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

June 27, 2017

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

Subject: Your 06/19/2017 Questions re: Blue Cross and Blue Shield of Vermont 2018 Qualified Health Plan Filing (SERFF Tracking #: BCVT-131037743)

Dear Mr. Hammerquist:

In response to your request on behalf of the Green Mountain Care board dated June 19, 2017, here are *your questions* and our answers:

1. *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?*
   We did observe growth in the individual subsidized segment of the population throughout 2016, from 16,541 in January to a maximum of 18,526 in November. However, as we do not collect information about previous coverage when a member enrolls with us, we cannot definitively state how much of this growth was due to the Medicaid eligibility verification. In any event, it would appear that the influx was well less than the estimated 6,500 members.

   We do not believe that our trend assumptions have been affected by this new population. The per member per month (PMPM) allowed costs of the individual subsidized segment rose only 3 percent from 2015 to 2016, from $561.46 to $577.47, so it appears that the population newly-enrolled from Medicaid may have dampened trend if anything. Furthermore, the slight growth in the individual subsidized population was more than overshadowed by the significant leap in group enrollment, driven largely by the change in the definition of a small group. From 2015 to 2016, the portion of total membership in the individual subsidized segment dropped from 27.5 percent to 25.5 percent while small group membership rose from 56.3 percent to 59.9 percent. Again, if anything, this would argue for a slight dampening effect on trends, as the small group population has a much lower PMPM cost of $497.19.

   It bears noting that the 2017 QHP rate filing projected that the new membership would have an immaterial impact on the rates.

2. *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?*

   We have not conducted systematic analysis of macro demographic or economic factors related to Vermont's economy; however, we are aware of several publicly available data points. Vermont's population has declined in overall size each year since 2013. Since the

2010 census, the percentage of the Vermont population over age 65 has increased by approximately 20 percent while the percentage of the population below age 18 has decreased by approximately 7 percent. Annual growth in the Vermont real GDP between 2006 and 2016 was 0.5 percent while the rest of the nation grew at 1.1 percent. These data points are consistent with the state's own economic and population projections. Given these data, we found no compelling reason at this time to develop analysis to model a younger workforce or improving economy. To the contrary, publicly available data in Vermont points to an ongoing shift toward an older population.

b. *Utilization AGF normalization - Why do you use the SOA Health Care Report for age factors? Could you compare those factors against your internal experience?*
Our data is not sufficiently credible when broken out by age and gender to form the basis of an age study. Consider that the SOA study used commercial data for over 30 million members, whereas we have fewer than 70 thousand in Qualified Health Plans. We believe that using a national study is the best – and only credible – approach for this particular assumption.

3. *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.*
The primary drivers of increases in utilization and intensity from calendar year 2015 to calendar year 2016 include:

- Per member per month costs for prescription drugs administered in the hospital or doctor's office, and therefore subject to the medical benefit rather than the retail pharmacy benefit, grew by over 16 percent from 2015 to 2016. The majority of this increase was in anti-cancer medications. Specialty drug utilization is anticipated to steadily increase over the next several years as new breakthrough drugs enter the market, some of which will be life-saving to many patients. (These are paid through either the pharmacy benefit or the medical benefit, depending largely upon the place of service.)
- The frequency of preventive visits is up about one percent year over year, while the cost per visit has increased by a further 4.5 percent, driven primarily by a 12 percent increase in the per-visit cost of women's services and a 5 percent increase in the number of colonoscopies. The increase in appropriate primary care and preventive care utilization is potentially a welcome trend, the benefits tend to be downstream, with savings not realized immediately in the same or immediately subsequent period.
- After several years of decreases, inpatient costs normalized for increases to reimbursement schedules are modestly on the rise. Inpatient days have decreased, but a significant increase in intensity resulted in a 0.7 percent utilization trend from 2015 to 2016. Vermont has made great strides over the last several years in eliminating unnecessary hospital admissions, and has reached a level that compares favorably with national benchmarks. While we will continue to work with hospitals to combat unnecessary utilization, we would naturally expect inpatient trends to level out rather than decreasing indefinitely. We have also found that as the number of admissions decreases, the patients who are admitted tend to be sicker – again, a natural progression of intensity as a component of utilization trend.

  Our approach to utilization trend is largely retrospective in nature. The underwriting cycle dictates that changes in trend are largely captured in rates two years subsequent to the

change. This was true when utilization trend was declining, and remains true now that it has begun to increase slightly from historically low levels.

4. *Pediatric 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?*

   We would expect the impact of greater awareness of the benefit to erode over time. That said, trend has been in excess of 10 percent for each of the last two years. Given the lack of evidence to the contrary, we would expect trend to continue at that elevated level in the short term.

5. *Please provide quantitative and qualitative support for the expected impact due to new Vermont rules on limiting opiate prescriptions.*

   It remains to be seen how the new rules will impact prescribing patterns. For instance, we may see a shift in the amount prescribed from the first fill to subsequent fills without an overall reduction in opioid use. Oxycontin & Oxycodone represent only 0.3 percent of BCBSVT's pharmacy costs, so even if there is a change in prescribing patterns, its impact on QHP rates will be immaterial.

   We would like to note that BCBSVT is supportive of the new prescribing guidelines and we are implementing utilization management rules to support those guidelines.

6. *Please provide quantitative and qualitative support for the expected impact due to new rules requiring generic substitution for interchangeable biological products*.

   Vermont law does not currently require this. Furthermore, the FDA has yet to give any of the four approved biologics "interchangeability" status. Therefore, biologics will have zero impact on 2018 rates and pharmacy costs.

7. *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?*

   We do not have insight into facility data for populations other than our own. However, data shows that we are seeing increased utilization within our own populations, whereas utilization had been flat in the recent past. Please see our response to Question 3 for a detailed actuarial and clinical analysis of the primary drivers of medical utilization trend.

   a. *Please further break down the impact between BCBSVT's Exchange population and the non-Exchange population.*

      We have observed similar utilization trends for QHP and other commercial lines of business from 2015 to 2016: 2.3 percent for QHP and 2.5 percent for other commercial. We would therefore conclude that the hospital budget overages have impacted the two populations similarly.

8. *Provider Trend*
   a. *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.*
      The All Payer Model requires that the overall trend experienced by Vermonters should not exceed 3.5 percent. We would therefore anticipate that any increase in excess of that 3.5 percent target experienced by the commercial population would be indicative of the cost shift. We calculated the cost shift as the excess of rates using the filed total medical trend of 4.7 percent over rates calculated under the assumption that the overall Vermont 3.5 percent trend would apply to QHP as well.
      ii. This response contains confidential information and will be provided under separate cover.
      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.*
      We understand that the GMCB considers all of these factors in their hospital budget review process. However, BCBSVT has not systematically analyzed Vermont's hospital budgets and cannot confidently opine on the approved revenue targets that determine the unit costs for commercial members. However, we note that the growth in covered members and the lessening of bad debt probably has led to lower unit cost increases. The net patient revenue targets that the GMCB has approved the last several years are historically low, as are the commercial unit cost increases that derive from them.

   b. *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, please provide the study.
      Since the implementation of Act 48, which transitioned the role of reforming Vermont's health care system to the GMCB, BCBSVT has not studied the impact of providers driving up costs by moving services to more expensive care settings. BCBSVT has fully supported the GMCB's work on all reform efforts and has actively participated in all applicable State Innovation Grant workgroups. We note that, in the past, stakeholders have generally been uncomfortable with payers attempting to dictate specific clinical pathways in order to reduce costs. That said, we understand these types of analyses are an important part of health care reform efforts and we will continue to cooperate with the GMCB and other state authorities to provide information to support such lines of inquiry.

9. *Please provide the projected cost sharing reduction subsidies as a percentage of the projected premium.*
   As noted in the Actuarial Memorandum, we estimate that the CSR funding needed for 2018 is $8.7 million. This equals 1.9 percent of total projected premium for QHP for 2018.

10. *If federal cost sharing subsidies are eliminated, please describe any approaches you would consider for adjusting rates in response to the change.*
    In the event that the federal government ceases to fund the CSR program, it would be BCBSVT's intention to work with all stakeholders, as well as the various implicated state

agencies, to develop an approach that minimizes harm to all involved. We are willing to consider all reasonable rate adjustment approaches, but feel that any approach must take into account that the vast majority of the QHP market does not participate in the CSR program – our QHP market includes small businesses and several thousand non-subsidized individuals, creating unique challenges for Vermont.

11. *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?*

    Capital required is only one of the factors that determines BCBSVT's overhead allocation. Other factors, including membership and detailed cost accounting of work required to administer each product line, are also reflected in the allocation. It is common industry practice to consider the capital intensity required by a product line as a contributor to the allocation of administrative expenses for that product line. Maintaining adequate reserves to manage the risk is a significant component of the plan's value proposition to the plan's insured customers. It is appropriate to charge customers for the significant capital required for insured business, and the work needed to manage that capital is appropriately reflected in the administrative expenses charged to those customers. Because it is common practice, this approach aligns rates for BCBSVT's products with market expectations. This ultimately benefits the QHP rates, as BCBSVT's sizeable ASO block pays for a significant portion of BCBSVT's fixed costs.

12. *How has BCBSVT chosen its target surplus? Is this supported by evidence such as a simulation of adverse events?*

    BCBSVT has determined a target surplus as part of our enterprise risk management program. We have a long history of maintaining our surplus in a range that is considered adequate, but by no means excessive. Periodically, we test the range by considering the impact of adverse events such as an increase in medical or pharmacy trends, premium inadequacy due to regulatory actions, insured membership growth, or the introduction of new treatments such as specialty pharmaceuticals, and quantify both the likelihood of these events occurring and the impact on RBC position if they did. Based on our calculations from the most recent round of testing (circa 2013), we concluded that RBC in the range of 500 percent to 700 percent would be adequate to provide us with solvency protection in the event of one or more of the modeled scenarios occurring.

    The advent of the ACA and Vermont's unique mandates pertaining to the single risk pool, along with the movement of many large groups from insured products to self-funded ERISA plans, has led to a significant concentration of BCBSVT's insured business. As such, we are currently in the process of re-evaluating our target RBC range to ensure that it remains adequate. We plan to make a formal recommendation to our Board of Directors later this year, and we will communicate our conclusions to the Department of Financial Regulation and the GMCB.

13. *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?*

       BCBSVT does not segregate or quantify the annual employee salary increase between inflationary and merit components; the budgeted increase (3 percent in recent years) is

the entire pool allotted for salary increases. Under our compensation process, each manager is allowed to increase the aggregate salaries of his/her direct reports by up to the budgeted increase. The manager has the discretion to award more or less than the budgeted increase to any given employee. This decision is generally based on performance (merit), but may also be determined based on an employee's position in his/her pay grade or other factors deemed relevant by the manager. All salary increase decisions must be approved by the manager and by all management levels above him/her, up to and including the divisional Vice President. This ensures consistency throughout the company, and that the overall budgeted increase is not exceeded.

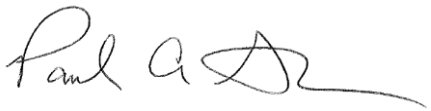
This approach allows BCBSVT to provide a total compensation package that will enable it to attract, retain, motivate and reward a highly qualified, diverse, and ethical workforce. BCBSVT values maintaining a competent, highly engaged workforce because it is essential to our delivering products and services that meet the very high standards we are known for, and doing so in the most efficient manner possible. To achieve this, we must compete against other employers throughout Vermont, and in some cases regionally or even nationally, for the same resources that we all desire: talented, competent and committed employees. This requires providing salary and benefit packages that are competitive with others in our marketplace.

Please see our response to Question 20 of the May 30 L&E inquiries for additional details regarding historical increases in personnel costs.

b. *Are all your employees getting similar increase? Please send the last three years' inflationary and merit increase percent by salary decile.*
As noted above, BCBSVT does not distinguish between the inflationary and merit portions of annual salary increases and therefore does not track the requested information. However, it is important to note that per the compensation process described above, the corporate target for salary increases applies to all employees of BCBSVT, up to and including the CEO, regardless of pay grade, management level, or any other factor whatsoever. As a result, BCBSVT can affirm that in any given year, each salary decile will necessarily average an increase very close to the overall budgeted increase.

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.