials which could have a material impact on the margin. For example, one-time expenses, restatements from 2015 learned in 2016, and/or true ups to 2016 learned in 2017.
4. Pg 18 SERFF: Change in Definition of Small Group - Could you describe the risk profile of the Large Groups 51-100 that moved into ASO and estimate if there was any ASO selection against the single risk pool.
5. Pg 166 SERFF: In reviewing the SERFF Trend exhibit, the year end 2016 is very high. Is this trend, seasonality, or is the IBNR too conservative? Can you provide a recast of this data with additional runout? EXAMPLE: Dec 2016 $590.54 in monthly allowed claims PMPM column is much higher than any other month.
6. Pg 16 SERFF: Your experience section of your actuarial memorandum says that capitated claims are targeted at 100% of Fee for service (FFS). Please explain why this is a reasonable capitation strategy given that the goal is to reduce claims cost below FFS levels. If the capitation program is successful and a provider reduces costs, how does that savings flow through to the rates?
7. In last year's VHC filing, you estimated that 6500 members previously in Medicaid in Vermont would join the BCBSVT QHP market by January 2017. How many of these individuals previously enrolled in Medicaid actually enrolled in your QHPs? How did this enrollment affect your trend estimates for 2018?

Questions related to benefit plan design:

8. Pg 12 SERFF: You mention 2017 Benefit impact is 0.4% impact on rates. Were there any specific plans that were under or overpriced? Further:
    a. Is the rate impact specific to a few underpriced plans or is it spread across all plans?
    b. If there were no changes to benefits what would the average rate increase have been, by plan design? Please indicate the actual rate increase and the benefit change.
9. Pg 16 SERFF: AV Metal Levels & AV Attestation - We can see that the Blue rewards cost about $3 PMPM (from admin section pg 28 and also included in the AV attestation) and you are expanding the program in 2018 (page 7 of actuarial memorandum). Please provide
    a. the cost of administering these programs,
    b. the anticipated savings these rewards drive,
    c. any evidence on the effectiveness of the program, and
    d. a description of where the anticipated savings are reflected in the price or AV estimate.

Questions related to membership projections and demographic changes

10. Pg 19 SERFF: Membership projections - Please outline what the rate increase would have been assuming static 2016 membership versus how much your rate filing membership projections drive the 2018 rate increase.
11. Pg 20 SERFF: Changes in Demographics -
    a. Please provide evidence that the projected period average age factor will continue the change from 2016 to March average and not start to decrease. Have you reviewed any macro demographic information or anticipated an acceleration in retirements or younger workers coming into the work force with the improving economy?
        i. For your calculations on impact of age and family size, how do you incorporate members aging into Medicare and individuals over 26 aging out of family plans? To what extent, if any, do you incorporate Vermont or BCBSVT specific data into these calculations?
    b. Could you provide evidence for your claim that family size is increasing and is likely to continue to increase?
    c. Page 19 SERFF: You state that you assume that group turnover leads to hiring of similarly-situated individuals. What evidence do you have on this point?
    d. Pg 25 SERFF: Utilization AGF normalization - Why do you use the SOA Health Care Report for age factors? Could you compare those factors against your internal experience?

e. There is an additional age adjustment in the specialty trend. Can you confirm this is a reduction in specialty trend and outline why the SOA factors are relevant to specialty Rx?

Questions related to medical utilization & severity trends

12. Please provide a more qualitative explanation to support your claim that utilization will increase in 2018. Please include your clinical team's interpretation and justification of your statistical results.
13. Pg 24 SERFF: Utilization Approach - If you applied actual utilization statistics, what would be the result?
14. Please explain whether you incorporated recent trends towards long-term birth control methods into your utilization projects in that this is likely to decrease unintended pregnancies.
15. Utilization Trend
    a. Pg 24 SERFF: You indicate you use a combined utilization and intensity measure. However on pg 27 you itemize Ocrevus, which is effectively an intensity measure. Why did you decide to make this additional intensity adjustment and how did you normalize out for other high cost items in the history (example high J Code trends over the past few years)?
        i. *In our analysis, we combine utilization and intensity within the utilization metric and analyze the unit cost separately. Historical experience is normalized for contract changes and then analyzed to derive a utilization trend in the absence of unit cost changes.*
    b. Pg 25 SERFF: Utilization Other Normalization - Did you attempt to normalize the data for business days or leap year impact? If not please make the adjustment.
    c. Pg 25 SERFF: Utilization Trend - Is this trend methodology consistent with your recent large group filing?
    d. Pg 31 SERFF: PEDI Dental Trend - Pedi dental has a high trend likely as people discover the benefit. It has been available for three years so wouldn't that impact eventually wear off?

Questions related to Rx spending & utilization

16. Pg 26 & 64 SERFF: Rx Trend - On page 64 OCREVUS is removed from Specialty Rx. In the unit cost section this is said to be a claim paid as medical. Please explain this removal and list any other Specialty Rx that are included in the Medical Utilization regressions and in the specialty Rx data.
17. Does BCBSVT apply any acuity level restrictions on specialty drugs such including Orkambi or HCV drugs? If yes, please explain how you incorporate this into your estimates of the number of individuals in your population who will use these drugs.
18. Please explain how you incorporate the fact that specialty HCV drugs cure the disease into your estimates of future utilization of the drug within your population.
    a. Please also explain any assumptions you incorporated into your filing about savings associated with specialty drugs, including but not limited to:
        i. Replacement of other scripts as most of these conditions may have required other maintenance scripts.

        ii. Long term benefit of healthier members
        iii. Adjustments for reinsurance receivables

19. Have you negotiated a contract with a new pharmacy benefits manager since the date of the filing? If you have, what annual contract improvements have been incorporated in the contract and what impact are they expected to have on pharmacy trend?
20. Please explain how you adjusted cost projections due to new Vermont rules on limiting opiate prescriptions.
21. Please explain how you adjusted cost projections due to new rules requiring generic substitution for interchangeable biological products.

Questions related to provider unit cost and provider mix:

22. Pg 13 SERFF: Could you outline the drivers of the delay in the All Payer Model and describe the current status of negotiations?
23. Page 4 SERFF: You claim that utilization has been escalating as evidenced by hospital net patient revenue overages in each of the past two years. Please provide data on the extent to which these overages were caused by the BCBSVT population as opposed to other commercial carriers, Medicaid, or Medicare populations. Further, what evidence do you have that these trends will continue?
24. Provider Trend
    a. Additional trend questions for information not included in SERFF document: Please provide a detail of
        i. Payment differential between physicians affiliated with a large health system and independent physicians.
        ii. Provider increase budget by provider. In this please identify any health system, independent physicians, rural hospitals.
        iii. Amount and type of alternative provider payment arrangements you have used in the past three years and/or you plan to use for the upcoming year. Please provide detail on the impact these arrangements have had on unit cost and utilization trends for the populations served under these payment arrangements.
    b. You stated in a press release that “The Medicare and Medicaid cost shift adds about another 2 percent” to the rate increase requested in this filing.
        i. Please describe in detail how you calculated this figure.
        ii. Explain how the cost shift factors into your approach when negotiating with providers.
        iii. You are discussing cost shift as one macro-economic impact on your provider payment negotiations; please explain why ACA growth in insured population with both less bad debt and growth in covered members to ease overhead strain haven’t led to lower unit cost increases.
    c. Have you explored increasing pay for primary care providers? Please provide estimates of rate impact if primary care pay was increased to incentivize primary care providers to come to Vermont and to allow patients to have more contact with their primary care providers.
    d. Please describe any incentives you include in your provider contracts to reward primary care providers for managing costs.

    e. Please provide a copy of any standard provider templates.
    f. Have you studied any movements of providers driving costs:
        i. Services moving into high cost health systems (example UVMMC).
        ii. Services moving from PCP to specialist.
        iii. Services moving from an office setting to a facility setting.

    If so could you provide the study, if not could you perform the study?

Questions related to ACA Factors including 3Rs and CSR

25. If federal cost sharing subsidies are eliminated, please describe any approaches you would consider for adjusting rates in response to the change.
    a. Some national groups are suggesting that the best approach for consumers would be to load the full rate impact onto silver plans. The idea is that the increase will be absorbed to some extent by federal premium subsidies.
        i. What is your opinion of this approach?
        ii. What would the impact be on silver plans if you took this approach?
    b. Would you be willing to work together with an outside stakeholder group to come up with the best solution?
26. How many current members receive CSR and/or premium subsidies?

Questions related to administrative costs and contribution to reserves

27. Pg 35 SERFF: Please identify any factors that have been keeping down administrative costs beyond true administrative efficiency, including but not limited to:
    a. Lack of depreciation or taxes on property.
    b. Lack of broker fees in administrative costs.
28. Large group admin costs increased by 25% due to redistribution of administrative costs according to the GMCB 04-17rr, SERFF Filing. Please describe how this redistribution impacted administrative costs for small and individual group.
29. Please explain the financial funds flow. For broker compensation, for example, do the employer groups pay broker fees directly to the brokers or is it a pass-through item billed by BCBSVT in addition to premium which is then passed on to brokers.
30. Pg 35 SERFF: Overhead Allocation - What is your justification for allocating overhead by capital requirements? Are there any other accepted methodologies that would have ASO accounts cover a larger portion of overhead?
31. Pg 36 SERFF: CTR - Some questions on the CTR of 2% and the exhibit:
    a. How has BCBSVT chosen its target surplus? Is this supported by evidence such as a simulation of adverse events?
    b. Pg 74 SERFF: 31.78% of accounts are listed as all other. Please describe these accounts. If this is ASO why is ASO allocated investment income if it is not allocated overhead?
    c. Is the investment income tax rate applicable given your recent losses?
    d. Why is capital allocated by premium when RBC is based on claims expense? Is there a material difference?

   e. Pg 38 & 12 SERFF: The 2.6% Federal Insurer Fee seems high. BCBSVT had losses in 2017; is there a chance that losses in 2017 can offset some of the tax impact to the insurer fee?
   f. Pg 23 SERFF: Net Cost of Reinsurance - Please verify that the Net Cost of Reinsurance reflects any experience refunds from the reinsurer.

32. Page 38 SERFF: You state that you calculated your future bad debt by taking a three-year average of uncollected premiums. Please break this out for each of the past three years.
33. Are your actual income to actual expenses for the past five years accurately reflected in your annual reports?
34. Pg 35 SERFF: Administrative Costs – Salaries – BCBSVT has a 3% target increase to employees:
    a. Typically this is broken out into inflationary and a merit portion. Shouldn't the merit portion tend to net out over time given that older higher paid employees retire and are replaced by younger lower paid employees?
    b. Are all your employees getting similar increase? Please send the last three years' inflationary and merit increase percent by salary decile.
    c. Please demonstrate the percentage of total admin each decile receives.
35. What is "other compensation" listed under corporate officer pay in your Act 150 disclosures?
    a. Please provide a description of all incentive payments your employees receive and which positions are eligible for each.
       For the past three years, please provide the salary set for each executive and board member position and clarify when more than one individual held the same job within the same year. For this purpose, please provide the salary everyone would have received if they had been employed for the full year, and specify any other compensation provided to each executive along with an explanation of this compensation if it is not clear. For each position, please be clear whether it was new or eliminated in any given year and how the salary for each specific position changed year to year. We are looking for components to perform a detailed and accurate comparison of executive compensation from year to year.
    b. Please specify what companies you or your board looks to for comparison when setting executive pay scales and provide their executive pay scales in the form and amount of detail you analyze for your comparison.

Dated at Montpelier, Vermont this 12th day of June, 2017.

s/ *Kaili Kuiper*________________
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CERTIFICATE OF SERVICE

I, Kaili Kuiper, hereby certify that I have served the above Memorandum on Judith Henkin, General Counsel to the Green Mountain Care Board, Noel Hudson, Health Policy Director of the Green Mountain Care Board, and Jacqueline Hughes, representative of Blue Cross Blue Shield of Vermont, by electronic mail, return receipt requested, this 12th day of June, 2017.

s/ *Kaili Kuiper*________________
Kaili Kuiper
Staff Attorney
Office of the Health Care Advocate