BlueCross BlueShield of Vermont

April 26, 2017

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

Subject: Your 04/19/2017 Questions re: The Vermont Health Plan
3Q 2017 TVHP Large Group Rating Program Filing (SERFF Tracking #: BCVT-130935776)

Dear Mr. Hammerquist:

In response to your request dated April 19, 2017, here are *your questions* and our answers:

General Methodology Questions

1. *Page 3*: Do your 2 months run out factors remove explicit conservatism and reflect any claims retractions that may take place in future time periods?*

   Completion factors are our best estimates and do not include margin. Our reserving models account for projected future claims adjustments when calculating completion factors.

2. *Page 3: Your administrative increases for this filing seem unreasonable. Can you demonstrate a drop in administrative expense to other lines of business? If yes, please specify what lines of businesses and how much of a decrease you are planning to apply to each.*

   The administrative costs underlying the previous Large Group filing were $29.62 per member per month (PMPM) for all lines of business combined versus $30.99 in the current filing, an increase of 4.6 percent. The administrative costs underlying the previous Large Group filing were $31.56 for lines of business other than Large Group, as compared to $30.52 in the current filing, a decrease of 3.3 percent. Note that these values are from the experience period in each filing and have not been adjusted for trend or projected changes in membership across all lines of business.

   Planned administrative charges for other lines of business are outside of the scope of this filing and have not yet been finalized.

3. *We did not see references to the impact of the change in definition of the Large Group size. What changes if any have you made to the filing to reflect this change in Large Group size?*

   We did not make any changes to reflect the change in the definition of Large Group in this filing. The manual rate (section 4.4 of the Actuarial Memorandum) only includes experience claims from groups that are impacted by this filing. Factors that are

calculated using more than just Insured Large Group data use sufficiently credible data and do not need to be adjusted for this change.

4. *Page 6: Underwriting judgement: what is your process of reviewing the Underwriter's rationale to ensure it is in line with factor filings and other regulation?*

   Every renewal is reviewed by a Senior Underwriter and the Manager of Underwriting and/or the Chief Actuary to ensure any underwriting judgment applied is reasonable, appropriate, and in line with the factor filing and other regulations.

Trend

5. *On page 2 you identify changes to the rating formula (pertaining to the credibility formula, calculation of ISL factors, and development of ASL and Refund-Eligible charges) and on page 3 you outline how you checked the average change in all accounts from the changes in factors. Please supply the distribution of changes to individual accounts by each of the formula changes and all of them in total. Please show a count of accounts impacted grouped by 2% intervals (that is 7+% increase, 5 to 7% increase, 3 to 5% increase, 1 to 3% increase,+-1% change, 1 to 3% decrease...,more than 7% decrease.)*

   A distribution of the impact of the four changes individually and in aggregate is below. The change is measured as the difference from the total premium or premium-equivalent developed from the filed rating formula.

Formula Changes	Credibility	ISL	ASL	Refund - Eligible	Total
More than 7% increase	3	0	0	0	3
5 to 7% increase	0	0	0	0	0
3 to 5% increase	8	0	0	0	9
1 to 3% increase	7	1	0	0	8
+/- 1% change	29	2	3	0	27
1 to 3% decrease	9	0	0	0	9
3 to 5% decrease	2	0	0	0	2
5 to 7% decrease	1	0	0	0	1
More than 7% decrease	0	0	0	0	0
Not Applicable	0	56	56	59	0

While the changes to ISL and ASL factor development affect three groups each and the changes to Refund-Eligible risk charge development affects no current groups, every Large Group is affected by the change to the credibility formula. We changed the formula in part to give more credibility to a group's experience in the rating formula, which will decrease the need for underwriting judgment.

6. *Page 10: Where in the utilization trend development do you reflect your attempts to mitigate unnecessary utilization?*
   a. *Are you planning to drive utilization to more optimal (high quality / low cost) levels?*

BCBSVT has a long track record of developing and implementing effective utilization management programs that enable the delivery of the right care in the right setting at the right time. Examples of our current programs include:

- Pharmacy step therapy, quantity limits and prior authorizations
- RationalMed pharmacy safety program. Integrates medical and pharmacy claim data to provide drug-drug and drug-condition interaction warning to pharmacists prior to a drug being dispensed.
- Whole person integrated medical and mental health substance abuse high utilization case management program.
- Integrated Utilization Management including medical prior authorizations.
- Radiology utilization management program.
- Prevalent Chronic condition management program – case management for common diseases such as diabetes and asthma.
- Rare condition case management working with Accordant Health Care a national case management vendor with subject matter expertise in rare disease.
- Better Beginnings perinatal support and care management program.
- Hospital readmission avoidance program integrated care and utilization management.
- End of Life program – care management for patients receiving palliative or hospice care.

The prescription drug programs alone saved over $20 million across our book of business in 2016. The medical programs contributed over an additional $20 million of savings through appropriate utilization. The impact of these programs are implicitly included in both the base claims data and the calculation of utilization trend.

Much of the utilization increase is in preventive visits and appropriate care. Our assessment of the drivers of potentially unnecessary utilization increase have led us to examine treatment patterns in outpatient facility (i.e. ER and outpatient surgical procedures), specialty pharmacy and more specifically in the areas of cardiovascular disease, GI endoscopy as well as mental health and substance abuse.

It takes several budget cycles to build and implement new utilization management programs, and for these programs to have an impact on care delivery. Programs are currently in development to mitigate ER use (utilization in Vermont is well above regional benchmarks) and outpatient surgical/facility procedures. We have also recently expanded programs in select areas:

- Specialty pharmacy
  i. We work with our pharmacy benefit manager, Express Scripts (ESI), to realize the best price points available in the market and reduce the impact of price inflation of specialty drugs
  ii. We have instituted innovative indication based pricing for certain classes of specialty drugs with ESI to leverage pricing by clinical utility with the pharmaceutical companies
  iii. We have a full time pharmacist who travels the state and "details" our network providers on new programs, adverse prescribing trends and alternatives to higher cost pharmaceuticals which are clinically appropriate. This detailing initiative has been well received by our network providers.
- Cardiovascular Disease
  i. We are working with our members to improve engagement with our disease management programs and our cardiac rehab program which have proven value to modulate adverse utilization
- Mental Health and Substance Abuse
  i. Through our partnership with Brattleboro Retreat, Vermont Collaborative Care, we have integrated a whole person approach to our case and utilization management programs through integrated resources which include focused clinical expertise in the areas of mental health and substance abuse. Through this and components of the program we have significantly driven down inpatient and ER utilization and increased outpatient ongoing care with a mental health and substance abuse provider. In addition we support the state Hub and Spoke program through innovative care management and payment programs as well as eliminating benefit based barriers to care for our members. We will continue to expand this work.

b. Please describe any activities intended to place providers at risk for unnecessary utilization or to review patterns of unnecessary utilization.

BCBSVT's Quality Improvement and Integrated Health Programs review patterns of utilization identifying potential outliers within our network. BCBSVT's Quality and Audit teams engage with providers identified as outliers, creating action plans to address concerns and at times including financial penalties.

In addition, BCBSVT and UVMMC are currently conducting a knee and hip replacement episode of care pilot wherein UVMMC is at 100% risk for costs exceeding the average episode price. BCBSVT is currently evaluating the impact of the pilot and potential for expansion.

On a broader level, BCBSVT continues to be involved in conversations with Vermont ACOs to evaluate the potential for a 2018 risk pilot. The pilot would be limited to a small population in the initial years and expanded if successful.

c. Are either action plans included as offsets to the utilization trend increase?

BCBSVT has had robust utilization programs in place for a number of years, therefore the impact of utilization programs is already in the base used to develop medical and pharmacy trend. It is critical that BCBSVT continue to develop and expand our suite of utilization management programs in order to help maintain the relatively low levels of utilization trend observed in recent years. We believe our future programs will continue to achieve similar levels of success as our current and past programs. Because the impact of continually expanding programming has already had an effect on observed utilization trends, making any further explicit adjustment to utilization trend is unnecessary.

7. *Page 12: Please demonstrate how you adjust for scripts transitioning from brand to generic and itemize the resulting drop in trend.*

The brand to generic transition is calculated discretely on a month-by-month basis, using anticipated end dates for brand patent protection and generic exclusivity. In general, when a brand drug loses its patent, the manufacturer has an exclusivity period during which it makes the only generic version of the drug. Following this period, which is typically six months, other manufacturers may bring their own generic versions to market. During the exclusivity period, the cost of a single-source generic most closely approximates its brand equivalent. Therefore, for the purpose of the GDR calculation, we assume that the brand drug will be utilized during the generic exclusivity period. In this way, we do not overestimate the cost impact of shifts to single-source generics. Significant cost savings occur once the exclusivity period is over and multiple generic versions are available. Therefore, the GDR is calculated as a ratio of multi-source generics to the total of all drugs. The GDR calculation assumes that once the exclusivity period expires all brand (or single-source generic) utilization will cease and become low-cost multi-source generic utilization. An illustrative example of the GDR calculation is provided below. The rolling 12-month dispensing rate that is calculated is used on Exhibit 3F. Please note that in this context, specialty drugs are not included in the GDR calculation.

Example of script transition from brand to generic:

		Scripts by Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Generic Exclusivity Ending	Feb	500											
	Mar	500	500										
	Apr	500	500	500									
	May	500	500	500	500								
	Jun	500	500	500	500	500							
	Jul	500	500	500	500	500	500						
	Aug	500	500	500	500	500	500	500					
	Sep	500	500	500	500	500	500	500	500				
	Oct	500	500	500	500	500	500	500	500	500			
	Nov	500	500	500	500	500	500	500	500	500	500		
	Dec	500	500	500	500	500	500	500	500	500	500	500	
	Jan	500	500	500	500	500	500	500	500	500	500	500	500
All Other Brand		100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
	Generic	894,000	894,500	895,000	895,500	896,000	896,500	897,000	897,500	898,000	898,500	899,000	899,500
	Total	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Monthly GDR		89.40%	89.45%	89.50%	89.55%	89.60%	89.65%	89.70%	89.75%	89.80%	89.85%	89.90%	89.95%
												Rolling 12 GDR	89.68%

The GDR for the year ended September 2016 was 86.4% and the projected GDR is 89.0%. This change decreased the pharmacy trend by 3.9%

Benefit Relativities

8. *Page 18: In your Induced Utilization approach, please explain how you controlled for the presence of multiple benefit offerings and its potential of adverse selection.*

   BCBSVT Large Group underwriting rules restrict multiple benefit offerings that would create an undue amount of adverse selection. These rules mitigate any adverse selection in the experience used to develop relativities.

9. *Page 18: Please describe any new or innovative benefit designs or aspects which you introduced and which could lead to a cost reduction in the rating period and specify the amount of the cost reduction.*

   Large groups are afforded flexibility in their benefit design. This allows groups to tailor benefits in a way which best serves the needs of their employees. As this is a factor filing rather than a rate filing, any new benefit selections will be priced at the time of renewal. As noted in Section 4.3 of the Actuarial Memorandum, an actuarial cost model is used to simulate the cost and utilization impact of plan design changes.

Administrative Cost

10. *Please provide your total administrative costs for all groups for each year over the past five years, the total population number served each year, and the per member per month administrative charge for Individual, Small group, and Large group for each year.*

    The table below includes administrative cost for total business (BCBSVT and TVHP) and for Large Group specifically. Note that the administrative cost excludes taxes and fees included in administrative cost per accounting rules, as well as broker commissions.

	Total Business (BCBSVT and TVHP)			Large Group Only
Calendar Year	Administrative Charges	Member Months	PMPM	PMPM
2012	76,197,077	2,469,206	30.86	30.07
2013	80,063,051	2,646,390	30.25	27.62
2014	79,149,610	2,930,539	27.01	26.83
2015	82,533,713	2,972,182	27.77	28.78
2016	83,309,713	2,947,287	28.27	29.60

11. *Pages 23- 25: Besides economies of scale could you describe any administrative cost savings programs? Such programs would include but are not limited to:*

    a. *Activities to remove waste or address inefficiency*
    b. *Insourcing or outsourcing functions at lower costs*
    c. *Reduction in broker compensation or other reductions to distribution channel costs*

    d. *Re-evaluation of and/or limits on senior management or board compensation packages*
12. *Pages 23-25: If any administrative cost reduction programs are described in your answer to question 14, how are the cost savings built into rate projections?*
13. *Pages 23-25: You mentioned an account's moving to ASO. Why wouldn't this account still pay its fair share of overhead cost as ASO? Did it receive a reduction in services offered?*
14. *Pages 23-25: We did not see information about the cost impact of Wellness programs. Please provide a demonstration of the administrative cost of Wellness programs and any support showing that the programs reduce medical costs.*
15. *Pages 23-25: Will Small Group or Individual lines receive an administrative cost reduction or is this an overall corporate increase?*

Our answer below is intended to respond to questions 11 through 15.

In the last 5 years we have reduced administrative costs per member per month by 8.4 percent. Only 6 cents of each dollar paid by our members goes to administrative costs, while over 90 cents are used to pay claims. The balance, 3 cents, is for assessments including the Federal Insurer Fee, VITL, HCCA and PCOR. A combination of knowledgeable and committed staff, robust processes and use of technology delivers world-class member experiences that place us consistently in the top quartile of Member Touchpoint Measures among BlueCross BlueShield plans and among national leaders in first call resolution.

We continuously look for ways to improve efficiency. Functions and contracts are regularly reviewed to ensure they are provided in the most efficient and cost effective manner possible. Executive compensation is benchmarked annually with an external advisor and reviewed at the BCBSVT Board level to verify that senior management is compensated appropriately. At a more granular level, employees are engaged through initiatives such as Blue IDEAs (Initiatives Deserving Exploratory Analysis), which was launched in 2014 to support the Plan's strategic objective of organizational efficiency and our mission of responsible cost management on behalf of our members. The focus of the program is to create long term competitive advantage through administrative cost reductions, and to establish a culture that recognizes the importance of continuous improvement and encourages and supports employees in this effort. Over the last three years, this program has created more than $4.3 million in administrative expense savings for the benefit of our members. These savings are passed through to members through the use of updated base experience in ongoing factor filings.

All lines of business pay their fair share of overhead expenses on the basis of capital requirements. Since Cost Plus business requires significantly less capital than more traditionally insured business, movement away from the Cost Plus line of business will have a significant impact on the per member costs included in this filing. As explained in the Actuarial Memorandum, the membership movement is only between Cost Plus and ASO and is not expected to have impacts on other lines of business.

Compared to industry benchmarks including much larger health plans, we perform near the median in terms of overall per member per month administrative costs. By market segment, our per member per month rates – including those for Large Group that were included in this filing – are aligned with the benchmark experience in the most recent benchmarking study. Prior to the increases in this and the previous filing, our Large Group admin rates were significantly below industry benchmarks.

BCBSVT believes wellness programming is an important part of our administrative services. We offer programs that help groups develop and implement worksite health and wellness programs. These programs help improve employee health, productivity, morale, retention and help to reduce health care costs. The experience cost of wellness services included in the administrative charges was $0.39 PMPM.

BCBSVT has had wellness programs in place for a number of years, therefore the impact of the programs is the group's claims experience. Because of the relatively small size of our health plan, it is difficult to measure the claims impact of our wellness programming. Reductions in medical costs and utilization trend are reflected in the rating through the use of base experience and our observations of utilization trend.

Please note that broker compensation is not included in administrative charges.

Large Group Financial Performance

16. *Page 31: Large Group performance has been historically poor. Is this a corporate wide issue or historically have other lines been subsidizing Large Group?*
17. *Page 31: Is there any implicit subsidization of Large Group by other lines of business built into future period projections?*

Our answer below is intended to respond to questions 16 and 17.

We rate each line of business independently and no subsidization across lines of business is included in any of our rating. The medical loss ratios demonstrated on Page 31 may be higher than those typically associated in the industry with solid financial results. However, because of BCBSVT's competitive administrative costs, the Large Group line has been performing to expectations in recent years. Consider the financial reporting loss and expense ratios in the chart below:

Year	Incurred Claims	Earned Premium	Administrative Charges*	Loss & Expense Ratio
2012	$394,390,754	$425,696,914	$28,060,304	99.2%
2013	$399,543,340	$428,024,970	$30,149,551	100.4%
2014	$398,416,821	$428,215,842	$26,201,323	99.2%
2015	$410,671,695	$438,023,593	$25,903,341	99.7%
2016	$335,400,839	$356,244,218	$20,674,875	100.0%

*Please note that in financial reporting, administrative charges include broker commission, federal fees and some taxes per GAAP accounting rules.

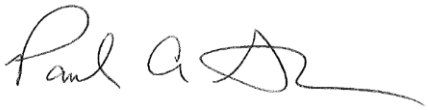
Other

18. *Exhibit 5B: SIC (Industry) factors: When was the last time you reviewed and to what extent are the industry factors supported by data? How do you ensure these do not implicitly or unintentionally adversely lead to discrimination in rates?*

    We updated the Industry Factors as part of the Q3 2016 Large Group Rating Program Filing (BCVT-130453174). Our membership base is not large enough to develop credible industry factors so we use a blend of data from industry sources.

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.