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November 22, 2013

Mr. Phil Keller  
Director of Rates and Forms  
Vermont Department of Financial Regulation  
89 Main Street, Drawer 20  
Montpelier, VT 05620-3601

**Subject: The Vermont Health Plan 1Q & 2Q 2014 Trend Factor Filing  
Vermont Filing Number: 68006**

Dear Mr. Keller:

The purpose of this letter is to provide our analysis and opinion regarding the reasonableness of the proposed first and second quarter 2014 (1Q/2Q14) trend factor filing for The Vermont Health Plan (TVHP). It should not be used for other purposes. In performing our analysis, we relied on the information in the filing itself, additional information provided by TVHP as requested in our follow up letter and the 1Q/2Q14 supplemental exhibits. We reviewed this information to determine whether there were any material changes in the methodology used relative to prior filings, and did identify the following: (1) mental health and substance abuse claims are now being included in the historical claims experience and (2) the drug trend is now being evaluated with TVHP and Blue Cross Blue Shield of Vermont (BCBSVT) data combined. These changes are discussed in more detail within the body of the report.

In the filing, TVHP proposes base annual uncapped<sup>1</sup> allowed trend factors equal to 4.1% for medical claims, 7.2% for pharmacy claims, and 4.6% for medical and pharmacy claims combined. This compares to the approved 3Q/4Q13 uncapped trend rates of 4.6% for medical claims, 8.1% for pharmacy claims and 5.3% for medical and pharmacy claims combined. Please note that medical capped trend rates are also included in this filing in addition to the uncapped trend rates described above. However, we have confirmed with TVHP that the capped trend rates will not be utilized in the future assuming recent changes made to TVHP's large group rate development methodology<sup>2</sup> are approved. As a result, this opinion letter has been written with emphasis placed on the filed uncapped trend rates.

It is important to note that the proposed trends will be used primarily for the development of 1Q/2Q14 large group proposals and renewals, however, the data underlying the development of these trends includes not only large group, but small group and individual products as well. While incorporating both small group and individual data boosts credibility, future consideration will need to be given to the appropriateness of including small group and individual data as these markets will be experiencing considerable changes in 2014 and beyond. Since service dates for this filing

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<sup>1</sup> Uncapped trend factors refer to trend rates which are based on, and applied in projections to, claims where there are no caps or limits (e.g., stop loss thresholds) on potential payment amounts. On the other hand, capped trend factors refer to trend rates which are based on, and applied in projections to, claims where caps or limits on potential payment amounts do exist. In general, capped trend factors are expected to be lower than uncapped trend factors due to the limited growth that can occur in the underlying claim costs where a cap exists, for claims which are close to or already equal to the specific cap level.

<sup>2</sup> See the most recent TVHP Merit Rating filing (VFN 64785)

are prior to 2014 (pre-ACA), we find the inclusion of small group and individual data within the filing to be reasonable.

## **Data Consistency**

With each rate filing, Oliver Wyman reviews the data which was utilized in any underlying analysis for consistency with the data utilized in the prior filing. During our review, we identified material differences between the data provided in the 1Q/2Q14 filing compared to the 3Q/4Q13 filing. As previously mentioned, two changes made by TVHP for this filing were to include mental health and substance abuse claims within the historical medical experience, and also to combine the TVHP and BCBSVT drug data for the purposes of evaluating the drug trend. Additionally, we note that TVHP removed the experience for one large group because it did not have experience throughout the entire experience period. During the course of our review, TVHP has demonstrated that, after removing the impact of these adjustments, the claims in the 1Q/2Q14 filing are consistent with the previous filing. Any remaining differences are primarily confined to the most recent months and are within a range where they can reasonably be attributed to restated reserve estimates and retroactive adjustments to claims.

## **TVHP FFS Trend Calculation**

For the 1Q/2Q14 filing, TVHP evaluated trends using two different approaches. In the first approach, TVHP examines historical rolling 12-month averages, and in the second, TVHP performs regression analysis on the rolling 12-month claims. Both of these analyses are performed on allowed claims for CDHP and non-CDHP business separately to remove the effect of benefit changes, which are adjusted for elsewhere in the rating formula. In addition, these analyses are performed on a per member per month (PMPM) basis so as not to skew the results when the size of the underlying population changes over time. Both methods are consistent with standard actuarial practices. We note that the ways in which the results from these approaches are applied in developing the ultimate proposed trend rates do vary between medical and drug. The development of the specific medical and drug trend rates is described in the subsections that follow.

## **Medical Trend**

In developing its proposed uncapped medical trends, TVHP examines claims separately for its CDHP and non-CDHP blocks for the period June 2010 through May 2013, with payments through July 2013. It is commonly accepted practice to include at least a couple of months of claim payment runout in order to avoid calculating trends which are highly sensitive to reserve estimates underlying the most recent months of claims. As noted earlier, mental health and substance abuse fee-for-service equivalent claims<sup>3</sup> are now being included in the historical experience since they will no longer be paid on a capitated basis and, therefore, must be considered in the development of the overall fee-for-service trend rate. TVHP then removes claims in excess of \$120,000 so that the results of its regression analysis are not skewed downward or upward by any unusually large claims in the underlying claims experience. The resulting trend rates based on claims capped at \$120,000 are then adjusted to reflect the equivalent trend rates if no cap existed. This is done by utilizing the stop loss dampening and deductible leveraging analysis performed by BCBSVT.

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<sup>3</sup> Fee-for-service equivalent claims are those claims that would have been paid had mental health claims been reimbursed on a fee-for-service basis rather than a capitated basis during the experience period.

Using the first method previously mentioned, which examines rolling 12-month PMPM allowed claims figures, TVHP calculated the following trends using the May 2013 data point.

Major Service Category	Observed Rolling 12-Month Trend	
	CDHP	Non-CDHP
Inpatient	2.0%	2.3%
Outpatient	5.5%	-2.3%
Professional	2.0%	-0.7%
Other	-1.3%	3.3%
<b>Combined Medical</b>	3.5%	-0.7%

These percentages represent the change in average claims PMPM between the time periods of June 2011 – May 2012 and June 2012 – May 2013. The average medical trend across all service categories in the table above is 3.5% for CDHP and -0.7% for non-CDHP. When weighted together based on the 12 months of completed allowed claims ending May 2013 for the CDHP and non-CDHP products, the resulting combined medical trend rate is approximately 2.3%.

Using the second method, in which TVHP performs a regression on the rolling 12-month allowed claims PMPM, the following trends were calculated:

Regression Type 12-Month Rolling	CDHP	Non-CDHP	Total
24-Point	5.6%	-1.4%	3.6%
36-Point	5.2%	-0.5%	3.6%

In Exhibit VIII of the rate filing, TVHP has provided a chart of the average age of the population by month. The average age/gender factor of the population and the male/female distribution has been very stable. In most cases, this demographic component should be normalized from the trends as it is typically captured elsewhere in the rating formula (i.e., through rates which vary by age and gender). However, given Vermont’s community rating structure, it needs to remain in the trends as long as it is anticipated to continue at the same rate. Given that the average age and the distribution of male and females have been relatively stable, we do not feel the demographics are skewing observed trends.

### Drug Trend

As described earlier, in developing its proposed drug trends, the data which was reviewed by TVHP reflects claims experience for both TVHP and BCBSVT. This approach is reasonable since both companies utilize the same reimbursement fee schedules and claims adjudication processes. Page 7 of Exhibit II within the filing shows the development of the proposed drug trend rate and, as can be seen, the overall proposed rate represents the combined impact of the estimated utilization and unit cost trends for each drug script type (i.e., generic, brand and specialty). The unit cost trends were developed based on the results of TVHP’s regression analysis of unit costs by script type, which were then adjusted for any changes in the PBM contracted rates. The utilization trends were developed based on the results of TVHP’s regression analysis of utilization

by specialty and non-specialty scripts (i.e., generic and brand combined). The non-specialty script result was then split into generic and brand specific utilization rates based on TVHP's projected generic dispensing rate<sup>4</sup> (GDR) for the rating period. We note that TVHP's projected GDR for the rating period was developed, as demonstrated on page 6 of Exhibit II, based on a review of which prescription drugs would be coming off of patent in the future, the historical utilization of those drugs, and a projection of how the patent expiration for those drugs would impact future generic vs. brand utilization. The following table summarizes the trend components calculated by TVHP. As noted previously, the overall trend rate of 7.2% represents the weighted average of the individual trend components using the most recent drug experience.

Trends	Generic	Brand	Specialty	Total
Utilization	1.9%	-6.4%	18.1%	0.6%
Cost	-3.7%	10.0%	6.8%	6.6%
Total	-1.9%	2.9%	26.2%	7.2%

There is one item that we wish to highlight with respect to TVHP's development of this proposed drug trend rate. We note that TVHP is anticipating that the GDR will not continue to increase at the annual growth rate which has been experienced in recent years, which has been approximately 4%. Instead, TVHP is assuming the GDR will increase at an annual rate of only approximately 1% from the 12 months ending June 2013 to the 12 months ending March 2015. The actuarial memorandum states that TVHP's expected GDR for the 12 month period of April 2014 through March 2015 will be 83.4%. For the 12 months ending June 2013, the GDR was 82.3%. The result of assuming a lower growth rate for the GDR is a higher projected drug trend than would be calculated if a higher GDR growth rate were assumed. This is because a higher GDR typically implies that more drugs are shifting from brand to generic script types in the future. Ultimately, generic scripts are lower cost than brand scripts and, therefore, a shift from brand to generic scripts would generally be expected to result in a lower overall trend rate over the period which this shift occurs.

### Proposed Trends

TVHP is proposing uncapped trend rates equal to 4.1% for medical services, 7.2% for pharmacy, and 4.6% for medical and pharmacy combined. As noted earlier, TVHP has also filed capped medical trend rates as it has in the past, however, these are not expected to be utilized assuming the approval of TVHP's recently filed large group merit rating methodology.

The selection of the 4.1% medical trend is based on the trend produced using 24-point and 36-point regression on 12-month rolling data capped at \$120,000, adjusted to reflect the equivalent trend rate if no cap were applied. The selected drug trend of 7.2% was determined by evaluating unit cost and utilization trend for generic, brand and specialty drugs as previously described.

### Independent Trend Calculation Medical Trend

In forming our opinion as to the reasonableness of TVHP's proposed 1Q/2Q14 medical trend rates, we performed several independent calculations. First, we evaluated the medical trend

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<sup>4</sup> The generic dispensing rate is equal to the number of generic scripts divided by the total number of drug scripts.

based on regression analyses of 12-month rolling averages on capped data (i.e., claims below a \$120,000 threshold). The following table summarizes the resulting historical trend rates by three different historical periods (i.e., 12 points, 24 points, and 36 points). Included in the table is the standard error<sup>5</sup> for each time period. It is important to note that we evaluated capped data in this approach in order to remove any potential skewing that could occur by including large claims. The resulting calculated trend rates were then adjusted in order to arrive at equivalent uncapped trends. This was done by using stop loss dampening and deductible leveraging factors which we discuss in the latter portion of this letter.

Data Points	12-Month Rolling Trend with Standard Error		
	CDHP	Non-CDHP	Total*
12 Points	4.5% ± 0.4%	-1.2% ± 1.3%	2.8%
24 Points	6.2% ± 0.2%	-0.9% ± 0.4%	4.1%
36 Points	5.7% ± 0.1%	-0.0% ± 0.2%	4.0%

\*Standard Error Excluded from Total

As can be seen, the 24 point and 36 point periods are producing consistent trends with relatively small standard error terms, while the 12 point regression is producing a trend that is over a percentage point lower than the other two time periods. This could suggest an emergence of lower trends. In order to investigate we further evaluated historical trends using uncapped monthly data. In order to eliminate the spikes in large claims over the regression period, we asked TVHP for monthly claims excluding claimants with more than \$25,000 in charges in a given month. These additional data allowed us to estimate large claims on a monthly basis by comparing the uncapped monthly totals to the capped monthly totals. For medical coverage, after partitioning the large claims, we then smoothed them over the 42-month period for which we had data, assuming a 10.2% annual large claims trend. Smoothing the large claims eliminates potential random fluctuation of high cost claims. The 10.2% annual large claims trend assumption was developed based on our review of TVHP's large claims over the period of December 2009 through May 2013.

Typically in our analysis, after large claims are smoothed, they are then added to the monthly capped totals. In this case, an additional step was required for the CDHP monthly data in order to accurately calculate the underlying trend. The CDHP data demonstrated significant seasonality, meaning earlier months within a calendar year had lower allowed claims compared to the months in the latter portion of the calendar year. The driver of this claims pattern is assumed to be the structure of the calendar year benefits (i.e., the higher deductibles) for these plans, which lead to a much more significant level of claims being submitted in the latter half of the calendar year than in the earlier months. The following table illustrates the difference for each month within the specified calendar year relative to the average annual claim cost for that year for the CDHP plans. The far right column represents the calculated seasonality factors which were developed on a quarterly basis as opposed to a monthly basis to smooth out any potential month to month volatility. The factors in the following table were calculated using CDHP medical claims.

<sup>5</sup> The standard error amount represents one standard deviation from the calculated sample mean. The smaller the standard error term, the more representative the data used will be of the underlying population.

Month	2010	2011	2012	Qrt Avg
January	0.92	0.96	0.92	0.95
February	0.89	0.87	1.02	0.95
March	1.00	1.01	0.96	0.95
April	0.99	0.96	0.94	0.98
May	0.94	0.92	1.01	0.98
June	1.08	1.04	0.92	0.98
July	0.90	0.93	1.01	0.97
August	0.95	0.96	1.01	0.97
September	1.00	1.01	0.97	0.97
October	1.04	1.04	1.13	1.10
November	1.09	1.09	1.03	1.10
December	1.19	1.21	1.09	1.10

Before performing the 24-point monthly regression we applied the quarterly seasonality factors in the table above to each month’s medical claims for the CDHP plans, with the goal being to remove the impact of the calendar year benefit structure on monthly claims patterns and allow for a better estimation of underlying trend. A separate set of seasonality factors was developed and applied to the CDHP drug claims before performing a regression analysis. In addition to applying these seasonality factors, a final adjustment was applied such that the overall claims volume for each unique 12-month period being analyzed tied back to the pre-seasonality adjusted claim volume. In reviewing the claims for the non-CDHP plans, we found that a clear seasonality pattern did not exist which would impact the trend analysis and, therefore, did not make a similar adjustment for those plans.

After smoothing the large claims and adjusting for seasonality we conducted a regression analysis on 24, 36 and 42 monthly data points. The table below summarizes the results. It should be noted that this analysis includes large claims which have been smoothed but, because large claims are included, ultimately represents allowed uncapped trends. To estimate \$120K capped trends, we applied an adjustment reflecting the same relationship as shown on Exhibit IV between TVHP’s capped and uncapped trends. The calculated \$120K capped trends are also shown in the table below.

Monthly Data Points	Uncapped Medical Trend			\$120K Capped Total Medical Trend
	CDHP	Non-CDHP	Total	
24	6.2%	5.9%	6.1%	5.3%
36	6.2%	2.8%	5.2%	4.6%
42	6.0%	1.8%	4.8%	4.2%

The results of the monthly regression analyses using 36 and 42 monthly data points are slightly higher than the 24-point and 36-point rolling average regression results described earlier. After examining the monthly uncapped non-CDHP data graphically we discovered unusually low payments for the last six months in 2012 followed by unusually high payments in first five months of 2013. The impact of the high payment months manifests itself the greatest in the 24-point

monthly regression. However, when evaluating historical trend based on 12-month rolling data the high months are materially dampened by the low months in 2012 (this is especially true as membership is decreasing). The result is a relatively high trend rate on a monthly basis but a relatively low trend rate on a 12-month rolling basis. For this reason we have not considered either the 12-point, 12-month rolling trend or the 24-point monthly trend in our final estimated range of medical trend. The table below provides a range of our estimated allowed medical trends compared to the allowed medical trends which are being proposed by TVHP.

Trend Category	TVHP	OW Range	
		Low	High
Medical (Uncapped)	4.1%	4.0%	5.2%
Medical (\$200K Capped)	3.6%	3.5%	4.6%

### Drug Trend

In forming our opinion as to the reasonableness of the proposed drug trend, we evaluated the utilization and unit cost trends for each drug type (i.e., generic, brand and specialty), similar to the approach which was utilized by TVHP. Our method involved the use of regression on 24 data points of 12-month rolling averages. We also considered the impact of a potential slowdown in the GDR relative to recent historical growth. The following table summarizes the estimated range of drug trends resulting from our analysis.

Trend Category	TVHP	OW Range	
		Low	High
Drug Trend (Uncapped)	7.2%	5.3%	9.5%

It is important to note that with over 80% of all scripts which are currently being filled representing generic drugs, it is our belief that the significant growth in the GDR of approximately 4%, which has been experienced in recent years, simply cannot continue indefinitely. Ultimately, however, we believe it is very difficult to predict when exactly the GDR growth will begin to slow down, and believe recent trends could possibly continue for the next couple of years. The low end of the above range represents a scenario in which the GDR continues to increase at a rate of approximately 4.0%. Under this scenario, the projected GDR for the 12 months ending March 2015 would be roughly 88.5%. Under the high scenario, we have estimated that the GDR would be roughly 84.0% for the 12 months ending March 2015, which would represent a growth rate of approximately 1.3% through that time period.

### Deductible Leveraging

TVHP provides their proposed leveraging factors in Exhibit IV, page 2 of the filing. The purpose of the leveraging factors is to adjust trend factors as necessary to reflect the leveraging effect of fixed dollar deductibles. We compared the proposed factors to those generated from our pricing model, after it was calibrated to TVHP's underlying allowed cost PMPM. The following table provides a comparison of TVHP's deductible leveraging rates to Oliver Wyman's estimated deductible leveraging rates.

**Deductible Leveraging Factors**

Ded	Medical - No Coins		Medical - W/Coins		Combined - No Coins		Combined - W/Coins	
	TVHP	OW	TVHP	OW	TVHP	OW	TVHP	OW
\$0	-0.2%	-0.2%	-0.2%	-0.2%	-0.3%	-0.3%	-0.3%	-0.2%
\$100	-0.1%	-0.1%	0.0%	-0.1%	-0.2%	-0.3%	-0.1%	-0.2%
\$150	-0.1%	0.0%	0.0%	0.0%	-0.2%	-0.2%	0.0%	-0.1%
\$200	-0.1%	0.0%	0.0%	0.0%	-0.1%	-0.2%	0.0%	0.0%
\$250	0.0%	0.0%	0.1%	0.1%	-0.1%	-0.1%	0.0%	0.0%
\$300	0.0%	0.1%	0.1%	0.1%	-0.1%	-0.1%	0.1%	0.0%
\$350	0.0%	0.1%	0.1%	0.2%	0.0%	-0.1%	0.1%	0.1%
\$400	0.0%	0.1%	0.2%	0.2%	0.0%	-0.1%	0.1%	0.1%
\$450	0.1%	0.2%	0.2%	0.2%	0.0%	0.0%	0.2%	0.1%
\$500	0.1%	0.2%	0.2%	0.2%	0.0%	0.0%	0.2%	0.2%
\$750	0.2%	0.3%	0.3%	0.3%	0.1%	0.1%	0.3%	0.3%
\$1,000	0.2%	0.4%	0.4%	0.4%	0.2%	0.2%	0.4%	0.3%
\$1,500	0.4%	0.5%	0.5%	0.5%	0.4%	0.4%	0.6%	0.5%
\$2,000	0.5%	0.6%	0.6%	0.6%	0.5%	0.5%	0.7%	0.7%
\$2,500	0.6%	0.7%	0.7%	0.7%	0.6%	0.7%	0.8%	0.8%
\$3,000	0.6%	0.8%	0.8%	0.8%	0.7%	0.8%	0.9%	0.9%
\$3,500	0.7%	0.9%	0.9%	0.9%	0.8%	0.9%	1.0%	1.0%
\$4,000	0.8%	0.9%	0.9%	1.0%	0.9%	0.9%	1.1%	1.1%
\$5,000	0.9%	1.1%	1.1%	1.1%	1.0%	1.1%	1.2%	1.2%
\$7,500	1.2%	1.3%	1.3%	1.3%	1.4%	1.4%	1.5%	1.5%
\$10,000	1.4%	1.5%	1.6%	1.5%	1.6%	1.6%	1.8%	1.7%

The factors we independently developed compare reasonably well with those proposed by TVHP.

**Stop Loss Dampened Trends**

TVHP provides their stop loss dampened proposed trend factors in Exhibit IV, page 3 of the filing. These factors reflect trends adjusted for the impact of various stop loss levels. Stop loss places a ceiling on the level to which claims can increase due to the effect of trend. As the stop loss level decreases from an unlimited level, the increase in claims below the stop loss level becomes further capped and the trends decrease.

We developed independent estimates of these dampened trends, assuming the underlying trend levels are consistent with the trends requested by TVHP. The following table compares the dampened trends filed by TVHP with those developed from our pricing model for select stop loss levels. As with the deductible leveraging factors, the two estimates compare well.

**Base Stop Loss Dampened Trends**

Attachment Point	Medical		Combined	
	TVHP	OW	TVHP	OW
\$35,000	3.1%	3.4%	3.7%	3.9%
\$120,000	3.7%	3.9%	4.2%	4.4%
\$1,000,000	4.3%	4.3%	4.9%	4.9%
Unlimited	4.3%	4.3%	4.9%	4.9%

\*\*\*\*\* Begin – Confidential Information \*\*\*\*\*



\*\*\*\*\* End – Confidential Information \*\*\*\*\*

**Conclusion**

We find that the 4.1% uncapped medical trend requested by TVHP is within our range of our independent estimates (4.0% to 5.2%). As such, we believe the proposed medical trend factor is reasonable. The requested 7.2% prescription drug trend is also within our range of independent estimates (5.3% to 9.5%). One key assumption regarding the drug trend is whether generic utilization will continue to grow as a percentage of the overall drug utilization. If the GDR continues to grow at a relatively high rate, then we would expect this to have downward pressure on the emerging drug trend, and the result would be a trend rate closer to the low end of the range we have developed. However, if the GDR growth rate begins to slow significantly, then this will have upward pressure on emerging trends, and the result would be a rate closer to the high end of the range we have developed.

Lastly, we note that the proposed trends are low as compared to those observed in the industry. The most recent semi-annual Oliver Wyman carrier trend survey<sup>6</sup> shows carriers are utilizing the following pricing trends for their group business:

	Medical PPO	Medical HMO	Pharmacy
75 <sup>th</sup> Percentile	11.1%	9.8%	10.7%
50 <sup>th</sup> Percentile	9.0%	7.7%	8.3%
25 <sup>th</sup> Percentile	7.2%	6.2%	7.0%

<sup>6</sup> This report presents pricing trends used by the 66 participating companies in the development of their rates for July 2013. These trends are used to develop premiums for approximately 108.3 million group members as reported by the participating companies.

Page 10  
November 22, 2013  
Mr. Phil Keller  
Vermont Department of Financial Regulation

The medical trend rate requested by TVHP is below the 25<sup>th</sup> percentile for both Medical PPO and HMO, even after adjusting for the impact of deductible leveraging, while the prescription drug trend is just slightly above the 25<sup>th</sup> percentile for Pharmacy.

## Opinion

In providing this opinion, I relied on the data and other information provided by TVHP in the rate filing and the supplemental exhibits. If this information is inaccurate, incomplete, or out-of-date, our findings and conclusions may need to be revised. While we have relied on the data provided by TVHP without independent investigation or verification, we have reviewed the data for consistency and reasonableness. Where we found the data inconsistent or unreasonable, we have requested clarification.

In my opinion, the proposed medical and drug trend factors are reasonable relative to the range of independent estimates I have developed and should generate premium that is not excessive, deficient, or unfairly discriminatory.

Since our analysis involves the projection of future contingent events, actual results will likely vary.

I have utilized generally accepted actuarial methodologies in arriving at my opinion. I am a member of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion.

Sincerely,



Ryan Schultz, FSA, MAAA  
Senior Consultant

Copy: Justin Feagles, Oliver Wyman Actuarial Consulting, Inc.  
Tammy Tomczyk, Oliver Wyman Actuarial Consulting, Inc.