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May 25, 2018

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2019 Vermont Individual and Small Group Rate Filing
SERFF Tracking #: BCVT-131497882

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 5/11/2018. The following additional information is required for this filing.

Notice regarding proper responses:

- A minimum-acceptable response to quantitative questions from us must include a spreadsheet calculation with retained formulas such that we can replicate the calculations therein.
- Explanatory responses are merely a supplement to the spreadsheet material and in of themselves will constitute a lack of response.

Questions:

1. Please provide quantitative support for the projected risk adjustment.
2. Please provide additional support for the 1.4% impact on rates that is driven by an observed increase in average claims costs due to the loss of healthy members that is not expected to be fully offset by an increase in risk adjustment.
3. Please provide support for the impact, if any, that each of the morbidity adjustments in this filing impact the projected risk adjustment, including the aging impact.
4. The impact of benefit changes factor $(1+c_1)$ includes a 0.6% increase in claims due to membership changes from calendar year 2017 to March 2018.
    a. Is this partially offset by projected changes to risk adjustment?
    b. Please explain how this impact is not partially included in the change in pool morbidity factor $(1+b_9)$.

5. Please support using different thresholds for removing high claims for the following:
    a. Changes in Benefits
    b. Utilization Trend
6. Please provide additional support for the cost containment strategies and the impact in Exhibit 3C including a summary of how these goals were set.
7. Please clarify if the paid through date for the data in the table on page 10 of the Actuarial Memorandum is paid through March 31, 2018.
8. Please provide an outline of the reinsurance arrangement that was used to calculate the cost of reinsurance.
9. Please provide support for the assumption that the 2019 assessment for the Vermont Vaccine Purchasing Program will be 60% of the original 2018 rates.
10. When normalizing claims to analyze utilization and intensity, what percentage of the remaining allowed claims, mentioned in the last paragraph on page 19 of the Actuarial Memorandum, are not for out-of-area services?
11. In the utilization analysis, an adjustment was made for losing young members, but not for losing healthy members. Please discuss the adequacy of the age-gender factors for this adjustment and the availability of another quantitative source for morbidity.
12. Clarify what is meant on the top of page 20 in the Actuarial Memorandum, by "The derived trend for other claims are assumed to be continuous."
13. Provide qualitative support for blending the dental trends from 2016 and 2017. The dental benefits have been available since 2014 and it is unclear why the dental trends would not level out at more standard dental trends going forward. What were the 2017 dental claims per pediatric member?
14. Are the administrative costs different for individuals who enroll directly through BCBSVT versus the Vermont Health Connect? Is the addition of the Reflective Silver Plans off-exchange expected to have an impact on the administrative costs?
15. Please describe any efforts being made to reduce administrative costs as the Company's overall membership has declined. Has a more detailed analysis been done to estimate the impact of declining membership on overall administrative costs?
16. Please provide the percentage of individuals in the on-exchange silver plans that receive:
    a. federal cost sharing reductions;
    b. only Vermont cost sharing reductions; and
    c. federal premium subsidies, with no cost sharing reductions.
17. Please provide an estimate of the impact of the refundable AMT credits on the Company's RBC level.

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but

no later than June 4, 2018. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist F.S.A., M.A.A.A.
Vice President & Consulting Actuary
Lewis & Ellis, Inc.
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BlueCross BlueShield of Vermont

June 4, 2018

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

Subject: Your 05/25/2018 Questions re: Blue Cross and Blue Shield of Vermont
2019 Vermont Individual and Small Group Rate Filing (SERFF Tracking #: BCVT-131497882)

Dear Mr. Hammerquist:

In response to your requests dated May 25, 2018, here are *your questions* and our answers:

1. *Please provide quantitative support for the projected risk adjustment.*

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

2. *Please provide additional support for the 1.4% impact on rates that is driven by an observed increase in average claims costs due to the loss of healthy members that is not expected to be fully offset by an increase in risk adjustment.*

   Claims costs are expected to be influenced by changes in the pool morbidity, health status of the newly insured, benefit mix changes and membership mix changes. These factors were calculated by estimating their respective impacts on the average allowed charge. These same categories were incorporated into the risk adjustment calculation (see response to Q1) using the expected risk scores of the various sub-groups of members instead of the allowed charges. The comparative result of these calculations is the claims impact on premiums exceeding the risk adjustment impact on premiums by 1.4 percent.

   The impact on premium rates specifically for the change in pool morbidity ($1+ b_9$) was 2.2 percent (please see also our response to question 4 below). The premium impact of the risk adjustment transfer is -1.1 percent. All other adjustments such as the impact of new members, benefit and membership mix have a combined 0.3 percent premium impact.

   If we used a different methodology for the change in pool morbidity (as described in our response to question 4b) the premium impact due to changes in pool morbidity would be 1.3 percent lower. This would imply the impact of demographic adjustments net of risk adjustment would be only 0.1 percent (0.9 percent impact for changes in pool morbidity, 0.3 percent for all other demographic adjustments and -1.1 percent due to the increase in expected risk adjustment transfer amount.

3. *Please provide support for the impact, if any, that each of the morbidity adjustments in this filing impact the projected risk adjustment, including the aging impact.*

The impact of aging will affect the risk scores for both BCBSVT and MVP. We assume both carriers will experience the same proportional impact due to aging and therefore will not change the projected risk adjustment transfer. Similarly, the loss of membership due to the individual mandate was assumed to have the same proportional impact to BCBSVT and MVP and any changes in the carriers' risk scores was assumed to offset.

The health status of new membership is projected to increase claims but is also projected to be partially offset by projected risk adjustment in that the risk adjustment calculation assumed that new members would have BCBSVT average plan level PLRS scores (see 'Adjusted 2018' tab within response to Q1). Since the average PLRS of BCBSVT's new members is assumed to be 1.443 and MVP's projected PLRS is 1.290 there is an offsetting impact of risk adjustment for this factor.

4. *The impact of benefit changes factor (1+c1) includes a 0.6% increase in claims due to membership changes from calendar year 2017 to March 2018.*
   a. *Is this partially offset by projected changes to risk adjustment?*
   b. *Please explain how this impact is not partially included in the change in pool morbidity factor (1+b9).*

   a. Yes, the projected risk adjustment used the membership distribution as known in March 2018 and applied it to the plan ID level risk adjustment information. Therefore, the increase in claims due to members selecting richer plans is partially offset by projected risk adjustment transfer.

   b. We agree that a more appropriate methodology would have been to adjust the morbidity calculation to normalize for the impact of induced utilization, thereby making the benefit changes and morbidity adjustments completely independent. This change would have a downward impact of 1.3 percent on the morbidity factor, which flows through to have the same average impact on rates. Please see below a modified table from Section 3.4.3 of the Actuarial Memorandum:

	Voluntary Cancelation in the Individual Market	Members in Groups that are no longer with BCBSVT	All Other Members	Total
Experience Period Allowed	$37,911,937	$39,657,452	$384,863,755	$462,433,145
Member Months	68,283	84,643	666,898	819,824
PMPM	$555.22	$468.53	$577.10	$564.06
Experience Period Average Induced Utilization	0.8820	0.9904	1.0129	1.0000
PMPM After Normalization for Induced Utilization	$629.48	$473.08	$569.77	$564.06

The factor (1+b9 on Exhibit 5) to adjust for the change in pool morbidity would become $569.77/$564.06 = 1.0101.

5. *Please support using different thresholds for removing high claims for the following:*
   a. *Changes in Benefits*
   b. *Utilization Trend*

Please note that we did not use truncation to measure changes in benefits. As required by the rating rules, we use the entire single risk pool to measure the actuarial value of each plan.

We did use truncation for the purpose of calculating the $1+c_6$ factor related to the impact of selection in order to mitigate any skewness in actual allowed charge relativities among metal levels. This level was chosen because it produced results that were a closer fit to the relativities used in the previous year's filing. There is no actuarial reason why we should adjust this truncation point to match that used in the trend analysis. Doing so would have resulted in an immaterial -0.06 percent rate impact.

The $250,000 threshold for removing high claims was set very deliberately for the utilization trend analysis. Calendar 2016 was an outlier in terms of number of high claimants and total cost of high claims, which seemed to be skewing regression and time series results for utilization trend. The $250,000 threshold represented around 0.1 percent of claimants for each of the three years (slightly higher in 2016). Lower thresholds appeared to be less skewed while higher thresholds had so few claimants as to be less impactful in terms of removing the skewness from the statistical models. Note that we completely removed – rather than truncating – claimants above the threshold because of the difficulty in attempting to assign truncated claims to a specific month or months without causing additional skewness to the statistical analyses.

Again, we do not believe there is any actuarial reason why the same attachment point necessarily should apply to the two analyses: the calculations are not related in any way, and the methodology itself above the threshold was not the same (truncation vs. removal). The threshold and treatment of large claims was appropriate for each of the two independent analyses.

6. *Please provide additional support for the cost containment strategies and the impact in Exhibit 3C including a summary of how these goals were set.*

BCBSVT provides targeted care management to support our members. We seek to continuously evolve and improve our approach and in the coming year we will institute three new programs which will enhance our ability to help our members find the right care at the right place at the right time. These programs include a refined methodology to identify emerging risk among our members using proprietary CRG and severity scores in a proactive fashion; a new real time notification system which will provide admission, discharge and transfer information at the time at which clinical events occur; and a mobile care management platform initially targeted to support patients during transitions of care. When we analyze the historical claims experience of our VISG population we see several trends which routinely drive claims costs. These include inpatient utilization exceeding our book of business rates for conditions such as circulatory system, musculoskeletal disease and neoplasms and ER utilization with as much as 60 percent of the utilization driven by potentially avoidable low complexity visits. Targeting these high impact areas will be our first priority with our new capabilities.

Case management has historically used retrospective claims to identify complex cases that would benefit from case management services. At BCBSVT we provide best in class whole person care management through an integration of medical and mental health & substance use expertise through our partnership with the Brattleboro Retreat known as Vermont Collaborative Care. Members receive single point of contact care management for all diagnoses supported by

teams of nurses, social workers and licensed mental health professionals. One of the weaknesses of historical identification methods for case management is a dependence on submitted diagnoses and historical claims experience driving identifications which are typically separated from an acute event or diagnosis due to the claims cycle. New methodologies seek to leverage existing CRG and severity indices to identify emerging risk patients in need of support before they become high cost & complex cases. We are currently initiating work flows to identify these members earlier in their care journey and provide support to link them with appropriate outpatient care and self-management skills proactively. Our and industry experience suggest that care management is a cost effective intervention which controls costs and adverse utilization such as avoidable inpatient admissions and ER visits.

As mentioned above the claims system provides notification of events usually 60 days after an event has occurred. Leveraging new technology systems BCBSVT will be receiving real time data on admissions, discharges and transfers from an external vendor who is able to interface with state HIE and hospital systems throughout the country. The vendor is located in the Northeast and has connections with all VT hospitals as well as most hospitals in the Boston area, NH, NY, and Maine. These real time notifications also contain clinical information and algorithms such as the NYU classification system for avoidable ER visits allowing targeting of patients in need of care management support and education about alternative sites of care such as their primary care, urgent care and our new telehealth capabilities. In addition currently we receive notifications of admissions but not notifications of transfers or discharges and this capability will therefore inform more timely care management interventions to support our members.

The final new capability is the evolution of care management communications options for our members with the addition of a secure mobile care management platform. Currently the bulk of our communications with members in care management are telephonic and mail (and even some in-person care management). While we have found that one on one single point of contact human relationships are the most effective method to create engagement with our members and change their health behaviors and use of the health system this meets the communication needs of only a segment of our population. New communication channels including asynchronous communication such as texting and electronic messaging on secure platforms are increasingly being sought by members. We have engaged with a secure mobile health communication platform to extend the reach of our care management team. This platform significantly increases the channels of communication with our members and better meets their needs. We will be using this platform to extend rather than replace our single point of contact care management structure and allow asynchronous communications including disease specific health education to occur. One of the first programs we will be initiating is in transitions in care using this technology. We will focus on decreasing repeat admission and readmissions using this technology. Other health plans who have initiated this technology have seen substantial increases in engagement with their members and better experience with both ER and inpatient admission utilization as a result.

Our chief medical officer reviewed studies provided by the vendors for each tool and also interviewed other health plans who have implemented the processes described above. On the basis of those confidential studies, we concluded that a 4 percent decrease in inpatient admissions and a 5 percent reduction in ER utilization were reasonable estimates for the impact of the new programs.

7. *Please clarify if the paid through date for the data in the table on page 10 of the Actuarial Memorandum is paid through March 31, 2018.*

Yes, the first row in the table on page 10 should have been labeled “claims incurred January 1, 2017 through December 31, 2017 and paid through March 31, 2018.”

8. *Please provide an outline of the reinsurance arrangement that was used to calculate the cost of reinsurance.*

   BCBSVT purchases a reinsurance policy from Swiss Re with an $800,000 retention level and a 10 percent co-participation provision. The policy is unlimited on a per member per contract basis. We assess the retention level annually to ensure that we are retaining an appropriate level of risk and are receiving the best value for our premium. We also do a full market check every three years.

   The premium for our policy is a flat PMPM rate without a refund provision. We believe we have achieved the greatest value by negotiating a low fixed premium rather than tying potential savings to the performance of the policy.

9. *Please provide support for the assumption that the 2019 assessment for the Vermont Vaccine Purchasing Program will be 60% of the original 2018 rates.*

   To estimate the 2019 rates for the Vermont Vaccine Purchasing program (VVPP), we started with Assessment Calculation Worksheet from the October 31, 2017 meeting[1]. Based on data in that workbook, we calculated an average quarterly cost per covered life of $6.20, for a total quarterly cost of the program of $2.3 million.

   VVPP has accumulated a surplus of $13,654,036[2] over the past 4 years. Based on CDC policy, the program must have reserves "greater than or equal to the amount of the program's quarterly vaccine purchase." This means that the program much have at least $2.3 million in reserves at all times.

   Using a constant total program lives of 379,225 (based on 2018 worksheet), a beginning balance of $13.7 million and the known reduction in rates for 2018, we calculated that with a 2019 rate of 60% of the original 2018 rates, the program would be able to reduce its reserves to an amount higher than the minimum reserve by a reasonable margin of error by the end of 2019.

10. *When normalizing claims to analyze utilization and intensity, what percentage of the remaining allowed claims, mentioned in the last paragraph on page 19 of the Actuarial Memorandum, are not for out-of-area services?*

    Before normalization, 84.3 percent of the calendar year 2017 allowed charges are not for out-of-area services. After normalization, 84.2 percent of the calendar year 2017 allowed charges are not for out-of-area services.

11. *In the utilization analysis, an adjustment was made for losing young members, but not for losing healthy members. Please discuss the adequacy of the age-gender factors for this adjustment and the availability of another quantitative source for morbidity.*

    It is certainly possible but would be a significant undertaking to use the CMS risk adjustment model or other risk adjustment model as a means of estimating morbidity changes. Given that our VISG population decreased by only 2 percent at 2017 open enrollment, we expect that demographic and induced utilization adjustments are more than sufficient as a means of normalizing trend for population changes. It is unclear whether using risk adjustment instead

[1] http://www.vtvaccine.org/vtvaccine.nsf/WebEvents/71E8875583526E888525816F00471054
[2] http://www.vtvaccine.org/vtvaccine.nsf/documents/2018AssessmentRateChangeNoticeAndLetterFromTheCommissioner.html/$File/2018%20VVPP%20Committee%20Recommendation%20letter%20and%20Notice%20of%20Assessment.pdf

would yield a materially different or more accurate result, particularly given the small magnitude of the change in population.

Given the material change in membership from 2017 to 2018, it is likely that we will explore alternate methods of trend normalization and/or development for the 2020 filing.

12. *Clarify what is meant on the top of page 20 in the Actuarial Memorandum, by "The derived trend for other claims are assumed to be continuous."*

For providers that BCBSVT directly contracts with, we know when new contracts take effect. For other providers, we do not know exactly when contracts are updated and have therefore assumed that changes happen uniformly each month rather than once a year.

13. *Provide qualitative support for blending the dental trends from 2016 and 2017. The dental benefits have been available since 2014 and it is unclear why the dental trends would not level out at more standard dental trends going forward. What were the 2017 dental claims per pediatric member?*

We decided to blend the dental trends from 2016 and 2017 to both account for the lower trend in 2017 but also reflect the historical higher trends. Below are the historical per pediatric member per month results.

Calendar Year	PPMPM	Trend
2014	$8.81	
2015	$10.09	14.5%
2016	$11.33	12.3%
2017	$11.89	4.9%

We are unaware of any national studies that are specific to pediatric dental as part of QHP plans. National studies indicate that dental trends for standalone adult plans range from approximately 4.0 percent to 6.5 percent. Given historical results and national trends for imperfectly analogous products, our selected dental trend of 7.2 percent seems to be clearly within the range of actuarial reasonableness.

It bears mentioning that reducing dental trend to the lowest observed figure in the history of the product would have an immaterial rate impact of -0.01 percent.

14. *Are the administrative costs different for individuals who enroll directly through BCBSVT versus the Vermont Health Connect? Is the addition of the Reflective Silver Plans off-exchange expected to have an impact on the administrative costs?*

BCBSVT does not allocate administrative expenses separately for individuals who enroll directly with BCBSVT and those enrolled through Vermont Health Connect (VHC). Direct enroll individual is similar to traditional individual business and very different from small group in that it requires more operational support for billing, dunning, follow up call support, etc. We have therefore not included an impact to our administrative costs PMPM – either upward or downward – for the addition of Reflective Silver Plans off-exchange.

15. *Please describe any efforts being made to reduce administrative costs as the Company's overall membership has declined. Has a more detailed analysis been done to estimate the impact of declining membership on overall administrative costs?*

At BCBSVT, one of our highest priorities is managing our administrative functions and costs as efficiently as possible. Our annual budgeting process is thoughtful and disciplined, with our administrative cost targets set specifically to ensure that we compare favorably to industry benchmarks despite our small scale, and more importantly, that we are keeping the cost of our services as low as possible on behalf of our fellow Vermonters. Our employees are highly engaged in our corporate efficiency program known as Blue IDEAs, which continually generates process improvements and administrative cost savings. In most years, we are able to manage our actual administrative expenses even lower than our aggressive budget targets.

Our budget and administrative expense management processes require that we factor in a number of variables, including both actual and projected membership levels. As groups and other types of membership tend to move among insurers frequently, causing our membership to fluctuate in both directions, it is important that we manage our staffing levels and the associated costs based on a total view of membership expectations over a period of several months. Due to the complexity of our business and the extensive training required in our operational areas, it is ultimately more costly for us to reduce staffing immediately upon each modest membership decline only to have to ramp our staffing back up when the membership returns. It is important to maintain staffing levels at an efficient competitive level through the inevitable membership fluctuations.

As a percentage of the total population that BCBSVT serves, the loss of VISG membership in 2018 is not highly significant. In this type of circumstance, our approach is to monitor our variable cost areas closely, and where appropriate based on current and projected membership expectations, manage staffing below the budgeted level by holding open positions vacant for a longer period of time.

16. *Please provide the percentage of individuals in the on-exchange silver plans that receive:*
    a. *federal cost sharing reductions;*
    b. *only Vermont cost sharing reductions; and*
    c. *federal premium subsidies, with no cost sharing reductions.*

Of the 11,048 projected on-exchange silver plans members,

a. 48.5 percent receive federal cost sharing reductions (CSR 87%, CSR 94% and CSR 100%)
b. 37.3 percent only receive Vermont cost sharing reductions (CSR 73% and CSR 77%)
c. 14.3 percent receive federal premium subsidies without cost sharing reductions

17. Please provide an estimate of the impact of the refundable AMT credits on the Company's RBC level.

The accumulated AMT credits are scheduled to be refunded over a four year period beginning, at the earliest, in late 2019 based on BCBSVT's 2018 filed federal tax return. The ultimate impact of the total AMT credit refunds on BCBSVT's RBC level is dependent upon a number of factors that are difficult to predict so many years ahead of time. These factors include, but are not limited to, the following:

- The continued existence of the Tax Cuts and Jobs Act, specifically the provisions related to the corporate AMT repeal and the refunding of accumulated AMT credits;
- The impact, if any, of sequestration on the amount of the AMT credits actually refunded by the IRS; and
- BCBSVT's risk profile, most significantly the volume of membership and insured premium and claims, at the time the final AMT credit refunds are received.

Based on BCBSVT's year-end 2017 Authorized Control Level Risk-Based Capital (ACL), and inclusive of assumptions about sequestration and other factors, the AMT credits projected to be refunded to BCBSVT are $16.6 million in 2019; $7.9 million in 2020; $3.6 million in 2021 and $2.8 million in 2022. At today's ACL, these amounts are approximately 65, 32, 16 and 14 RBC percentage points respectively. However, this projection will likely change significantly by late 2022 or early 2023 when the final AMT credit amount has been refunded due to changes in ACL changes in the normal course of business. For example, in the absence of material changes in other factors, claims trend alone could be expected to greatly reduce this estimate as BCBSVT's ACL will almost certainly continue to increase.

Assuming the AMT credits are refunded to BCBSVT in accordance with the provisions set out in the Tax Cuts and Jobs Act, these funds will be used to the direct benefit of our customers as they are received from the IRS. The method(s) for returning the AMT credits to customers will be determined at that time and may include lower premium rates than would otherwise have been necessary, replenishment of member surplus shortfalls (e.g. not charging the market for the 2018 CSR funding shortfall), or other appropriate measures designed to improve access and/or minimize the costs of health care for Vermonters.

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.
Chief Actuary