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

June 22, 2017

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

Subject: Your 06/20/2017 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 June 20, 2017, here are *your questions* and our answers:

1. *Please reconcile the trends in the URRT with those in Exhibit 3I.*
   Please see attached Responses to BCBSVT 2018 Filing Inquiries – 06.20.2017.xlsx, Q1 tab.

2. *Please revise the Responses to BCBSVT 2018 Filing Inquiries – 05.30.2017.xlsx, Q7 tab to include updated claims incurred in 2016 paid through April 30, 2017. Please also review the adjusted claims for contract normalization factors for claims incurred in 2017.*
   Please see attached Responses to BCBSVT 2018 Filing Inquiries – 06.20.2017.xlsx, Q2 tab. Claims incurred in 2017 were normalized to the contract levels in place in December 2016 to ensure consistency with the filing exhibits.

3. *It is our understanding that carriers now have access to the issuer-specific 2016 benefit year risk adjustment transfer report on the EDGE Server Management Console. If applicable, please provide revised projections for the 2018 risk adjustment transfer and the impact on the rate increase.*
   We received issuer-specific 2016 year risk adjustment data on June 16, 2017. The 2016 risk adjustment receivable is $330,153 (compared to a projected $792,942 in the filing). Analogously with our filing methodology, we calculate MVP's coding growth factor by using the same completion factor (1.023) derived in the filing (from the 2015 data point) and the ratio of the 2016 MVP Final risk score (1.415) to the 2016 MVP Interim risk score (1.336). This results in a coding growth factor of 3.56 percent. We continue to assume that BCBSVT coding growth will be 1/3 of MVP's in 2017 and 2/3 in 2018. Since the time of the filing, it has come to our attention that we inadvertently excluded the 14 percent reduction in statewide average premium per the 2018 Notice of Benefit and Payment Parameters. We have added the adjustment to our calculation. All other methodology and assumptions are identical to those used in the original filing. The updated projected risk adjustment transfer for 2018 is a *payable* from BCBSVT to MVP of $853,414. This increases the filed average rate increase to 12.9 percent.

4. *Please further breakout the number of new hepatitis C claimants by quarter in the response to question #11 in the response date June 11. What is causing the projected hepatitis C claims to be higher in 2018 than in 2016 in Exhibit 3G(2)?*
The data excluded from the 2016 experience was for all hepatitis C claims incurred in 2016 for the 26 claimants. Note that not all of these claimants incurred all their claims in the same calendar year, while some get two scripts in the same month.

The table below shows the number of claimants by quarter based on the first script they incurred:

Quarter treatment commenced	Claimants	2016 incurred allowed	2016 Months	Total Months (as of February 28,2017)
2015 Q4	1	28,897	1	5
2016 Q1	2	195,051	6	6
2016 Q2	7	521,311	17	17
2016 Q3	7	579,439	19	19
2016 Q4	10	527,883	19	25
	27	1,852,581	62	72

We assumed that each of the 26 projected claimants in 2018 would incur 3 months of claims in 2018, which is why the total projected allowed is higher in 2018 even though the number of claimants is the same as in 2016.

5. *Is the assumption that the 10 projected members who will use PCSK9 inhibitors in 2018 consistent with the 2016 experience? In other words, did the 8 members who used PCSK9 inhibitors in 2016 stay on these drugs for the remainder of the year?*
Only one of the 8 claimants in 2016 stopped taking a PSCK9 inhibitor. That claimant only incurred one month of claims. All other claimants were still using a PSCK9 inhibitor in 2017.

The patients who have received authorizations for these medications either have Familial hypercholesterolemia or they have had a cardiac event and failed multiple statins and diet attempts. These conditions have an elevated mortality rate, which typically leads to a high level of adherence of the medication.

6. *Please reconcile the 3 members that used Orkambi in 2016 in the response to question #13 in the response date June 11 and the total cost of Orkambi claims removed for 2016 in Exhibit 3G(2). Did the members use Orkambi for the entire year and was Orkambi significantly more expensive in 2016?*
Our answer to question 13 dated June 11 used QHP members at a specific point in time. Over the calendar year 2016 for the experience base used for specialty pharmacy trend, we had 7 claimants with at least one Orkambi claim with an average of 8 months of claims. For the 2018 projection, we used the 2016 average monthly allowed charges from 2016 and multiplied by a projected 9 members for 12 months.

7. *Please reconcile the expected increase in utilization of Orkambi in 2018 with the note released by Vertex on September 28, 2016 that they are approaching peak utilization for Orkambi in the U.S. (http://investors.vrtx.com/releasedetail.cfm?releaseid=991350).*
   Vertex's statement is related to national numbers. Individual markets will experience utilization patterns that are different from national results. For example, BCBSVT's 33rd ranked drug by total plan cost is Genotropin (growth hormone) despite it being ranked 524th across Express Scripts' book of business. With specialty drugs, national trends are not necessarily a good indicator of local trends.

8. *Is Ocrevus expected to be approved for BCBSVT members with the relapsing form of MS (RMS)? If so, what is the average cost of drugs for these members?*
   Ocrevus will be approved for both types of MS: relapsing remitting and primary progressive. It will be the only treatment on the market for patients with the primary progressive form of MS. It is expected to have an annual cost of $65,000.

9. *Was the 15% of the average cost of MS drugs removed from the specialty trend in Exhibit 3G(2) based on the cost in 2016 or was it trended forward to 2018?*
   It was based on 2016 actual cost.

10. *Please provide the rationale for assuming that the uncollected premiums would more closely mirror the three-year average, rather than the recent data. Was any consideration given to the reason why the uncollected premiums dropped significantly in 2016? If so, please provide.*
    The drop in uncollected premiums in 2016 is due to multiple factors that are not expected to continue in 2017 and 2018. From 2014 to 2016, the dunning process and cancellations for non-payment were initiated based on the payment data of Vermont Health Connect (VHC). In 2016, thousands of members were originally renewed by VHC and then later cancelled via the 834 process; however, the files were not sent to BCBSVT until months later. By the time BCBSVT received the files in July 2016, terminations were not coded as non-pay and no applicable grace period would be written off; thus, these amounts were not captured as uncollected premium.

    Starting in 2017, we have a new and more diligent dunning process that is initiated by BCBSVT based on the accounts receivable balances in our own system. We expect that this will trigger more terminations for non-pay and result in an increase in the uncollected premium percentage.

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.