MEMORANDUM

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

TO: Green Mountain Care Board, Data Governance Council

FROM: Rebecca C. Heintz, Blue Cross General Counsel

DATE: August 3, 2022

RE: Comments to Proposed Revisions to VHCURES Reporting Manual

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Blue Cross and Blue Shield of Vermont ("Blue Cross") respectfully submits the following comments to the Green Mountain Care Board's proposed revisions to the Reporting Manual for Vermont's All Payer Claims Database known as VHCURES. These comments follow up on our meeting with the GMCB staff members on May 25, 2022. These comments are in addition to Blue Cross's letter expressing privacy concerns over the GMCB's collection and maintenance of identified claims data, dated August 2, 2022.

We appreciate the opportunity to submit these comments, and we hope you find them useful.

Comment to Proposed Addition of Race and Ethnicity Data Elements

The proposed revisions follow the Common Data Layout (CDL) data elements by providing for collection of certain demographic information, namely: Race (ME021, ME022, ME023), Hispanic Indicator (ME024), and Ethnicity (ME025, ME026, ME027). We currently do not collect this information from our subscribers and members. We recognize, however, that having health insurers and state insurance departments collect this demographic information could be beneficial to identifying and addressing disparities in health insurance and health care.

In light of the sensitive nature of this demographic data, we suggest that collection and use of race and ethnicity data be done only pursuant to carefully crafted data collection and use principles to help maintain data privacy and to help ensure the information is used only for permissible purposes. The National Association of Insurance Commissioners (NAIC) Special Committee on Race and Insurance has issued Principles for Data Collection[1] that contain important recommendations for the collection of race, ethnicity, and language data, including:

[1] National Association of Insurance Commissioners (NAIC) Special Committee on Race and Insurance, *Principles for Data Collection*, December 20, 2021 (available at https://content.naic.org/sites/default/files/inline-files/Principles%20for%20Data%20Collection%20-%20Final%20-%20Dec%202021.docx).

- Utilizing industry-wide best practices for data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness.
- Ensuring that disclosure of this demographic data is voluntary and based on self-identification or disclosure.
- Providing respondents with reasoning for why the data is being requested and assurance that it will support efforts to provide equitable care.
- Developing and implementing trainings on how to obtain this demographic information.
- Providing trainings on how to maintain the privacy of this information.

The Principles also contain important limitations on the use of demographic data by health insurers and state insurance departments, including:

- Distinguishing between the collection of demographic data to be used for specific, permissible purposes (such as analysis of health disparities and inequities) from prohibited uses of such data (such as in rating, underwriting practices, and benefit determinations).
- Applying HIPAA protections to demographic data, and considering such data to be PHI.
- Ensuring that demographic information is aggregated and does not identify any single individual.
- Analyzing demographic data to advance and improve services and advance health equity.

Comment to Proposed Addition of Actuarial Value

The proposed revisions require health insurers to submit actuarial value (AV) for individual and small group plans (ME034). As we learned when required to add an ACO attribution data element to the VHCURES data extract, adding a data element is labor intensive and expensive. Furthermore, we do not include this data element in the systems that currently feed into the VHCURES extract, further increasing the chances for costly data maintenance and errors. Because the AV values of all of the plans available in the individual and small group market are publicly available and static (meaning they do not change throughout the plan year), we do not believe that requiring the AV value as a new data element is the most effective and least burdensome way to collect this data. We would prefer to work with the GMCB to communicate the AV values of the various health plans to the GMCB annually.[2] If a particular researcher chooses to focus on this data element, adding the data to the research data set will be less expensive then requiring a re-engineering of the entire VHCURES data extract.

Please note that only Blue Cross and MVP sell insurance in the individual and small group market; other payers will not incur this expense as they will not be submitting this data.

Comment on Total Monthly Premium Amount

This requires the average “monthly fee paid by a subscriber and/or employer” for health insurance. Does this amount include subsidies paid by the government?

[2] This data is already reported to the GMCB in the rate filings, but we recognize that the GMCB staff that work on the VHCURES extract may not have ready access to the rate filing data.

Comment to No Changes to Market Category Data Elements

ME003 requires the submission of Insurance Type/Product. We have long been baffled by the available codes. These are enrollment codes and many of them would never be applicable to an enrollment. A simple example is: "15 – Medicare Secondary Workers Compensation". A person's enrollment would never reflect if the coverage is secondary to worker's compensation coverage – such coordination of benefits happens by claim, not by enrollment. A person can have some claims that are secondary to workers compensation insurance, and some claims that would not be, because workers compensation insurance covers injuries associated with a work related injury – not all of a person's medical expenses. Further, some of these categories don't have an obvious relationship to the Vermont market. For example: "PC – "personal care" is unclear. Likewise, some of these codes would never be used because there are no submitting entities ("PE – property insurance (personal)") that would use them.

The only codes Blue Cross has ever reported are:

- IN - Indemnity
- PS - POS
- HM - HMO
- PR- PPO
- EP- EPO
- MP - Medicare Primary

We believe the quality of the data collected by VHCURES could be improved if illogical code choices were removed.

Similarly, ME030 requires the submission of the market category code. Blue Cross has regularly expressed concern that many of these categories reflect insurance categories that are inconsistent with the Vermont insurance regulatory framework. To enhance data integrity, we suggest removing those options that should never be selected by an insurer, as well as clearly indicate how certain markets should be reflected in the data.

Consistent with Vermont and federal law, Blue Cross generally considers the current Vermont market as made up of the following insurance markets:

- Large group fully insured
- Large group self-funded
- Small group fully insured
- Individual insurance
- Association health plan fully insured
- Association health plan self-funded
- Medicare Supplement
- Medicare Advantage
- Medicaid
- Self-funded governmental plan

Note that a large part of the Vermont insurance market is self-funded. Self-funded insurance is when an employer assumes the risk of benefit claims expenses directly. The data currently collected does

not distinguish between self-funded plans and those that are fully insured. It would seem this distinction could be relevant for some research purposes, yet it's not an option.

We include some notes related to each of the currently available categories in the following table:

Element	VHCURES Description	Blue Cross Notes
IND	For policies sold and issued directly to individuals	This is an appropriate market category
FCH	[F]or policies sold and issued directly to individuals on a franchise basis	It's unclear what type of insurance this refers to, but all individual insurance in Vermont must be offered on Vermont Health Connect, thus it seems this would be an illegal offering
GCV	For policies sold and issued directly to individuals as group conversion policies	The conversion of group policies to individual policies no longer occurs, although some might interpret this as coverage provided through COBRA
GS1	For policies sold and issued directly to employers having exactly one employee	This is not permitted.
GS2	For policies sold and issued directly to employers having between two and nine employees	Small group insurance must be offered through Vermont Health Connect and is available to employers ranging in size from 2 and 100 employees. Blue Cross monitors employer size in three categories – 2-20 (such insurance can be secondary to Medicare); 21 – 100 (must be offered through Vermont Health Connect); and 101 and above (large group insurance). The accuracy of the data collected regarding employer size when an employer is not close to one of these cutoff points is of questionable quality.
GS3	For policies sold directly to employers having between 10 and 25 employees	See above comment
GS4	For policies sold directly to employers having between 26 and 50 employees	See above comment
GLG1	For policies sold directly to employers having between 51 and 99 employees	See above comment.
GLG2	For policies sold directly to employers having 100 or more employees	In Vermont, employers 2-100 are considered small group employers. 101 and above are large group employers. Thus, technically this data element calls for a small subset of the small group market to be included with large group insurers.

GSA	For policies sold and issued directly to small employers through a qualified association or trust	This is appropriate, subject to the note above about self-funded insurance

Blue Cross has expressed concerns about these data elements in the past, but we understand that there has not been time to engage in any clean-up. However, given the other changes that will be implemented, we suggest that this would be a good time to make these changes. Improving the available elements a payer can choose so that they match the market will improve the quality of the data collected. As suggested previously, we believe working with the Department of Financial Regulation could help ensure that VHCURES codes align with current market rules. Blue Cross would appreciate participating in that work if it would be helpful.