BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association

March 20, 2019

Mr. Kevin Ruggeberg, A.S.A., M.A.A.A.
Consulting Actuary
Lewis & Ellis, Inc.

Subject: Your 03/13/2019 Questions re: Blue Cross and Blue Shield of Vermont 2020 Association Health Plan Filing (SERFF Tracking #: BCVT-131835459)

Dear Mr. Ruggeberg:

In response to your request dated March 13, 2019, here are *your questions* and our answers:

1. This question involves confidential and proprietary information and has been provided under separate cover.

2. *How much enrollment is anticipated for 2020 on the AHP product? Is this new enrollment expected to counteract the increasing non-benefit expense PMPM driven by decreases in large group enrollment?*

   We have not undertaken any formal projections of 2020 AHP membership. We anticipate an increase in AHP membership would not have a material impact on total BCBSVT membership since the majority of new membership would likely come from other BCBSVT lines of business.

3. *The memorandum states that a pooling point for a given fully-insured group's renewal is "based on the size of the case." Is this based on an explicit table or is there underwriter discretion at this step?*

   The pooling limit is based on the group's membership in the current month. Please see the table below for details. The underwriter may apply discretion in the event the current month's membership is not appropriate for determining a pooling limit (e.g. a significant change in enrollment due to an acquisition or layoff).

Membership (Current Month)	Pooling Limit
0 to 299	$70,000
300 to 499	$90,000
500 to 999	$110,000
1,000 to 1,499	$145,000

1,500 to 1,999	$170,000
2,000 to 2,499	$190,000
2,500 to 2,999	$215,000
3,000 to 3,999	$235,000
4,000 to 4,999	$275,000
5,000 to 7,499	$300,000
7,500 to 9,999	$350,000
10,000+	$400,000

4. *Trend leveraging is caused by fixed-dollar benefit parameters like deductibles and copays. Explain why the AV was used to determine trend leveraging rather than, for instance, the out-of-pocket maximum and/or deductible.*

   We use the AV as it is the best single measure that describes the overall richness of the benefit. We developed each curve from existing benefit-specific leveraging factors and tested for fit. Each of the curves we developed was deemed to be an acceptable fit for the benefits they model. Using less comprehensive measures such as deductible or out-of-pocket maximum ignores the other benefit parameters, such as copays, and the influence they have on the leveraging factor. There would be a wide variance of the leveraging factor for a single deductible or out-of-pocket due to these other parameters, which would make fitting an appropriate curve to the data both more difficult and less accurate.

5. *Please provide Exhibits 2B and 2D in excel format.*

   Please see the attached file *Response to 2020 AHP Filing 03.13.2019 Inquiry – Q5.xlsx* for the requested exhibits.

6. *How do the utilization trends in Vermont compare to the Blue Trend Survey or other nationwide utilization trends?*

   One proprietary source notes that over the past several years, utilization in several medical categories has been negative, due in part to economic recession. Beginning in 2016, economic recovery has led to the reversal of the negative utilization trends, and this movement is expected to continue to increase utilization trend through 2019.

   Another reason for an increase in national utilization trends is a plateau in the shift towards high-deductible health plans[1]. According to one survey, adoption of HDHPs has resulted in a decrease in utilization in past years. Now that the migration towards HDHPs has slowed, the damping effect of benefit changes on utilization trend is disappearing.

   Particular to Vermont, we note that in their large group filing, CIGNA developed both national and Vermont-specific medical trends[2]. The Vermont trend was 7.5 percent, compared to the national trend of 6.25 percent. CIGNA filed a utilization trend of 1.7

[1] Medical Cost Trend: Behind the Numbers 2018, page 12
https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers/reports/hri-behind-the-numbers-2018.pdf
[2] http://ratereview.vermont.gov/sites/dfr/files/2018/Objection%20Letter%201%20%26%20Response.pdf
Response to Objection 3, page 5

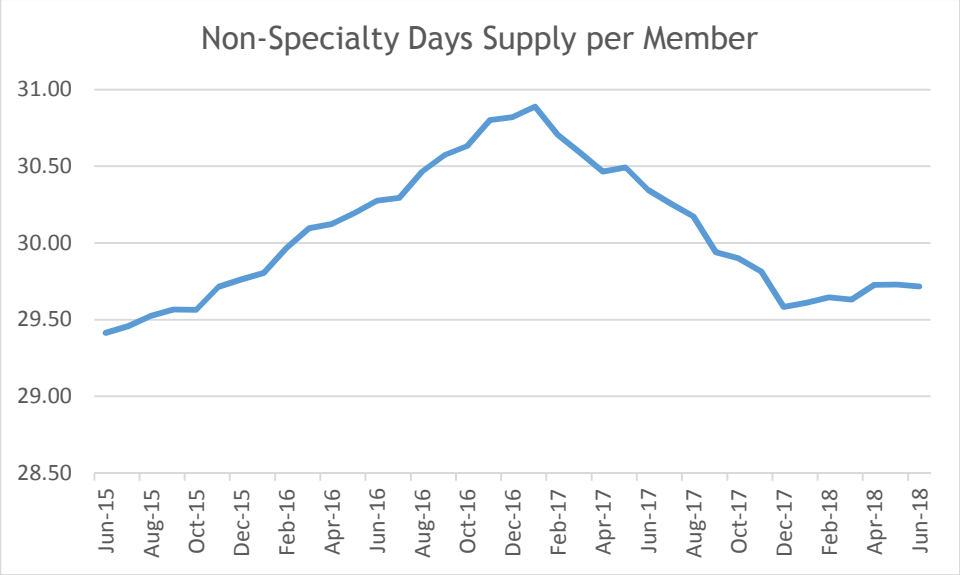
percent and a mix trend of 2.2 percent for Vermont, for a combined utilization/mix trend of 3.9 percent.

Finally, unit cost increases for Vermont hospitals have reached historical lows in part due to budget overages caused by excess utilization.

Given the information available, it would appear that the increase in utilization trend in Vermont is not an outlier compared to national trends.

7. *It appears from Exhibit 2D that non-specialty drug utilization has been decreasing in recent years. Describe why they are being trended forward at 0% annual.*

Non-specialty drug utilization has oscillated around a single 30 days supply per member for a number of years. The rolling days supply by member month is provided below for non-specialty drugs. Given that the days supply is near a historic low and leveled off over the last several months of the experience period, we did not think it was appropriate to project decreases in utilization.



8. *The generic cost trend development appears to include historical cost for drugs which were generic at the time. If this is the case, the "cost/supply" reflects the unit cost increases that result from newly genericized drugs during the study period. In Exhibit 2F, brands "going generic" between the experience period and the projection period are projected to have a higher allowed charge per supply than existing generics. Address the concern that this methodology appears to possibly be double-counting the unit-cost impact on generic drugs of previously brand drugs "going generic."*

The generic cost trend developed in the memorandum included all drugs identified as generic, including recently introduced generics in addition to drugs that have been generic for a number of years. This was the method we had used in previous filings, which included an adjustment for a projected generic dispensing rate in the ultimate trend

development. This year's filing uses a new method of accounting for brands going generic, considering them separately from other generic drugs. Following this change, we agree that it would be more appropriate to use a generic cost trend that does not include the impact of new generic drugs.

We developed a cost trend for generic drugs using drugs that were generic for the entire experience period, thereby eliminating the impact of the mix of old and new generic drugs from the cost trend. The result of a monthly 24-point regression on these drugs is a 0.0 percent generic cost trend. Using this trend in place of the filed 3.5 percent generic cost trend reduces the total pharmacy trend from 9.1 percent to 8.5 percent (before the impact of contracting changes). Please see the attached file *Response to 2020 AHP Filing 03.13.2019 Inquiry - Q8.xlsx* for the development of the generic and total trends.

Note that the Exhibit 2D provided in response to Question 5 shows the generic cost trend as filed, while the Exhibit 2D in this response is the updated version.

9. *The medical utilization data used to develop utilization trends is adjusted for contract differences, but it does not appear that it is adjusted for changes in the mix of groups enrolled. Particularly given the material changes in enrollment on this block in recent years, was any consideration given to whether increases in utilization were the result of a changing population being contained in the underlying data? For example, if young healthy groups have shifted towards ASO and competitors, would this not create apparent utilization trend?*

The trend experience base includes enrollment from BCBSVT Cost Plus groups, BCBSVT ASO Groups of under 5,000 members, BCBSVT insured large groups, BCBSVT insured small groups, TVHP insured small groups, and TVHP insured large groups. BCBSVT experienced membership losses in the small group market in January 2018. We modified the trend base to exclude any small groups that had membership in December 2017 but no membership in January 2018, but neglected to update the memorandum to reflect the change.

Since we include BCBSVT ASO groups in the experience based used to develop trend, movement of any groups with favorable experience to an ASO arrangement would not affect the trend calculation.

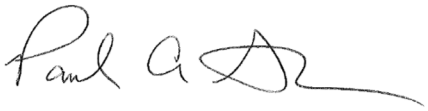
Using an open block of experience to develop trend allows for a broader membership base, which adds consistently and credibility to the trend experience base. We are cognizant of the impact of enrollment changes, and believe including ASO groups and adjusting for significant membership changes, such as the loss of small group membership in January 2018, appropriately controls for the impact of membership changes within the block.

10. The manual rate of $536.12 appears to be on a paid basis, as demonstrated in Section 6.1 of the memorandum. However, Exhibits 1A and 4A appear to show that this paid amount is blended with an experience rate that is "benefit-adjusted" by dividing out the benefit relativity. Please explain where the member cost sharing of the manual rate data is taken into consideration.

The manual rate and benefit-adjusted experience rate are both on a paid basis. The benefit adjustment normalizes each group's benefits and tier structure to the average experience of the block on a paid basis. A BRV of 1.0000 represents a benefit that is equivalent to the underlying paid claims rate of the BRV claims base. The benefit adjustment controls for possible benefit variations across groups, rather than a conversion to allowed claims.

Please let us know if you have further questions.

Sincerely,



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Paul Schultz, F.S.A., M.A.A.A.