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July 2, 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 elaborate on the process to estimate the impact on administrative costs PMPM due to the decrease in membership. As the individual and small group membership decreases, are some of the fixed costs spread out over other lines of business through a reduced allocation by line of business?
2. Please discuss the key drivers of the increase in the projected pharmacy trends compared to the prior filing for:
    a. non-specialty drugs; and
    b. specialty drugs.
3. Please provide a comparison of 2018 specialty and non-specialty claims to the same time period for 2017.
4. We note that the historical non-specialty utilization claims were normalized for induced utilization changes. Please describe why a similar adjustment was not made to the historical specialty drugs.

5. Provide additional support for the note in the Actuarial Memorandum that "We do not expect that the AWP for [new generic drugs] will significantly change from the experience period due to the lack of generic competition for the main drugs in this category." Additionally, please support applying the 3.5% generic unit cost trend to these new drugs as they move from brand to generic.
6. Please provide additional support for choosing the 24-month regression result of 3.5% for the generic unit cost trend, given that this result is on the high side of the regression and year-over-year results.
7. Please analyze the seasonality experienced with specialty drugs and summarize the results.
8. Please reconcile the administrative costs in this filing with the Supplemental Health Care Exhibit.

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 July 6, 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
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(972)850-0850

BlueCross BlueShield of Vermont

July 6, 2018

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

Subject: Your July 3, 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 request dated July 2, 2018, here are *your questions* and our answers:

1. *Please elaborate on the process to estimate the impact on administrative costs PMPM due to the decrease in membership. As the individual and small group membership decreases, are some of the fixed costs spread out over other lines of business through a reduced allocation by line of business?*
   As described in the actuarial memorandum, the administrative charges are impacted by membership changes at the enterprise level. This is consistent with previous calculations of membership impacts (see the 2017 QHP rate filing for example). The total enterprise projected member months include the total in-force March 2018 members plus the projected losses for VISG due to the elimination of the individual mandate penalty. Using total enterprise membership and total enterprise administrative expenses, we calculated a PMPM with experience membership and with projected membership. Since approximately 50 percent of administrative charges are variable, we included half of the increase in PMPM due to membership losses in calculating the increase of 3.4 percent.

   BCBSVT allocates fixed costs on the basis of capital requirements. With the loss of membership in 2018, the VISG line of business will have a lower capital requirement and therefore a lower allocation of fixed costs in 2018. However, since capital requirements for fully insured lines are closely proportional to claims costs, which are in turn largely driven by membership, the PMPM projection for any particular line of business is not significantly influenced by the absolute level of membership.

2. *Please discuss the key drivers of the increase in the projected pharmacy trends compared to the prior filing for:*
   a. *non-specialty drugs; and*
      The increase in non-specialty drug trend compared to the previous filing is mostly due to the increase in utilization trend:

Component	2018 Filing	2019 Filing
Utilization Trend	0.5%	2.1%
Generic Cost Trend	4.6%	3.5%
Brand Cost Trend	12.4%	12.3%
Projected Generic Dispensing Rate	89.9%	89.6%

In 2017, we experienced an uptick in the non-specialty utilization as compared to previous years.

Year	Days Supply PMPM	Increase
2015	29.2	1.8%
2016	29.8	1.9%
2017	30.9	3.5%

The increase in days supply PMPM for non-specialty drugs is mostly due to an increase in antidepressants, anti-hyperlipidemics and anti-hypertensives.

b. specialty drugs.

The specialty drug trend increased from 14.0 percent in the 2018 filing to 20.3 percent in the current filing. This is mostly driven by the increase in the base specialty trend (without exclusions) and the change to the methodology for the inclusion of the cost of Ocrevus. At the time of the 2018 filing, it was our understanding that Ocrevus would be included in the medical benefit, and the cost of the drug was therefore added to the medical trend. We now know that Ocrevus is processed by ESI and applied to the retail pharmacy benefit, and we have included the cost in the specialty drug trend calculation. Had we known at the time of the 2018 filing that Ocrevus would be applied to the retail pharmacy benefit, the specialty drug trend would have been 15.7 percent instead of 14.0 percent.

The increase in the base specialty trend reflects the increase experienced in 2017. As shown on page 2 of Exhibit 3F, the calendar year 2016 increase over the calendar year 2015 was 6.0 percent while the increase of calendar year 2017 over calendar year 2016 was 26.6 percent. This was driven by continued large increases in anti-inflammatory drugs (e.g. Humira, Enbrel; increased allowed PMPM over 30 percent each year), an ongoing increase in dermatological agents (e.g. Stelara and Cosentyx) and an increase in antivirals such as Harvoni.

3. *Please provide a comparison of 2018 specialty and non-specialty claims to the same time period for 2017.*

The table below compares claims incurred from January through May and paid through June for 2017 and 2018 for the single risk pool.

	2017 Allowed	2018 Allowed	2017 PMPM	2018 PMPM	Δ
Non-specialty	$18,811,923	$16,044,555	$54.17	$59.86	10.5%
Specialty	$13,923,908	$14,340,911	$40.10	$53.50	33.4%
Total	$32,735,831	$30,385,466	$94.27	$113.36	20.3%

These enormous increases for the first five months of 2018 indicate that our pharmacy trends are likely understated.

4. *We note that the historical non-specialty utilization claims were normalized for induced utilization changes. Please describe why a similar adjustment was not made to the historical specialty drugs.*

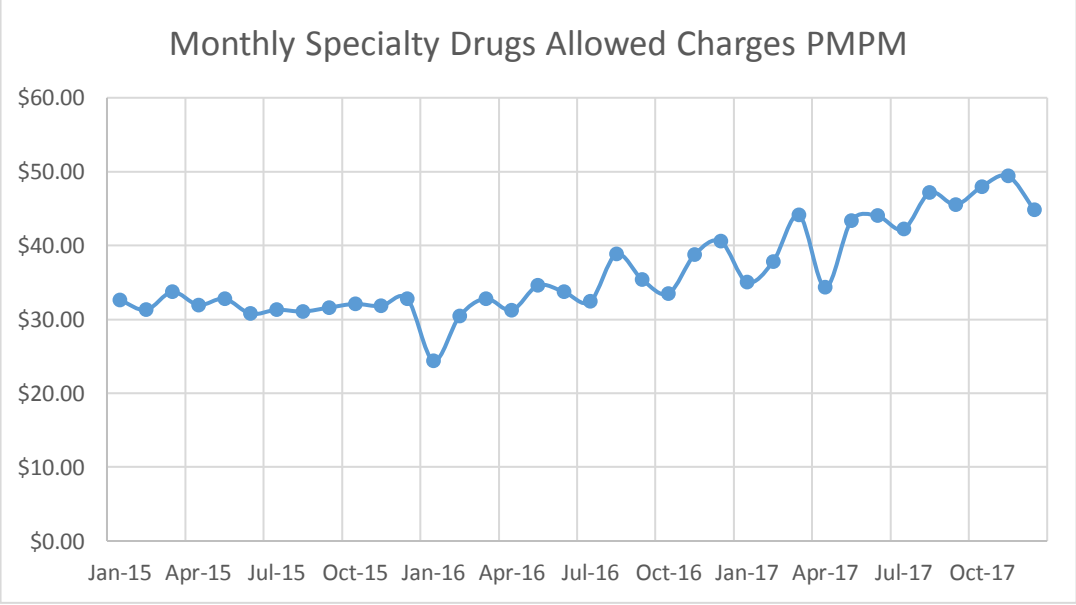
Specialty drug utilization is not influenced by benefit design and therefore no adjustment for historical induced utilization is needed. These drugs have thorough prior authorization requirements, so we can confidently conclude that utilization is clinically required and unlikely to change due to benefit design. Even in the absence of tight clinical management protocols, the low Vermont mandated pharmacy out-of-pocket maximum would preclude the need for an induced utilization adjustment specific to specialty drugs.

5. *Provide additional support for the note in the Actuarial Memorandum that "We do not expect that the AWP for [new generic drugs] will significantly change from the experience period due to the lack of generic competition for the main drugs in this category." Additionally, please support applying the 3.5% generic unit cost trend to these new drugs as they move from brand to generic.*
   We receive the list of drugs expected to go generic and the expectation of the pricing of the new generic versions of these drugs from ESI. They informed us of the expectation that the AWP for the new generic drugs would not be very different from the brand version due to a lack of competition among generic manufacturers. Once these drugs go generic, we expect them to trend at the same rate as other generics.

   It is worth noting that even if we assumed no trend on these drugs – an assumption that is not supported in the data or by industry experts – the impact on pharmacy trend would be an immaterial decrease of 0.035 percent.

6. *Please provide additional support for choosing the 24-month regression result of 3.5% for the generic unit cost trend, given that this result is on the high side of the regression and year-over-year results.*
   The twelve month average increases have been trending upwards from the year ended December 2016 to the year ended December 2017, from 0.3 percent to 3.2 percent. It is our reasonable expectation that this upward trend will continue, leading to our selection of a unit cost trend very modestly higher than the most recent year-over-year trend observation. Furthermore, the 24-month regression result contributed to a pharmacy trend that is reasonable in the aggregate.

7. *Please analyze the seasonality experienced with specialty drugs and summarize the results.*
   The graph below shows the monthly PMPM for specialty drugs, excluding new treatments and adjusted for aging (column T from Exhibit 3F). Both observation and statistical analysis demonstrate that specialty drugs do not follow a seasonal pattern.



8. *Please reconcile the administrative costs in this filing with the Supplemental Health Care Exhibit.*

The Supplemental Health Care Exhibit (SHCE) is on a STAT accounting basis while the administrative charges in this filing were developed based on GAAP accounting.

In the SHCE, administrative charges are included in lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4. Line 1.5 also includes a portion of the income taxes that are not part of administrative expenses. Those need to be excluded to reconcile to STAT administrative expenses (note that BCBSVT had negative income taxes for 2017). STAT and GAAP accounting treat some expenses differently, mainly related to ITS fees and pensions. For the filing, we start with GAAP administrative expenses then exclude federal and state fees (Federal Insurer Fee, PCORI, HCCA and GMCB billbacks) and fees paid to outside vendors from the base administrative charges, as those are added back into the premium separately.

		Individual and Small Group
SCHE lines 1.5 to 1.7, 6.1 to 6.5, 8.1, 8.2 and 10.4.	A	$28,386,745
Less taxes in SCHE 1.5 that are not admin	B	(4,812,235)
Total administrative charges - STAT basis	C = A – B	$33,198,980
Differences in STAT and GAAP treatment	D	(2,429,226)
Total administrative charges - GAAP basis	E = C + D	$30,769,754
Federal and State fees	F	1,657,256
Fees for outside vendors	G	403,656
Total base administrative charges	H = E – F – G	$28,708,842
Member months	I	819,824
Experience base administrative charges PMPM	J = H / I	$35.02

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.
Chief Actuary