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

DELIVERED VIA E-MAIL

August 2, 2016

Mr. Noel Hudson, Esq.
Director of Health Policy
Green Mountain Care Board

Subject: Your 07/28/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hudson:

In response to your request dated July 28, 2016, here are *your questions* and our answers:

1. *Please state the proposed percentage increase in total provider payments, the proposed percentage increase in total payments for providers under the Board's hospital budget review process, and the proposed percentage increase in total payments for providers not under the Board's hospital budget review process. Hearing Transcript (Trans.), P. 48, lines 17-25.*

   As described on page 17 of the Actuarial Memorandum (Exhibit 1 of the Binder, p. 24), the provider payments increases for medical claims included in this filing were as follows:

	Percent of Total Medical Allowed Claims	FY 2016 Unit Cost Increase[1]	Assumption to 2017[2]	Total Annual Trend
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	53.0%	4.2%	2.9%	3.5%
Other facilities and providers	47.0%	3.0%	3.2%	3.1%
Total	100.0%	3.6%	3.1%	3.3%

   The increases in the table above compared QHP allowed medical claims in the experience (calendar year 2015) to the projected calendar year 2016 and 2017. The allowed medical claims are projected based on actual cost increases when known and estimated cost increases based on previous budget increases and contracting expectations when actual increases are not known at the time of filing.

   We are aware that the GMCB received the 2017 Fiscal Year hospital budget requests and that it reported an average commercial rate increase of 2.2%[3]. There are four methodology differences

[1] Reflects the increase from calendar year 2015 to projected calendar year 2016
[2] Reflects the increase from projected calendar year 2016 to projected calendar year 2017
[3] http://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/B17_PrelimFindings_update_from_B16_system_only_728final.pdf

driving the apparent difference between the GMCB figure of 2.2 percent and our filed unit cost increase of 2.9 percent for providers impacted by the GMCB hospital budget review. First, the 2.2 percent includes the full impact of the 3.7 percent rate reduction approved by the GMCB for RRMC effective May 1, 2016. Due to the timing of the reduction, this had only a partial impact on our stated 2016 to 2017 unit cost trend. Second, the GMCB figure does not account for the timing of increases and decreases. Our unit cost trend accounts for timing by specific month of increase. Third, the GMCB figure is based on a weighting by, presumably, overall facility expenditures. Our unit cost trends are weighted by expenditures specific to BCBSVT QHP business at each facility. Fourth, the GMCB number is calculated by averaging the overall stated commercial increases, unlike our unit cost trend, which specifies increases by type of service (inpatient vs. outpatient vs. professional).

Since the time of the hearing, we have learned that there is a discrepancy between what one facility reported to us as their proposed contracted increase for fiscal year 2017 and the commercial ask included within their budget filing to the GMCB. Despite numerous conversations, we have been unable to resolve this discrepancy to date. As we testified at hearing, if we use the original proposed contracted increase for this facility and assume that all other commercial rate increases submitted to the GMCB flow directly through contracting (which is, in itself, not necessarily an accurate assumption), the resulting unit cost is calculated as very slightly higher than that used in our filing. If we instead use the commercial rate ask in their budget filing for this facility as well, the resulting unit cost trend is equal to that used in our QHP rate filing.

In other words, for the many reasons outlined above, the unit cost trend of 2.9 percent proposed in our QHP rate filing is equivalent or slightly lower than the unit cost trend that can be calculated assuming that the commercial rate asks in the proposed hospital budgets flow directly through to contracts for the VHC network on which QHP business is written. We would therefore reiterate that it would be incorrect to lower our proposed unit cost trends due to the recent hospital budget submissions.

At the hearing, the GMCB requested that we provide the historical percentage of claims that are subject to the GMCB hospital budget process (Transcript P.49, lines 18-21). The table below shows the percentage of claims included in BCBSVT's QHP filings for the small group (up to 100 employees) and individual market, adjusted for network consistent with the filing, for providers under the GMCB's control and for claims that are not.

	Percent of total allowed claims for		
Year	Medical Claims for Facilities and Providers under the GMCB's control	Other Medical Claims	Pharmacy Claims
2012	45.6%	38.5%	15.9%
2013	46.9%	37.2%	15.9%
2014	44.4%	38.8%	16.7%
2015	43.9%	38.8%	17.3%

The table above includes pharmacy claims, which is why the percentages are different from the previous table within this response[4].

[4] 53% = 49.9% / (43.9% + 38.8%)

2. *BCBSVT's proposed utilization trend was based on a regression analysis of an 18-month experience period. The regression analysis resulted in an age- and benefit-adjusted utilization trend of 1.7%. BCBSVT further adjusted that figure to 1.0%, stating that the company believed 2015 data was producing an artificially inflated utilization trend. Exhibit 1, p. 24. Please explain fully the actuarial methodology behind the further adjustment, including why BCBSVT arrived at 1.0% and not another figure.*

   Actuarial Standard of Practice #8, which provides guidance to actuaries preparing regulatory filings for health plan entities, requires that:

   > "The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit plan; and any relevant industry and government studies that are generally known and reasonable available to the actuary."

   In selecting a utilization trend assumption, we considered recent past experience of the QHP market – as described via the regression analysis – along with recent BCBSVT experience across the balance of our book of business, a review of industry trend data, and our own professional judgment. The resulting trend of 1.0% represents the lowest possible assumption that is both reasonable based upon our review of relevant information and produces a result that is reasonable and adequate when aggregated with all other assumptions, consistent with ASOP #8. L&E agreed with our approach, including our adjustments for induced utilization, aging population, *the unexpected seasonal patterns in 2014,* and the potential up-take in 2015, finding it to be reasonable and appropriate. L&E, p. 5 (italics supplied).

3. *BCBSVT's proposed pharmacy utilization trend was based on a regression analysis of an 18-month experience period, resulting in an age- and benefit adjusted utilization trend of 1.4%. BCBSVT then further adjusted this figure to 0.5%. Exhibit 1, p. 26. Is this adjustment a pharmacy-allocated share of the larger utilization trend adjustment identified in Question 4 (sic), or is there a separate actuarial justification for the pharmacy trend adjustment? Please identify and explain any pharmacy-specific actuarial assumptions underlying this adjustment.*

   While pharmacy utilization trend is considered separately from medical trend, the same actuarial principles described in our response to Question 2 still apply.

   In selecting a utilization trend assumption, we considered recent past experience of the QHP market – as described via the regression analysis – along with recent BCBSVT experience across the balance of our book of business, a review of industry trend data, and our own professional judgment. The resulting trend of 0.5% represents the lowest possible assumption that is both reasonable based upon our review of relevant information and produces a result that is reasonable and adequate when aggregated with all other assumptions, consistent with ASOP #8. L&E "mirrored" our approach and found the complex analysis we used to account for the ever-changing pharmacy environment to be reasonable and appropriate. L&E, p. 5.

4. *Please state the expenses BCBSVT is projecting, both in dollars per member per month and as a percentage of total administrative costs, for administering prior authorizations requirements. Please also state the benefits, including claim-cost savings PMPM, that BCBSVT attributes to its prior authorization requirements. Trans. pp. 59-64.*

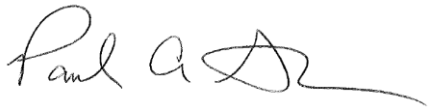
   BCBSVT's "Prior Authorization" program, which is part of our integrated health management practices and one of several programs aimed at the use of appropriate levels of care, member safety and cost containment, costs $0.90 per member per month (PMPM) or 2.7% of administrative expense. This program generated approximately $3.1 million[5], or $3.84 PMPM, of savings for a 12 month period. With a cost of $0.90 PMPM, the net savings of this program is $2.94 PMPM, or approximately $2.4 million.

   Furthermore, BCBSVT's utilization management programs for pharmacy produced savings of $9.5 million, or $11.83 PMPM over the last 12 months. With a cost of $0.21 PMPM, the net claims cost savings for these programs is $11.62 PMPM, or $9.3 million.

   The total cost of BCBSVT's integrated health management practices is $2.33 PMPM or 7.1% of administrative expense.

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

Sincerely,



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

[5] Based on the book of business average of $3.84 PMPM