LEWIS & ELLIS
Actuaries and Consultants
700 Central Expressway South
Suite 550
Allen, TX 75013
972-850-0850
lewisellis.com

June 28, 2018

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2019 Vermont Individual and Small Group Rate Filing
SERFF Tracking #: BCVT-131497882

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2018. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. Describe how the company has worked to mitigate medical cost inflation through the contract negotiation process with providers, whether or not they are included in the GMCB hospital budget review process.

2. (a) Provide a spreadsheet showing the breakdown of administrative expenses by PMPM and by percentage of total administrative expenses for 2017 (actual), 2018 (projected) and 2019 (proposed) across each of the company's books of business. Categories may include, but not be limited to: payroll and benefits, taxes, licenses, fees (including billback, calculated consistent with 2018 legislation), marketing and advertising, auditing and consulting, utilization management, and cost containment. For each category not subject to a standardized definition, provide a brief narrative outlining what is included and a breakdown of the specific cost components. Note whether each component cost is fixed or variable.

(b) If allocated costs vary across such books of business, describe how the variance is justified.

3. Provide the company's prior authorization policy and describe and quantify its impacts on administrative expenses and members' costs of care and quality of care.

4. Describe how the carrier incentivizes providers, and if applicable its PBM, to recommend generic or non-specialty drug alternatives to high cost specialty drugs, or to suggest behavioral changes instead of pharmaceuticals.

5. Explain and quantify the impacts of the cost shift from Medicare, and from Medicaid, on the rates paid by purchasers of plans in this filing. Is the cost shift consistent across all books of business?

6. Explain how the company reconciles risk adjustment payments when the final payment allocation becomes known. If a risk adjustment assumption proves incorrect, what was the effect on (a) the filing containing the incorrect assumption, and (b) future filings?

7. Last year, the company indicated that the CSR defunding in 2017 and 2018 would have a significant rate impact. Explain the rate impact in the 2019 filing.

8. Provide the number of enrollees by metal level and by CSR level (% of FPL), who are projected to migrate to the Reflective Silver plan or to another metal level (with a breakdown of the migration numbers), due to the elimination of CSRs. (This information can be submitted in a format comparable to that provided during the QHP plan review process and to the legislature.)

9. Describe the company's contingency plan for the possibility that the Cost Sharing Reduction program could be funded by Congress or the federal Administration during the 2019 plan year.

10. Describe your outreach and customer service plans to educate Vermonters who may be affected by the loss of funding for cost-sharing reductions

11. Discuss the following relating to changes in federal and state law:
    a. Explain whether and how the Vermont legislature's passage of a state individual mandate, effective in 2020, coupled with an outreach effort in the interim to minimize the number of Vermonters who may drop coverage, alters the filing's proposed rate increase due to the elimination of the federal individual mandate. Provide copies of any testimony or information you provided to the legislature in 2018 on this subject.
    b. Describe your outreach and customer service plans to educate Vermonters on maintaining continuous coverage or enrolling in coverage.

12. Provide a calculation of what the RBC would be for the QHP business only. What is its effect on overall company-wide RBC?

13. Provide the annual amounts of anticipated AMT credits for each of the four years 2019 to 2022, and the specific plan for allocating the credits among members and books of business in 2019.

14. According to the filing, the federal insurer fee cost $12,130,000 in 2018 and is projected to cost $14,435,000 in 2020. Provide the spread, in dollars and percentages, of this cost across BCBSVT's business lines in 2018, and the corresponding projected spread of this cost in 2020.

15. BCBSVT indicates the recovery of claims due to its new waste, fraud and abuse programs for ACA-Compliant plans has grown from .09% of claims in 2014 to 1.1% in 2017. Describe the key elements leading to the success of this new program.

16. Please provide quantitative support for the long-term target CTR of 1.5%. What CTR is necessary to offset the impact of trend?

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than July 5, 2018. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist F.S.A., M.A.A.A.
Vice President & Consulting Actuary
Lewis & Ellis, Inc.
jhammerquist@lewisellis.com
(972)850-0850

BlueCross BlueShield of Vermont

July 10, 2018

Mr. Josh Hammerquist, F.S.A., M.A.A.A.
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 06/28/2018 Questions re: Blue Cross and Blue Shield of Vermont 2019 Vermont Individual and Small Group Rate Filing (SERFF Tracking #: BCVT-131497882)

Dear Mr. Hammerquist:

In response to your request dated June 28, 2018, here are *your questions* and our answers:

1. *Describe how the company has worked to mitigate medical cost inflation through the contract negotiation process with providers, whether or not they are included in the GMCB hospital budget review process.*

   BCBSVT reimburses all non-hospital Vermont professional and ancillary services through its various Community Fee Schedules (Community Schedules). The Community Schedules are reviewed regularly for continued relevance in the marketplace, and providers reimbursed under the Community Schedules only receive increases or decreases to rates if BCBSVT implements a change. While the most effective way to mitigate the effects of medical cost inflation would be to limit fee schedule increases to zero, this is not a practical approach. BCBSVT is committed to supporting independent primary care, professional and ancillary providers and to ensuring member access to care. Were increases eliminated, the provider community would react very negatively, putting our members in the middle of any dispute. This is not a desired outcome for anyone and is not indicative of how BCBSVT treats its partners.

   Please see our June 20, 2017 confidential response to question 3 of the inquiry letter of June 15, 2017 for information regarding providers subject to the GMCB hospital budget review process. Hospitals have recently testified before the GMCB that they expect to receive the increases approved by the GMCB, and therefore limit negotiations accordingly[1].

   BCBSVT is advantaged through participation in the Blue Card network, which offers best in class discounts throughout the country. BCBSVT achieves a similar advantage through our direct contracting with New Hampshire entities.

   Additional detail would involve proprietary information regarding our provider contracting approaches with specific entities. It is unclear whether the question, as posed, requires this proprietary information. If such detail would be helpful, we would be happy to submit a confidential response upon request.

[1] GMCB Hearing February 28, 2018, testimony of UVMMC.

2.

a. *Provide a spreadsheet showing the breakdown of administrative expenses by PMPM and by percentage of total administrative expenses for 2017 (actual), 2018 (projected) and 2019 (proposed) across each of the company's books of business. Categories may include, but not be limited to: payroll and benefits, taxes, licenses, fees (including billback, calculated consistent with 2018 legislation), marketing and advertising, auditing and consulting, utilization management, and cost containment. For each category not subject to a standardized definition, provide a brief narrative outlining what is included and a breakdown of the specific cost components. Note whether each component cost is fixed or variable.*

b. *If allocated costs vary across such books of business, describe how the variance is justified.*

All segments within BCBSVT's book of business benefit from the scale of the enterprise in that fixed costs are shared by all segments and variable costs are allocated based on relevant volumes of transactions processed, e.g. membership volumes in the case of enrollment services or claims volume in the case of claims processing. Past studies have shown that approximately 50 percent of our costs are fixed in nature while the remaining 50 percent are generally more variable. Our operations model is managed functionally with all customer segments being supported by centralized functions, e.g. customer services. As a result, we allocate costs to segments based on an allocation methodology that is maintained and refreshed periodically to keep pace with organizational changes.

BCBSVT also participates periodically in in-depth benchmarking studies to understand how well we are managing costs relative to industry experience. Each segment typically has differing costs per member per month based on the requirements of that particular line of business, e.g. billing frequency, benefit complexity, regulatory requirements, etc.

BCBSVT administrative costs compare well to industry benchmarks as shown in the table below:

Segment	**2017 Actual BCBSVT Costs PMPM**	**Latest Median Benchmark Costs PMPM**
Large Group insured	$38.00	$41.02
Small Group & Individual insured	35.50	
ASO	19.64	23.58
Medicare Supplement	29.08	28.06
FEP	22.28	22.68
Medicare Part D	17.74	13.94
Overall Enterprise	**$27.27**	**$31.00**

Where possible, costs are allocated directly to lines of business. Certain categories of costs are allocated based on membership or claims, as appropriate. For instance, Customer Service is allocated based upon member months, while Claims Adjudication is allocated based on number of claims. Overhead costs are allocated on the basis of capital requirements.

BCBSVT total administrative costs by key function are as follows:

Function	2017 Cost PMPM	% of total costs
Rating & Underwriting	$0.40	1.5%
Sales & Marketing	$1.74	6.4%
Advertising & Promotion	$0.68	2.5%
Enrollment & Billing	$1.69	6.2%
Customer Service	$1.66	6.1%
Provider Network Management	$1.70	6.2%
Medical Management, Quality Assurance & Wellness	$3.91	14.3%
Claims Adjudication	$2.60	9.5%
Technology, Security & Infrastructure	$8.19	30.0%
Finance & Accounting	$1.38	5.1%
Corporate Services	$2.56	9.4%
Corporate Executive & Governance	$0.56	2.0%
License/ filing fees	$0.20	0.7%
Total	**$27.27**	**100.0%**

3. *Provide the company's prior authorization policy and describe and quantify its impacts on administrative expenses and members' costs of care and quality of care.*

According to the National Academy of Medicine, $765 billion a year is lost in waste by the U.S. health care system. That is approximately 25 percent of the cost of health care per year. This is care and resources that does not improve the health of patients. Prior authorization is one of many tools to help to control this waste, and it helps to provide evidence based utilization for many procedures and services. These appropriate use criteria embodied in our medical and radiological policies provide criteria, rationale and evidence to support their recommendations. These programs affect a small percentage of total care and strive to influence and support the provision of high quality care backed by evidence. Not only is the provision of care which is not evidence based wasteful, it puts patients at significant risk of clinical complications and "medical misadventures" leading to further negative health impact and cost.

The prior authorization policy is publicly available[2]. The 2017 costs of our prior authorization programs for the QHP population is $785,385, which is 3 percent of total administrative costs. Avoided costs for the QHP population through these prior authorization programs are $9,723,222. This does not include avoided costs from case management, disease management programs and other programs. This is over a 12:1 ratio of avoided costs to administrative cost of the programs, and represents a net premium savings of approximately 2.2 percent.

4. *Describe how the carrier incentivizes providers, and if applicable its PBM, to recommend generic or non-specialty drug alternatives to high cost specialty drugs, or to suggest behavioral changes instead of pharmaceuticals.*

BCBSVT drives the use of generic drugs in multiple ways. Members are incentivized via the copay structure of their benefits with lower copays for generic drugs. There are also utilization management programs such as step therapies and prior authorizations that increase the use of generic drugs. However, BCBSVT also tries to influence the prescribing behavior of the providers in a variety of ways. For example, BCBSVT has a pharmacist who travels the state each day meeting with doctors to discuss their prescribing with them. The pharmacist discusses new generics available in the market and programs BCBSVT has in place to encourage the use of those generic drugs. The pharmacist, through our program called medication therapy management, also provides voluntary workplace consultations to patients recommending changes to medications and/or behavioral interventions in coordination with their primary care provider and a case manager as necessary. This has been a very well received program. Additionally, the pharmacist sends each prescriber a Prescriber Medication Analysis which shows the prescriber their prescribing metrics (including the prescribing of generics) vs their peers. Lastly, the pharmacist provides doctors with a pocket-size formulary book which shows, by drug class, which drugs are available as generic drugs in that class.

Going forward, BCBSVT's pharmacy benefit manager, Express Scripts, is rolling out an electronic tool called Real Time Benefit Checks (RTBC). RTBC will be integrated into the prescriber's EMR such that when the prescriber starts to prescribe a patient a drug, the RTBC will populate the screen with the cost of the drug to that specific patient. If the drug they are prescribing is not covered or not on BCBSVT's formulary, the screen will show the therapeutic alternatives including the generic drugs that they could prescribe in place of the original drug. The patient's cost for the alternative generics will also be on the screen which will demonstrate to the doctors the savings to the patient by prescribing the generic version. This software has been shown to GMCB's Primary Care Advisory Group who felt it would be a valuable tool. RTBC is being rolled out on different timetables for each EMR vendor. RTBC will be available to users of Epic EMRs, including the largest hospital systems in Vermont, in October 2018.

"Generic drugs" for specialty drugs are called biosimilars. Biosimilars are just starting to enter the market. Unfortunately, the FDA has not finalized its guidance on how it will deem biosimilars to be interchangeable with the innovator brand version of the drug. Once the FDA issues those final guidelines, manufacturers will be able to seek and attain the "interchangeable" designation. Once that occurs and interchangeable

[2] http://www.bcbsvt.com/provider/prior-approval-authorization/pa-requirements-and-forms

biosimilars enter the market, BCBSVT will employ strategies similar to the ones mentioned above in order to maximize the use of those less expensive biosimilars. This year, the Vermont legislature updated the language in the mandatory generic substitution law to include interchangeable biosimilars. BCBSVT worked closely with the Senate, House and Legislative Council to craft and pass the language of the new bill.

5. *Explain and quantify the impacts of the cost shift from Medicare, and from Medicaid, on the rates paid by purchasers of plans in this filing. Is the cost shift consistent across all books of business?*

The concept of the "cost shift" is premised on the idea that Medicare and Medicaid don't compensate a provider for the full cost that the provider incurs delivering the service. In turn, commercial payers have to cover those unfunded costs so that providers break even or have some margin. This theory isn't without some debate[3]. Nonetheless, in Vermont, it is generally understood that the cost shift does occur and places additional pricing pressure on those insured through the commercial market. However, a payer such as BCBSVT does not have access to provider specific data that would allow it to quantify the exact impact of cost shift from public payers, since such an analysis requires an understanding of each individual provider's actual costs for members served by each payer. When attempting such a quantification, BCBSVT relies on data typically produced by the government, which presumably has far more access to provider cost data, as well as government program payments for such services. For example, see the Green Mountain Care Board analysis of cost shift estimates from January 2018: http://gmcboard.vermont.gov/sites/gmcb/files/Summary%20of%20FY18%20Approved%20Budgets.pdf, slide 16, accessed July 5, 2018.

With some minor exceptions, BCBSVT uses the same fee schedule for a given provider across the entire book of business. As such, the overall impact of the cost shift would be the same across the entire book.

6. *Explain how the company reconciles risk adjustment payments when the final payment allocation becomes known. If a risk adjustment assumption proves incorrect, what was the effect on (a) the filing containing the incorrect assumption, and (b) future filings?*

Final risk adjustment payments are known six months following the end of a given plan year. Any difference between the filing estimate and final result either contributes to or depletes surplus, in much the same way as any other actuarial assumption.

The previous year's risk adjustment result is the basis of the following year's filing assumption. For instance, the 2017 risk adjustment payment was the starting point for our 2019 filing assumption. The 2017 risk adjustment payment has been calculated by CMS to be significantly more favorable than our 2017 filing assumption. As a result of starting from this more favorable baseline, our 2019 filing assumption is also significantly more favorable than previous years' filing assumptions.

[3] See, for example: Contrary to Cost-Shift Theory, Lower Medicare Hospital Payments Rates for Inpatient Care Lead to Lower Private Payment Rates, C. White, Health Affairs 32, No. 5 (2013): 935-943 or Hospitals Respond to Medicare Payment Shortfalls By Both Shifting Costs and Cutting Them, Based on Market Concentration, J. Robinson, Health Affairs 30, No. 7 (2011).

7. *Last year, the company indicated that the CSR defunding in 2017 and 2018 would have a significant rate impact. Explain the rate impact in the 2019 filing.*

   Please see the Q6 tab of the attached *Responses to VISG Inquiry Letter 6.xlsx*. The impact of silver loading on non-loaded plans is immaterial.

   Note that BCBSVT has elected *not* to increase 2019 rates to recover losses expected to total some $6.8 million due to the defunding of CSR in 2017 and 2018.

8. *Provide the number of enrollees by metal level and by CSR level (% of FPL), who are projected to migrate to the Reflective Silver plan or to another metal level (with a breakdown of the migration numbers), due to the elimination of CSRs. (This information can be submitted in a format comparable to that provided during the QHP plan review process and to the legislature.)*

   Please see the Q8a tab of the attached *Responses to VISG Inquiry Letter 6.xlsx* for the enrollment matrix.

   As noted in our response to question 10.b.iii to the HCA letter of June 15, 2018 (responses provided on June 22, 2018), in researching this response it became apparent that we implicitly assumed that members receiving premium subsidies but no CSR subsidies would choose to pay the silver load rather than moving to a similarly-priced gold plan or significantly less expensive bronze plan. The appropriateness of this assumption is questionable, as none of these members benefit from remaining on a silver loaded plan. We believe that it would be more appropriate to assume that all non-CSR members receiving premium tax credits would instead choose to enroll in a non-silver VHC plan. Our product team expects that the following migration is likely to occur:

70%	Blue Rewards Silver	to	Blue Rewards Gold
30%	Blue Rewards Silver	to	Blue Rewards Bronze
70%	Standard Silver	to	Standard Gold
30%	Standard Silver	to	Standard Bronze
70%	Standard Silver CDHP	to	Blue Rewards Gold CDHP
30%	Standard Silver CDHP	to	Standard Bronze CDHP

   The resulting matrix of enrollees by metal level and CSR level can be found on the Q8b tab of the attached *Responses to VISG Inquiry Letter 6.xlsx*. Using these enrollment assumptions, the proposed rates for silver loaded plans would be 1.6 to 2.1 percent higher while the non-silver loaded plans would be increase by 0.09 percent (generally 50 to 60 cents).

9. *Describe the company's contingency plan for the possibility that the Cost Sharing Reduction program could be funded by Congress or the federal Administration during the 2019 plan year.*

   At this date is appears unlikely that CSR funding will be restored. During a congressional hearing on June 6, 2018, HHS Secretary Alex Azar testified that HHS will *not* block "silver loading" for the loss of CSR funding. The Secretary said that there is no time to set limits on how states require insurers to load premiums to account for the loss of CSR funding and that rules cannot be written before insurers set the rates for 2019. Secretary Azar also noted that HHS may consider new rules regarding silver loading for future years, while acknowledging concerns that such a change could increase premiums for non-silver plans.

   In Vermont, there is no vehicle for changing plans and rates off cycle, nor would this be operationally easy for Vermont Health Connect. BCBSVT's first course of action, if the federal government decides to start to make 2019 CSR payments going forward, would be to avoid accepting the funding at all since, if rates are approved as filed, CSR benefits will have already been funded. If refusing the payments is not an option or the rates are underfunded, BCBSVT would work with the GMCB, DVHA and other stakeholders to determine a universal solution in the best interest of members.

10. *Describe your outreach and customer service plans to educate Vermonters who may be affected by the loss of funding for cost-sharing reductions*

    Please see question 10c of our response submitted through SERFF on June 22, 2018.

11. *Discuss the following relating to changes in federal and state law:*

    a. *Explain whether and how the Vermont legislature's passage of a state individual mandate, effective in 2020, coupled with an outreach effort in the interim to minimize the number of Vermonters who may drop coverage, alters the filing's proposed rate increase due to the elimination of the federal individual mandate. Provide copies of any testimony or information you provided to the legislature in 2018 on this subject.*

       Please see question 6 of our response submitted through SERFF on June 21, 2018.

       BCBSVT testified on the impact of the repeal of the individual mandate penalty before the GMCB and the House and Senate committees of jurisdiction, and also participated in the Federal Issues Working Group discussions. The dates of the testimony were January 3 before the GMCB, February 22 before the House Health Care Committee and March 27 before the Senate Finance Committee. While we did not distribute any materials, the main points of our verbal testimony are as follows:

       The individual mandate is an important component of the Affordable Care Act and helps to ensure a stable public health insurance marketplace. While it is a key incentive to encourage the maintenance of health insurance coverage, it is part of a comprehensive health care system and should not be viewed in isolation. The impact of the individual mandate is anticipated to be more modest in Vermont than the estimates cited nationally. BCBSVT supported enacting a state-level individual mandate.

b. Describe your outreach and customer service plans to educate Vermonters on maintaining continuous coverage or enrolling in coverage.

Please see question 6 of our response to Agatha Kessler dated July 5, 2018.

12. Provide a calculation of what the RBC would be for the QHP business only. What is its effect on overall company-wide RBC?

The RBC calculation does not lend itself to a precise calculation for specific product lines, but with a few baseline assumptions it is possible to create a reasonable approximation.

In order to create a VISG-specific RBC, we started with the December 31, 2013 Authorized Control Level Risk Based Capital (ACL). An ACL distribution by line of business can be created by breaking down the various components of the Health RBC calculation as of a particular point in time. The known line of business splits contained in the RBC calculation are the Underwriting Risk (H2) and Business Risk (H4), in which BCBSVT records activity for premiums, claims and administrative expenses. The other risks contained within the Health RBC calculation (H0 Affiliate Asset Risk, H1 Other Asset Risk, and H3 Credit Risk), represent a smaller portion of the Capital Requirements ratios. A significant portion of Affiliate Asset Risk is known, as it relates to BCBSVT's equity in subsidiaries. The remainder of Asset Risk, as well as all of Credit Risk, was allocated proportionally to the sum of Underwriting Risk and Business Risk.

This process resulted in an allocation of 43.05 percent of ACL to Vermont Individual and Small Group lines of business (BCBSVT Small Group, TVHP Small Group, Nongroup, Safety Net and Catamount). We therefore allocated an identical percentage of total BCBSVT surplus to VISG as well. Please see the Q12a tab of the attached *Responses to VISG Inquiry Letter 6.xlsx* for these calculations. The resulting December 31, 2013[4] VISG RBC was 575 percent.

To determine a QHP RBC estimate for December 31, 2017, we calculated the increase in December 31, 2013 ACL due solely to the difference in claims from 2013 VISG products to 2017 QHPs, based on the Underwriting Risk formula within the RBC calculation that applies to BCBSVT major medical lines of business[5]. This increase in ACL was added to the base VISG ACL to calculate a December 31, 2017 QHP ACL. The QHP surplus as of December 31, 2017 is simply the sum of the baseline December 31, 2013 surplus and the cumulative QHP losses from 2014 through 2017 of $16.3 million[6]. Dividing these two quantities results in a December 31, 2017 QHP RBC of 293 percent.

It is arguably appropriate to allocate investment income among lines of business based upon their aggregate contribution to surplus as of any given year. This approach allocates

[4] Our original response to this question, submitted via email on July 6, 2018, identified this as the 2017 VISG RBC. We have amended our response to identify the correct date as 2013.
[5] Additionally, the Underwriting Risk associated with TVHP Small Group business was reclassified as BCBSVT Underwriting Risk. This adjustment to reflect the aggregation of risk on BCBSVT books creates a lower ACL requirement due to the covariance adjustment that excludes only Affiliate Asset Risk.
[6] Note we used restated GAAP results for this calculation. STAT results as recorded are different primarily due to timing, but would produce a substantially similar result as of December 31, 2017.

some $5.9 million in after-tax investment income to QHPs from 2014 through 2017. Even using this more generous approach, the QHP-specific RBC as of December 31, 2017 is only 336 percent. This amount is significantly lower than BCBSVT's target RBC range, and in fact is well below the monitoring level established by the Blue Cross Blue Shield Association.

Please see the Q12b tab of the attached *Responses to VISG Inquiry Letter 6.xlsx* for the calculation of the December 31, 2017 QHP RBC of 336 percent.

	December 31, 2013	December 31, 2017
Approximate RBC for QHP business only	575%	336%

13. *Provide the annual amounts of anticipated AMT credits for each of the four years 2019 to 2022, and the specific plan for allocating the credits among members and books of business in 2019.*

Please see question 17 of our response submitted through SERFF on June 4, 2018.

14. *According to the filing, the federal insurer fee cost $12,130,000 in 2018 and is projected to cost $14,435,000 in 2020. Provide the spread, in dollars and percentages, of this cost across BCBSVT's business lines in 2018, and the corresponding projected spread of this cost in 2020.*

Enacted on January 22, 2018, Section 4003 of Division D of H.R. 195 temporarily suspended the Federal Insurer Fee for 2019 only. The reference in this question is to language within the BCBSVT 3rd Quarter Large Group formula and factor filing. Because that Large Group filing will be used to develop rates for groups with plan years starting in approximately October 2018, and will continue to be used for groups with plan years extending through approximately August 2020, the federal insurer fee collected in 2018 and 2020 is relevant for that particular filing.

The filing currently under consideration is for VISG plans offered exclusively during calendar year 2019. As such, the federal insurer fee is not relevant to the 2019 VISG filing.

The federal insurer fee is allocated across insured lines of business on the basis of gross written premium, consistent with how the fee is assessed.

15. *BCBSVT indicates the recovery of claims due to its new waste, fraud and abuse programs for ACA-Compliant plans has grown from .09% of claims in 2014 to 1.1% in 2017. Describe the key elements leading to the success of this new program.*

    BCBSVT has continued to improve its FWA recoveries via relationship with an innovative and competent vendor partner that combines data analytics with industry knowledge to supplement our internal capabilities. Because FWA programs frequently have a "lifecycle", beginning with high initial recoveries that tend to decline over time as providers adapt their billing and practice patterns, it is important to continually analyze and identify new areas of opportunity. Leveraging our vendor's capabilities and supplemental resources has allowed us to continue to evolve and enhance our program accordingly.

16. *Please provide quantitative support for the long-term target CTR of 1.5%. What CTR is necessary to offset the impact of trend?*

    At a typical long-term rate of claims increase of 7 percent, including trend, population changes and membership increases, a CTR of 1.5 percent is required to maintain RBC at the midpoint of our target range. Please see the Q16 tab of the attached *Responses to VISG Inquiry Letter 6.xlsx*.

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

BLUE CROSS AND BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

RESPONSE TO ACTUARIAL INQUIRY DATED JUNE 28, 2018

From Exhibit 6A

	NON-STANDARD PLANS							STANDARD PLANS						REFLECTIVE PLANS				Total
	GOLD Blue Rewards	GOLD Blue Rewards CDHP	SILVER Blue Rewards	SILVER Blue Rewards CDHP	BRONZE Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	BRONZE Integrated	Catastrophic Blue Rewards	SILVER Blue Rewards	SILVER Blue Rewards CDHP	SILVER Deductible	SILVER CDHP	
Plan Level Adjusted Index Rate	**$599.08**	**$569.88**	**$583.24**	**$574.01**	**$454.57**	**$458.86**	**$717.12**	**$614.29**	**$577.67**	**$584.52**	**$451.86**	**$461.98**	**$465.87**	**$248.56**	**$517.50**	**$515.79**	**$518.52**	**$533.50**	**$580.86**
Projected Membership	1,164	6,499	2,212	684	598	2,226	10,262	5,836	6,457	1,695	1,597	1,512	485	264	814	1,691	5,645	2,950	**52,591**
												Excess of Loaded plans over Reflective plans:			12.7%	11.3%	11.4%	9.6%	

Using the membership movement assumption proposed on tab Q8b

	NON-STANDARD PLANS							STANDARD PLANS						REFLECTIVE PLANS				Total
	GOLD Blue Rewards	GOLD Blue Rewards CDHP	SILVER Blue Rewards	SILVER Blue Rewards CDHP	BRONZE Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	BRONZE Integrated	Catastrophic Blue Rewards	SILVER Blue Rewards	SILVER Blue Rewards CDHP	SILVER Deductible	SILVER CDHP	
Plan Level Adjusted Index Rate	**$599.73**	**$570.49**	**$593.80**	**$583.41**	**$455.05**	**$459.36**	**$717.91**	**$614.97**	**$587.21**	**$593.01**	**$452.35**	**$462.48**	**$466.38**	**$248.82**	**$518.06**	**$516.34**	**$519.08**	**$534.08**	**$582.42**
Projected Membership	1,349	6,765	1,973	592	677	2,226	10,262	6,488	5,574	1,334	1,876	1,626	485	264	814	1,691	5,645	2,950	**52,591**
												Excess of Loaded plans over Reflective plans:			14.6%	13.0%	13.1%	11.0%	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

RESPONSE TO ACTUARIAL INQUIRY DATED JUNE 28, 2018

		PROJECTED for 2019																		
		Blue Rewards Gold	Blue Rewards Silver	Blue Rewards Silver OFF	Blue Rewards Bronze	Blue Rewards Gold CDHP	Blue Rewards Silver CDHP	Blue Rewards Silver CDHP OFF	Blue Rewards Bronze CDHP	Standard Platinum	Standard Gold	Standard Silver	Standard Silver OFF	Standard Bronze	Standard Silver CDHP	Standard Silver CDHP OFF	Standard Bronze CDHP	Standard Bronze Integrated	Catastrophic	Loss due to Individual Mandate	**TOTAL**
INFORCE AS OF MARCH 2018	Blue Rewards Gold	1,164																		20	**1,184**
	Blue Rewards Silver		238	814	12		28	94												48	**1,234**
	Blue Rewards Silver - CSR 73%		242				26														**268**
	Blue Rewards Silver - CSR 77%		544				60														**604**
	Blue Rewards Silver - CSR 87%		841				93														**934**
	Blue Rewards Silver - CSR 94%		347				39														**386**
	Blue Rewards Bronze				252															37	**289**
	Blue Rewards Gold CDHP					6,499	10	331												66	**6,906**
	Blue Rewards Bronze CDHP								1,892											152	**2,044**
	Standard Platinum									10,262										107	**10,369**
	Standard Gold										5,836									80	**5,916**
	Standard Silver						47	824				882	5,645							241	**7,639**
	Standard Silver - CSR 73%						52					999									**1,051**
	Standard Silver - CSR 77%						77					1,469									**1,546**
	Standard Silver - CSR 87%						120					2,288									**2,408**
	Standard Silver - CSR 94%						43					816									**859**
	Standard Silver - CSR 100%											3									**3**
	Standard Bronze				168				168					1,597				168		77	**2,178**
	Standard Silver CDHP						19	442							361	2,950				108	**3,880**
	Standard Silver CDHP - CSR 73%						12								240						**252**
	Standard Silver CDHP - CSR 77%						20								374						**394**
	Standard Silver CDHP - CSR 87%						29								556						**585**
	Standard Silver CDHP - CSR 94%						9								164						**173**
	Standard Bronze CDHP				166				166								1,512	166		114	**2,124**
	Standard Bronze Integrated																	151		23	**174**
	Catastrophic																		264		**264**
	Total	**1,164**	**2,212**	**814**	**598**	**6,499**	**684**	**1,691**	**2,226**	**10,262**	**5,836**	**6,457**	**5,645**	**1,597**	**1,695**	**2,950**	**1,512**	**485**	**264**		

BLUE CROSS AND BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

RESPONSE TO ACTUARIAL INQUIRY DATED JUNE 28, 2018

		PROJECTED for 2019																		
		Blue Rewards Gold	Blue Rewards Silver	Blue Rewards Silver OFF	Blue Rewards Bronze	Blue Rewards Gold CDHP	Blue Rewards Silver CDHP	Blue Rewards Silver CDHP OFF	Blue Rewards Bronze CDHP	Standard Platinum	Standard Gold	Standard Silver	Standard Silver OFF	Standard Bronze	Standard Silver CDHP	Standard Silver CDHP OFF	Standard Bronze CDHP	Standard Bronze Integrated	Catastrophic	Loss due to Individual Mandate	**TOTAL**
INFORCE AS OF MARCH 2018	Blue Rewards Gold	1,164																		20	**1,184**
	Blue Rewards Silver	185		814	91			94												48	**1,232**
	Blue Rewards Silver - CSR 73%		242				26														**268**
	Blue Rewards Silver - CSR 77%		544				60														**604**
	Blue Rewards Silver - CSR 87%		841				93														**934**
	Blue Rewards Silver - CSR 94%		347				39														**386**
	Blue Rewards Bronze				252															37	**289**
	Blue Rewards Gold CDHP					6,499	10	331												66	**6,906**
	Blue Rewards Bronze CDHP								1,892											152	**2,044**
	Standard Platinum									10,262										107	**10,369**
	Standard Gold										5,836									80	**5,916**
	Standard Silver							824			652		5,645	279						241	**7,641**
	Standard Silver - CSR 73%						52					999									**1,051**
	Standard Silver - CSR 77%						77					1,469									**1,546**
	Standard Silver - CSR 87%						120					2,288									**2,408**
	Standard Silver - CSR 94%						43					816									**859**
	Standard Silver - CSR 100%											3									**3**
	Standard Bronze				168				168					1,597				168		77	**2,178**
	Standard Silver CDHP					266		442								2,950	114			108	**3,880**
	Standard Silver CDHP - CSR 73%						12								240						**252**
	Standard Silver CDHP - CSR 77%						20								374						**394**
	Standard Silver CDHP - CSR 87%						29								556						**585**
	Standard Silver CDHP - CSR 94%						9								164						**173**
	Standard Bronze CDHP				166				166								1,512	166		114	**2,124**
	Standard Bronze Integrated																	151		23	**174**
	Catastrophic																		264		**264**
	Total	**1,349**	**1,974**	**814**	**677**	**6,765**	**590**	**1,691**	**2,226**	**10,262**	**6,488**	**5,575**	**5,645**	**1,876**	**1,334**	**2,950**	**1,626**	**485**	**264**		

Authorized Control Level RBC as of December 31, 2013- updated based on H2 & H4 ratio to LOBs

	Total	Nongroup	BCBSVT Small	BCBSVT Large	Cost Plus	ASO	Safety Net	Catamount Health	FEP	Med Supp	Med D	NEHP	ITS	TVHP Large	TVHP Small	TVHP Medigap	CBA
H0 - Asset Risk - Affiliates (1)	**$14,055,323**	$803	$12,954	$21,167	$6,829	$1,420	$682	$12,388	$2,431	$1,382	$326	-$33	$180	$5,007,819	$8,748,845	$238,130	$1
H1 - Asset Risk - Other (2)	**$10,919,933**	$45,545	$734,429	$1,200,044	$387,160	$80,534	$38,667	$702,327	$137,801	$78,329	$18,483	-$1,861	$10,228	$208	$342	$27	$7,487,672
H2 - Underwriting Risk	**$29,604,985**	$439,164	$7,099,109	$11,659,244	$1,047,873	$15,635	$375,574	$6,833,255	$1,260,389	$715,058	$159,683	$0	$0	$0	$0	$0	$0
H3 - Credit Risk (3)	**$1,225,040**	$16,255	$262,126	$428,310	$138,182	$28,744	$13,801	$250,669	$49,183	$27,957	$6,597	-$664	$3,651	$74	$122	$10	$25
H4 - Business Risk	**$4,903,487**	$18,739	$284,799	$405,938	$2,844,609	$794,049	$13,178	$227,900	$125,056	$72,456	$26,142	-$18,714	$102,836	$2,086	$3,437	$270	$706
Subtotal - H0-H4	**$60,708,768**	$520,507	$8,393,417	$13,714,703	$4,424,652	$920,382	$441,902	$8,026,538	$1,574,859	$895,181	$211,231	-$21,272	$116,895	$5,010,187	$8,752,746	$238,436	$7,488,405
H0 - Asset Risk - Affiliates	14,055,323																
Square Root (H1, H2, H3, H4)	31,956,924																
ACLRBC After Covariance before BOR	46,012,247																
Basic operational risk (BOR)	-																
ACLRBC After Covariance after BOR	46,012,247																
ACL (50% of ACLRBC after covariance)	23,006,124	43.05%	9,904,131														
		Ind & SG	Ind & SG														
Total Adjusted Capital	132,369,496	43.05%	56,985,037														
H0-H3 totals (based on H2 & H4)																	
H0 - Asset Risk - Affiliates	14,055,323	803	12,954	21,167	6,829	1,420	682	12,388	2,431	1,382	326	(33)	180	5,007,819	8,748,845	238,130	1
H1 - Asset Risk - Other	10,919,933	45,545	734,429	1,200,044	387,160	80,534	38,667	702,327	137,801	78,329	18,483	(1,861)	10,228	208	342	27	7,487,672
H3 - Credit Risk	1,225,040	16,255	262,126	428,310	138,182	28,744	13,801	250,669	49,183	27,957	6,597	(664)	3,651	74	122	10	25
	26,200,296	62,603	1,009,509	1,649,521	532,170	110,698	53,149	965,383	189,414	107,667	25,406	(2,558)	14,059	5,008,100	8,749,309	238,166	7,487,698
H2 - Underwriting Risk	29,604,985	439,164	7,099,109	11,659,244	1,047,873	15,635	375,574	6,833,255	1,260,389	715,058	159,683	-	-	-	-	-	-
H4 - Business Risk	4,903,487	18,739	284,799	405,938	2,844,609	794,049	13,178	227,900	125,056	72,456	26,142	(18,714)	102,836	2,086	3,437	270	706
	34,508,472	457,904	7,383,908	12,065,182	3,892,482	809,684	388,753	7,061,155	1,385,444	787,514	185,825	(18,714)	102,836	2,086	3,437	270	706
Total allocated H0-H4	60,708,768	520,507	8,393,417	13,714,703	4,424,652	920,382	441,902	8,026,538	1,574,859	895,181	211,231	(21,272)	116,895	5,010,187	8,752,746	238,436	7,488,405
Share of Total	**100.00%**	0.86%	13.83%	**22.591%**	**7.288%**	**1.516%**	0.73%	13.22%	**2.594%**	**1.475%**	**0.348%**	**-0.035%**	**0.193%**	**8.253%**	14.42%	**0.393%**	**12.335%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

RESPONSE TO ACTUARIAL INQUIRY DATED JUNE 28, 2018

Calculation of December 31, 2017 QHP RBC

	Enterprise		VISG			
	Investment Income	Surplus	Investment Income	Surplus	VISG %	Tax Rate
2013		132,369,496		56,985,037	43.05%	20%
2014	4,626,709	138,363,389	1,593,438	61,097,770	44.16%	20%
2015	4,154,355	148,423,755	1,467,566	58,042,490	39.11%	20%
2016	4,212,181	135,263,874	1,317,770	47,203,488	34.90%	20%
2017	5,410,282	134,053,991	1,510,435	46,564,271	34.74%	20%

	From Q12a			
RBC Risk	December 31, 2017	With Claims Increase		VISG
H0	14,055,323	5,306,478	2013 Claims	271,359,571
H1	10,919,933	10,919,933	2017 Claims	373,101,581
H2	29,604,985	47,125,110	Increase	101,742,011
H3	1,225,040	1,225,040		
H4	4,903,487	4,903,487		
ACL	23,006,123	**26,971,781**		

				RBC
VISG	43.05%		December 31, 2013 VISG	575%
ACL	9,904,131	13,869,788	December 31, 2017 QHP	336%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2019 VERMONT INDIVIDUAL AND SMALL GROUP RATE FILING

RESPONSE TO ACTUARIAL INQUIRY DATED JUNE 28, 2018

Minimum Required CTR Calculation		**2018 Forecast Claims**	**Long-Term Typical Claims Increase**	**Restated to Reflect Typical Increase in VISG Claims**	Claims Increase
Vermont Individual and Small Group	A	$324,089,593	***1.070***	$346,775,864	$22,686,271

Estimated YE 2018 Authorized Control Level (ACL)	B	**$24,592,654**
Estimated ACL Reflecting VISG Claims Increases to 2019	C	**$25,489,866**
Increase in Capital Required to Maintain RBC at midpoint of target range	D = 600% x (C-B)	$5,383,272
Tax Rate for 2019 (FIT)	E	0%
Additional Required Grossed Up for FIT	F = D/(1-E)	$5,383,272
Filed 2019 VISG Premium	G	$366,572,694
Required VISG CTR Factor to Maintain Target RBC	CTR = F/G	1.5%

	Estimated YE 2018 ACL	Estimated ACL Reflecting VISG Claims Increases to 2019
H0	2,867,435	2,867,435
H1	16,335,645	16,335,645
H2	42,341,256	44,297,062
H3	1,248,004	1,248,004
H4	9,173,470	9,173,470
ACL	**24,592,654**	**25,489,866**