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

June 7, 2017

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

Subject: Your 05/30/2017 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 dated May 30, 2017, here are *your questions* and our answers:

Reasons for Rate Increase

1. *Provide quantitative support for the attribution of:*
   a. *1.3% due to increases in the wholesale price of prescription drugs;*
   b. *2.1% due to payments to providers of medical services; and*
   c. *2.8% due to utilization trend.*

   To calculate the reasons for rate increase, we start with the approved rates from the previous year and sequentially change one input at a time until we get to the proposed filed rates. We then combine some of the steps when describing the reasons for rate increase. Please see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q1 tab for a simplified exhibit detailing steps in question. There are minor differences between the increases calculated independently for the exhibit and those generated by the mechanical, iterative process that was used to populate the Actuarial Memorandum. These immaterial differences are due to covariance influenced by the order of operations, along with a minor rounding impact.

2. *Provide a list of other adjustments that comprise the reduction of 0.2% on the top of page 5 of the Actuarial Memorandum.*

   The other adjustments include adding Dental and Vision to the base (line A of exhibit 5), the change in the percentage of bad debt, the impact of the membership distribution by plan, and the minor impact to calculations of including dental and visions claims in the base (line A of Exhibit 5) rather than as a separate line item in the calculation of the index rate.

3. *Provide a breakdown of the impact of benefit changes by plan.*

Plan	2018 Pricing AV (Exhibit 2F)	Impact of 2018 plan changes
Catastrophic	69.34%	-0.45%
Blue Rewards Bronze	66.77%	N/A
Blue Rewards Bronze CDHP	66.78%	-0.54%
Blue Rewards Gold	82.40%	-1.59%
Blue Rewards Gold CDHP	79.61%	-1.33%
Blue Rewards Silver	74.15%	-1.60%
Blue Rewards Silver CDHP	72.39%	-0.11%
Standard Bronze	67.73%	-0.63%
Standard Bronze CDHP	68.22%	-0.26%
Standard Bronze Integrated	68.97%	N/A
Standard Gold	85.03%	-1.05%
Standard Platinum	92.68%	-0.26%
Standard Silver	75.70%	-1.75%
Standard Silver CDHP	77.11%	-0.49%

4. *What are the key drivers of the 5.9% difference between the actual and expected Contribution to Reserve in 2016?*
   There are three major drivers that contributed to the 5.9 percent difference in actual and expected contribution to member reserves:

   1) Pricing actuarial value exceeded the expectation in the 2016 filing. ~ 2.7 percent
   2) Vermont Health Connect membership changes made retroactively to 2014 after the date of the 2016 filing made it clear that the experience period allowed costs used for the 2016 filing were significantly understated. ~ 1.2 percent
   3) Three R's Risk Adjustment and Transitional Reinsurance booked at YE 2016 were less beneficial than assumed in the 2016 filing. ~1.7 percent

   The three R's estimates underlying the 5.9 percent difference represent BCBSVT's assumptions as booked in our 2016 year-end financials. Final three R's results for 2016 will be known and booked at the end of June 2017.

Trend

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

6. *Please provide a complete list of which contracts with facilities and providers have been finalized as of the date of this filing. For any contracts that have not been finalized as of the date of this filing and the assumed contract increase is not equal to the prior increase, provide a detailed explanation for the change.*
   At the time of filing, none of the contracts with effective dates after the filing date were finalized.

There are two reasons why future contracts increases were not set equal to the most recent increases. First, we included the ordered increases from the GMCB[1]. The ordered increases are summarized below.

Facility	Ordered Increase
UVM Medical Center	0.72%
Central Vermont Medical Center	0.72%
Northeastern Vermont Regional Hospital	3.20%
Northwestern Medical Center	-1.10%
Southwestern Vermont Medical Center	2.85%

If we had simply assumed that each facility would receive future increases equal to the most recent increase, the medical cost trend would have been 0.36 percent higher than the filed medical cost trend.

The balance of our response involves confidential and proprietary information and will be provided under separate cover.

7. *Please update Exhibit 3B with the latest available utilization data for 2017.*
Please see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q7 tab. We included claims incurred through February 28, 2017 and paid through April 30, 2017.

8. *Please update Exhibit 3C with data going back to January 2013 and the latest available data for 2017.*
Please see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q8 tab. We included claims incurred through February 28, 2017 and paid through April 30, 2017.

9. *Please provide qualitative analysis for the suspected drivers of the recent increase in utilization trends.*
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.
- 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.
- 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.

Continued hospital budget overages in 2016, which led to the GMCB orders to reduce the commercial ask in the upcoming budget process, give further credence to the higher utilization trends experienced by the QHP line of business.

[1] http://gmcboard.vermont.gov/sites/gmcb/files/files/hospital-budget/GMCB%20FY16%20Hospital%20Budget%20Press%20Release.pdf

10. *Please provide additional descriptions of the fraud, waste and abuse programs, including an explanation for why recoveries are expected to level out at 2016 levels.*
    Please see the attached document for a full description of BCBSVT's comprehensive anti-fraud, waste and abuse program ("*BCBSVT Anti-Fraud Plan 05-18-2017.pdf*").

    Through enhanced vendor capabilities, BCBSVT was able to achieve significantly improved FWA recoveries in 2015 and 2016. Once a set of practitioners is audited, information about audit and sanctions diffuse to other practitioners, and these additional "audit aware" practitioners put forth extra effort to ensure that billings are accurate and in compliance with BCBSVT payment policies. While we continually enhance our programs through the use of analytic data, we do not expect the enhancements made over the past two years to continue to escalate in the future. New programs are often difficult to implement due to provider abrasion and pushback. For these reasons, we believe that our FWA programs can continue to achieve the results attained in 2016, but are unlikely to surpass those levels.

11. *Provide the number of new hepatitis C claimants for each quarter year from 2014 to 2016.*
    The treatment for hepatitis C can span two calendar years. The table below counts each claimant in the year in which they started their treatment.

Year	Claimants
2014	18
2015	34
2016	26

12. *Please compare the projected utilization of PCSK9 inhibitors in 2018 to the utilization in calendar year 2016, including a narrative description of the differences.*
    We had 8 members taking a PCSK9 in 2016 and project that this number will increase to 10 in 2018. PCSK9 is approved for two indications: treatment of familial hypercholesterolemia after failing one high-dose stating for 60 days, and for members who have had a heart attack and then failed two different high-dose statins for 60 days. We estimated the projected 2018 claimant based on current membership, incidence studies for familial hypercholesterolemia, and historical patterns of failed high-dose statin use. With the QHP population aging and members having more time to try and fail high-dose statins, we believe that an increase in projected utilization of PCSK9 is appropriate. Additionally, in late February 2017, Amgen started advertising Repatha directly to consumers via television commercials. Past experience has shown that pharmaceutical advertising is effective in increasing utilization.

13. *Please compare the projected utilization of Orkambi in 2018 to the utilization in calendar year 2016, including a narrative description of the differences.*
    We had 3 members using Orkambi in 2016, 4 members using Orkambi in the first four months of 2017, and project that 9 members will be prescribed that medication in 2018. Orkambi was approved in mid-2015 and we continue to believe that it will become more popular as more doctors and patients know about it. Per guidance from our Chief medical Officer, we assumed that 50 percent of our members over age 12 currently diagnosed with cystic fibrosis would be prescribed Orkambi in 2018.

14. *When does BCBSVT expect Ocrevus to reach near peak utilization? How does this compare to other recent high cost specialty drugs that have been released? If this drug is expected to reach near peak utilization quicker than experienced by other high cost specialty drugs, explain the rationale for this assumption.*
    The last release of a major new treatment in the Multiple Sclerosis (MS) category was Tecfidera in March of 2013. BCBSVT had 223 claims for Tecfidera in 2013. In 2014, its first full year on the market, the number of scripts jumped to 1,091. Claims then leveled off to 1,153 in 2015 before declining to 805 in 2016. This rapid early growth speaks to the quick adoption of new drugs by Vermont neurologists treating MS patients. We anticipate a similar trajectory for Ocrevus, which was approved by the FDA in March 2017.

15. *Provide quantitative support for the brand drugs losing exclusivity for each month in the projection in Exhibit 3F.*
    Please see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q15 tab.

Risk Adjustment

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

Other Questions

18. *Please provide the Average Age-Sex Factor for 2014 and 2015 membership calculated using the methodology described in section 3.4.5 of the Actuarial Memorandum.*
    Using the same methodology as described in section 3.4.5 of the Actuarial Memorandum, the average age-sex factor was 1.2485 for 2014 and 1.2516 for 2015.

19. *We note that in 2018 it is assumed that there will only be 0.03% of claims without active membership, which is a large decrease from 2016. Does the emerging 2017 experience support this assumption? When did VHC indicate the improvements would be made?*
    Since inception, VHC has indicated improvements are being made to its system. However, in 2017, BCBSVT implemented a new process to base dunning and termination for nonpayment primarily on BCBSVT's Accounts Receivable records, rather than relying on VHC. While it is still early in 2017, the emerging 2017 experience is encouraging as we are experiencing a lower volume of retroactively cancelled membership. We expect that the ultimate rate of claims without active membership will match that experienced by other lines of business.

20. *What has the historical increase been in personnel costs been over the last 5 calendar years.*
    Personnel costs – including salaries, payroll taxes and employee benefits – have increased by an average of 7.3 percent from 2012 through 2016. The number of full-time employees increased by an average of 5.8 percent over the same time period, primarily through the in-sourcing of certain IT functions and volume-driven growth due to increased membership. Personnel costs per full-time equivalent employee (FTE) therefore increased by an average of 1.4 percent over the five-year period, including an average 3.3 percent annual increase in employee benefit costs per FTE.

    The average is significantly influenced by the change in personnel driven by the one-time events noted above. As we expect more of a steady state into the future, we have projected a more standard average increase in personnel costs moving forward of 3.0 percent. This assumption is lower than the 4.1 percent increase experienced from 2015 to 2016 despite a

stable count of FTEs, which was largely driven by a 12.8 percent increase in employee benefit costs that we do not expect to continue at such a high rate into the future.

21. *In Exhibit 7B, if the Projected Premium Increase in cell E6 is changed to 0%, then the Required QHP Insured CTR Factor to Maintain Target RBC increases to 3.6%. We would expect this to result in 0% based on the explanation of the calculation on Page 29 of the Actuarial Memorandum. Please provide a revised exhibit or explain why this analysis is incorrect.*
Item J referred to the results from separate linked workbook, and that functionality was lost when links were removed. We've enhanced the exhibit (see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q21 tab) to add functionality by including a very close approximation of the full calculation. The three factors in the calculation represent the UW Risk Claims Ratio (essentially claims as a percentage of premium), the Underwriting Risk Factor, and the Managed Care Discount Factor from the December 31, 2016 RBC calculation.

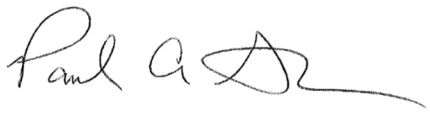
22. *Please provide the percentage of uncollected premium for each year that is included in the average of 0.20%.*
The table below includes the total billed premium for QHP and the total uncollected premium for the 30-day grace period.

	2014	2015	2016	Total
Uncollected Premium	$646,000	$800,840	$207,098	$1,653,938
Total Billed Premium	$255,193,256	$333,919,610	$386,227,017	$975,339,883
Percent of Billed Premium	0.25%	0.24%	0.05%	0.20%

23. *Please explain why the HCCA, federal insurer fee and GMCB Billbacks were not excluded from the MLR Premium in Exhibit 8, or provide revised exhibits.*
The HCCA is not considered a fee in the MLR calculation. The federal insurer fee and the GMCB billbacks were inadvertently excluded from the calculation in Exhibit 8. Please see attached Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q23 tab for the revised Exhibit 8. Our expected loss ratio for 2018 is 91.1 percent.

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.