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

June 24, 2016

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

Subject: Your 06/21/2016 Questions re: Blue Cross and Blue Shield of Vermont 2017 Qualified Health Plan Filing (SERFF Tracking #: BCVT-130567350)

Dear Mr. Hammerquist:

In response to your request dated June 21, 2016, here are *your questions* on behalf of the Health Care Advocate and our answers:

1. *Please list and quantify the services included in the projected "Other Medical" benefit category on the URRT.*
   Please see the table below:

Other Medical URRT	Utilization per 1,000	Average Cost/Service	PMPM
Other Medical Categories	**1,454.54**	**$ 175.42**	**$ 21.26**
Durable Medical Equipment	230.42	$ 378.70	$ 7.27
Drugs administered other than oral	149.09	$ 529.17	$ 6.57
Enteral and Parenteral Therapy	0.98	$ 355.21	$ 0.03
Physical Therapy	1,061.14	$ 81.85	$ 7.24
Radiation Treatment Delivery	12.91	$ 136.79	$ 0.15

2. *Was the experience period adjusted for an unusually high amount of large claims? If it was, please explain the adjustment.*
   The 2015 experience period did not have an unusual amount of large claims; therefore, no such adjustment was made.

3. *The product of all Population Risk Morbidity Adjustments in Exhibit 5 equal an adjustment of 1.004. Please explain why this is different than the 0.995 included on the URRT.*
   The difference between the factors lies within the selection of factors used, as illustrated in the tables below. Please note that Exhibit 5 was not intended to reflect the URRT definition of population risk morbidity adjustments.

Description	Index Label	Factor
Impact of the Change in Small Group definition	1+b1	1.0114
Impact of the Health Status of the newly insured	1+b3	1.0086
Changes in pool morbidity	1+b9	0.9896
Impact of different benefit plans (in experience vs projection)	1+c1	0.9859
Total used in URRT		**0.995**

Description	Index Label	Factor
Impact of the Health Status of the newly insured	1+b3	1.0086
Changes in pool morbidity	1+b9	0.9896
Changes in demographics (age, gender, region, etc.)	1+c3	1.0058
Total		**1.004**

4. *Regarding the "Other" Adjustments in Exhibit 5 and the URRT, please reconcile the Other Adjustments in Exhibit 5 to the URRT.*
   As noted in the response to Question 3 above, "Impact of different benefit plans," Other Adjustment 1+c1, is part of the Population Risk Morbidity factor in the URRT. The remaining "Other" adjustments within Exhibit 5 are part of the "Other" factor within Section II of the URRT. The balance of the URRT "Other" factor consists of Item 1+b8, "Impact of VHC Settlement," along with the total of the additive adjustments in section E of Exhibit 5.

5. *Please explain why the Taxes and Fees PMPM in the MLR calculation (Exhibit 8) only amount to $1.08 PMPM as opposed to the $4.61 in Exhibit 7C and the URRT.*
   Vermont HCCA taxes are included as claims in the Exhibit 8 calculation of the MLR, but are included within Taxes and Fees within the URRT.

6. *Please provide the Part II justification for all plans with more than a 10% rate increase.*
   Please see our Plain Language Summary, available here on the GMCB rate filing website: http://ratereview.vermont.gov/sites/dfr/files/2016/BCBSVT/Plain%20Language%20Summary.pdf

7. *Section 3.4.3 of the Actuarial Memorandum at page 10 discusses changes in the morbidity of the population insured. It describes upward pressure attributable to those members migrating from Medicaid and downward pressure resulting from adverse experience for voluntary cancellations. It does not discuss new enrollees that were previously uninsured. Do you have any estimates regarding the morbidity of this group?*
   We do not make an explicit assumption that there will be new enrollees who were previously uninsured.

8. This question involves confidential and proprietary information and will be provided under separate cover.

9. *On page 13 of the Actuarial Memorandum, you explain that VHC agreed to pay you for 2014 claims for which members had been retroactively cancelled. What settlement amount was received for 2014? What settlement amount is anticipated for 2015? What is the timing of any payments or expected payments?*
   VHC reimbursed BCBSVT $1,572,974, or about 0.5% of allowed claims, for 2014 claims incurred by members whom VHC had retroactively cancelled. The settlement for 2015 will take place upon completion of the financial reconciliation, which is ongoing. Until this work is completed, we do not know the settlement amount. As such, we included an assumption of 0.5% of total 2015 claims, equivalent to the outcome for 2014.

10. *On page 17 of the Actuarial Memorandum you describe the Pharmacy Trend Development. You indicated: "In this filing, we removed the contract adjustment from the cost trend calculation and added a factor to the overall trend calculation to account for the contracting changes. Accordingly, we based our cost trend calculation on Average Wholesale Price (AWP), which does not reflect contracted discounts, instead of contract-adjusted allowed charges as in previous filings." How were contracted discounts and rebates considered in the trend calculation?*
    Discounts and rebates are known contracting changes that are separate from the determination of underlying pharmacy trend. Rather than reflecting these in the trend calculation itself, they are included separately in the Index Rate development as Changes in Pharmacy Contract (1+c5) and Projected Pharmacy Rebates (e1), respectively.

11. *At the end of page 19 and continuing onto page 20 of the Actuarial Memorandum, you discuss how you have incorporated the impact of Viekira. At the top of page 20 you state: "There is no discount reflected in the claim, however we do receive large rebates from ESI for Viekira claims. As drug rebates are credited to groups in a separate part of the renewal formula, we used the claim cost of $30,000 per month in the trend development." Since there are no renewals formula that apply to small groups in this pool, please explain why rebates for all the specialty drugs that you have singled out in this section should not be incorporated into the cost estimates?*
    The phrase "As drug rebates are credited to groups in a separate part of the renewal formula" was extraneous. As with all other rebates, those for specialty drugs are included separately from trend in our estimate of Projected Pharmacy Rebates, item e1 in the Index rate development.

12. *On Page 24 of your Actuarial Memorandum you report that you completed an extensive cost accounting study. Please quantify the impact of any changes to your cost accounting on the administrative costs of the Qualified Health Plans. What other insurance lines were adjusted to offset any changes to the allocated administrative costs for the Qualified Health Plans?*
    Please see our response to Question 3 of the inquiries received on June 9, 2016.

13. *In 2016, how many small businesses with 51-100 employees purchased plans from you on the Exchange and how many were self-funded? How did the number of small groups and morbidity of these small groups compare to the estimates you made in your 2016 Vermont Health Connect filing? How many additional small groups do you expect to enroll in 2017?*
    Please see our response to Question 4 of the inquiries received on June 9, 2016. None of our previous large group customers of 51-100 employees who purchased QHPs from us in 2016 had previously been self-funded.

14. *Please explain your provider contracting timeline. When do you establish the rates you will pay different providers and how often are they renegotiated?*
    Negotiations with Vermont hospitals occur annually, concluding after the release of hospital budget orders by the GMCB. Most changes are implemented in October, with the exception of hospitals that have a January fiscal year.

    Our New Hampshire hospital negotiations also occur annually. Like most Vermont hospitals, updates are generally reflected in October, with the exception of Dartmouth Hitchcock negotiations, which occur on a July fiscal year basis. Non-facility contract review,

negotiations and updates occur throughout the year reliant upon the premium approval obtained through rate review process.

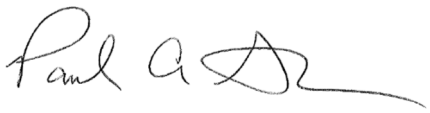
15. *Please explain any assumptions you made in your filing based on current Health Care reform initiatives in Vermont.*
    We have not included in our filing any assumptions, positive or negative, related to Vermont health care reform efforts. Apart from the continued inclusion of the cost of the Blueprint fees in the filing, we do not anticipate that any potential reforms would impact the cost of health care in 2017.

16. *Your predicted federal risk adjustment payment is one third of the amount MVP predicts it will pay. Can you explain this discrepancy?*
    We have no detailed knowledge of the methodology or calculations MVP used in their rate filing, and we are therefore unable to comment.

17. *Please indicate whether you believe that it is necessary to make any adjustments to this filing as the result of legislative changes in Vermont during the 2016 session or to federal changes that were not included in your original filing and that will affect rates. Please provide details about each such necessary adjustment.*
    Vermont legislators mandated the coverage of vasectomies at no cost share for non-CDHP plans. They also mandated a special enrollment period for pregnant women. Neither of these pieces of legislation have a material impact on rates. We are aware of no state or federal legislation that would require an adjustment to rates.

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

Sincerely,



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