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March 14, 2014

Green Mountain Care Board
 State of Vermont
 89 Main Street, Third Floor, City Center
 Montpelier, VT 05620

Re: Blue Cross and Blue Shield of Vermont, 2Q 2014 Benefit Relativity Factor Filing (SERFF # BCVT-129370654)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2Q 2014 Benefit Relativity Factor Filing for Blue Cross and Blue Shield of Vermont and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. Blue Cross Blue Shield of Vermont (BCBSVT) is a non-profit hospital and medical service corporation. BCBSVT provides large group coverage to employers in Vermont.
2. The present filing is a factor filing that modifies the large group benefit relativities based on trend and experience for new or renewing groups in the second quarter of 2014 or later. In developing rates for experience rated large groups it is typically the case that the plans of benefits to be rated are different from those from which the experience arose. To adjust for this, benefit relativity values are calculated for each plan of benefits. These relativities are used to convert a large group's experience under the plan in force in its experience period to the expected experience under any new plan in the rating period. For groups that are not fully credible, the benefit relativity factors will be applied to the manual rate.

For any future benefit variations or special benefits not included in this filing, the relativities will be calculated using the same methodology described in this filing.

3. BCBSVT has five different plan designs that are available to all large employers. Within each plan design, various levels of benefit options are available. There are approximately 33,162 Vermonters affected:
 - Consumer Driven Health Plan (CDHP): 9,872 Vermonters
 - Vermont Freedom Plan (VFP): 10,267 Vermonters
 - Comprehensive (COMP): 92 Vermonters
 - J Plan (JPLAN): 1,536 Vermonters

- Vermont Health Partnership (VHP): 11,395 Vermonters
4. The requested benefit relativity factor changes represent a piece of the overall rate charged for large groups. The factors will be used as described in the approved BCBSVT Group Merit Rating Program filing (SERFF# BCVT-128267446, VFN 59619).
 5. The overall average impact of the benefit relativity factors are neutral to the cost of coverage and are only used to create reasonable and adequate pricing differentials among specific benefit plan designs. The impact of this filing by plan design:
 - Consumer Driven Health Plan (CDHP): -7.7%
 - Vermont Freedom Plan (VFP): -5.8%
 - Comprehensive (COMP): -0.2%
 - J Plan (JPLAN): 0.6%
 - Vermont Health Partnership (VHP): 6.5%

Standard of Review

Pursuant to Green Mountain Care Board Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

BCBSVT provided the methodology used to calculate the benefit relativity factors. This includes the projection of the claims experience that was used to recalculate the paid claims based on each provider network and plan design. The Company also described the process used to adjust the paid claims for the fact that utilization patterns for richer than average/(leaner than average) benefit levels are higher /(lower) than for an average benefit level. Exhibits were provided that summarized the benefits for each plan and the corresponding benefit relativity factor and Medicare carve-out factor.

Company's Analysis

1. The Company's experience period included claims from August 2012 to July 2013 paid as of October 2013. The allowed costs for the experience period claims for BCBSVT and its subsidiary The Vermont Health Plan (TVHP) were combined and trended to July 1st 2015. Adjustments were made for network differences.

The combined experience was used to simulate the paid PMPM values for each benefit plan. The simulated paid PMPM value for each plan was divided by the average paid PMPM to create a relativity factor.

The Company considered this full re-pricing approach a significant enhancement over last year's approach of using continuance tables and cost/frequency tables to model the impact of cost sharing.

The change in benefit relativity factors is neutral on average, but the change for a particular large group will vary. The updated manual rate and benefit relativity factors lead to a potential

change in the manually-rated claims projection from a -17.5% decrease to an 11.2% increase, all else being equal. The manually-rated claims projection is credibility blended with actual experience as part of the merit rating formula. Therefore, the range given above is a maximum and will be dampened if a customer's claim experience is even partially statistically credible.

2. Because the experience includes claims from members from all plans, the company estimated the impact of induced utilization to account for the difference in average benefit levels. This resulted in an induced utilization factor for each plan that was multiplied by the relativity factor described above to calculate the final benefit relativity for each plan.

Induced utilization represents the tendency of consumers to increase utilization as their cost sharing decreases. The induced utilization factors were normalized so the average benefit would have a factor of 1.00. The Company modeled the correlation between the medical paid-to-allowed ratio and the medical utilization frequency (Professional and Outpatient Visits + Inpatient Admissions).

In addition to this model, the Company also calculated the induced utilization using the other methods for comparison.

- HHS Payment Parameter¹
- Allowed Charges
- Allowed Charges without Inpatient Admissions

After the evaluation of the induced utilization estimates above, the Company felt it was prudent to use their initial approach which produced a more consistent and stable result from employer to employer.

The Company modeled the correlation between the pharmacy benefit design and the number of scripts in two ways.

- The generic dispensing rate increases as the difference between the generic and brand copays increase.
- The utilization frequency (number of scripts) increases as the paid-to-allowed ratio increases.

3. Benefit relativity values were calculated for Medicare carve-out plans by combined BCBSVT data from 2009 – 2012. This resulted in an average experience ratio of carve-out to active allowed charges of 0.3979. Due to limited credibility of internal data on Medicare carve-out, the 2012 Milliman Health Cost Guidelines were used to develop the slope of the factors by deductible.

L&E Analysis

1. The experience period included claims from August 2012 to July 2013 paid as of October 2013. The Company combined claims from the various benefit designs and then used this data to simulate the paid PMPM for each benefit design. This was done to isolate the impact of the benefit design and not include the impact of different populations within each benefit plan.

¹ This refers to the induced utilization factor that HHS uses to estimate the monthly advance payments for cost-sharing reductions. The Company included this as an example of publically available industry data for comparison purposes.

With over 1.5 million member months from both Insured Group and Self-Funded business, we consider the experience to be appropriate and credible for benefit relativity analysis.

The experience period claims were projected to July 1st, 2015 with a medical trend of 4.0% and pharmacy trend of 4.7% for a combined total trend of 4.1%. Use of this trend is reasonable and the benefit relativities are not sensitive to small changes in trend. For example, if the Company had included a utilization trend of 0.4%, we independently estimated the maximum impact on the benefit relativity factors would be less than 0.1%.

The move to a full re-pricing approach appears appropriate and reasonable and improves upon the approach used in the previous filing and results in premiums that are more closely matched to the expected claims costs.

2. The approach chosen by BCBSVT to estimate the impact of induced utilization is reasonable and appropriate at the time of this filing, because it reduces the variability between the benefit relativity factors and is more in line with results based on industry data.

However, if future results continue to consistently modify the relationship between the medical paid-to-allowed ratio and the allowed charges, then the other methods that the Company evaluated for estimating the induced utilization adjustment should be reconsidered.

3. The 2012 Milliman Health Cost Guidelines were not trended forward to before calculating the slope of the Medicare carve-out factors by deductible. However, this does not impact the average factor and only has a minimal impact on the slope. We consider this to be appropriate and reasonable for calculating the slope of the Medicare carve-out factors.

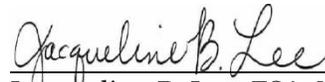
Recommendation

L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board approve the filing as requested.

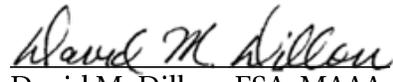
Sincerely,



Josh Hammerquist, ASA, MAAA
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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations², promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct³, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Joshua A. Hammerquist, ASA, MAAA, Assistant Vice President at Lewis & Ellis, Inc. (L&E).
- Jacqueline B. Lee, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents

The date of this document is March 14, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is February 25, 2014.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

² The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

³ These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law

This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods

The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.