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April 6, 2015

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 Q3 2015 Large Group Filing (SERFF # BCVT-129910512)

The purpose of this letter is to provide a summary and recommendation regarding the proposed 2015 Large Group Filing for Blue Cross and Blue Shield of Vermont (BCBSVT) and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides large group coverage to employers in Vermont.

2. This filing establishes the formula, manual rate and accompanying factors that will be used for renewals. It combines five filings that have historically been filed separately, including trend, benefit relativities, administrative costs, aggregate stop loss and large claim factors for large groups. The combined filings will facilitate a review of the overall impact for these large groups. By combining these filings, the Company will be able to more clearly calculate an average increase in the aggregate factors that impact the rates for large groups. The overall impact of this filing was estimated based on the previously approved factors from the five separate filings.

3. This filing addresses BCBSVT Insured and Cost Plus large groups. There are approximately 13,100 subscribers and 26,900 lives affected across 61 groups.

4. The Company is requesting a total allowed trend of 7.2%. The total allowed trend represents the change in total medical and pharmacy spending, which includes payments from both the insurance company and member cost sharing.

   The expected average paid trend is 8.1%. Paid trends directly impact the premium that employers are charged, because it reflects the change in payments from only the Company and excludes member cost

sharing. In the chart below, the paid trends are higher than the allowed trends due to the leveraging[1] effect of fixed first dollar cost sharing such as deductibles and copays.

	Allowed Trend	Paid Trend
Medical	6.6%	7.4%
Pharmacy	10.0%	11.4%
Total	7.2%	8.1%

The actual paid trends for each employer will vary based on the cost sharing design of the plan as well as if the medical and pharmacy benefits are separate or based on an integrated benefit design.

5. The overall impact of this filing is 9.7% ($44.73 PMPM).[2] This percentage is itemized below and incorporates assumptions and changes from prior filings as well as this filing.
    - Trend: **8.7%**
        - Trend 2015 to 2016: 5.5%
        - Updated trend factors from experience period to 2015: 3.2%
    - Updated Experience: **0.7%**
        - Manual Rate: 1.6%
        - Experience Period: -0.9%
    - Retention: **0.3%**
        - Admin: -0.3%
        - Contribution to Reserve: 0.9%
        - Other[3]: -0.3%

Standard of Review

Pursuant to Green Mountain Care Board (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 proposed methodology used to calculate the 2015 Insured and Cost Plus large group premiums. The Company provided exhibits and support for each component of the premium development, including trend, administrative costs, contribution to reserves, aggregate stop loss and risk charge factors, network changes and large claim factors.

For medical trend development, the Company used claims incurred between December 1, 2010 and September 30, 2014, paid through November 30, 2014. Completion factors were used to estimate the ultimate incurred claims based on best estimates (i.e. no margin for conservatism was included).

[1] Trend leveraging is a result of fixed deductibles and copays not increasing with trend which causes paid trends to be higher than allowed trends. Note that if the fixed deductibles and copays were increased at the same rate as trend, then allowed trends would equal paid trends.

[2] The Company estimated the overall impact for groups renewing in January from their current 2015 rates to the projected 2016 rates.

[3] Other includes net cost of reinsurance, transitional reinsurance, insurer fee and broker commissions.

The data includes claims from BCBSVT Cost Plus groups, BCBSVT Insured Large Groups and The Vermont Health Plan (TVHP) Insured Large Groups. BCBSVT and TVHP cover substantially similar populations under similar benefit packages. The Company felt that combining these homogeneous populations created greater consistency and credibility within the trend factor development. Adjustments were made to the data to reflect network differences between the two companies.

Company's Analysis

1. *Medical Trend Development:* The Company is requesting a total allowed medical trend of 6.6%. This total allowed medical trend amount is broken down into 0.0% for utilization and intensity and 6.6% for unit cost.

   Utilization and Intensity

   The Company normalized the allowed costs for the past 46 months to remove the impact of unit cost changes and to isolate the change in utilization and intensity of services. This data was then analyzed by using exponential regression over 24, 36 and 46 month time periods. The results of these regressions are shown in the table below:

Utilization & Intensity Regression	46 Months	36 Months	24 Months
Inpatient	1.2%	0.9%	-8.3%
Outpatient	-2.1%	-2.6%	0.8%
Professional	-0.9%	-1.3%	-0.3%
Total	-1.0%	-1.5%	-1.8%

   The Company also provided the table below that demonstrates that the negative utilization and intensity trends are partially a result of large groups buying plans with a lower actuarial value over the last several years. This "buy-down" effect reduces the induced utilization for the insured members. Using the Company's induced utilization factors, the average "buy-down" effect impact over the last three years is a 0.7% reduction in the expected utilization.

Year Ending	Paid to Allowed	Induced Utilization	Change
November 2011	91.4%	104.9%	
September 2012	90.9%	104.2%	-0.6%
September 2013	90.1%	103.3%	-0.9%
September 2014	89.7%	102.7%	-0.6%
3 Year Average			-0.7%

   The Company chose to use a utilization and intensity trend assumption of 0% because:

   1. Historical negative utilization and intensity trends are partially a result of a reduction in induced utilization;
   2. Inpatient utilization and intensity trend is unduly influenced by an unexplained decrease in the inpatient utilization in 2014; and
   3. The Company does not believe that a negative utilization trend is a reasonable representation of the longer-term outlook on the use of services.

Unit Cost Trend
The unit cost trend for medical trend is projected to be 6.6% based on an analysis of the hospital budget increases implemented during 2014 as well as other providers in the BCBSVT service area. To validate the prospective trend assumption, the 36-month regression of historical results was analyzed for Inpatient, Outpatient and Professional/Other claims. This regression analysis produced a 4.8% trend estimate for claims through September 2014. The Company notes that "this result is significantly influenced by the timing of contract increases: a significant facility increase in 2013 for the BCBSVT managed network was followed by a smaller than typical increase in 2014."

The Company believes their prospective view of unit cost changes yields the more accurate analysis and is better aligned with the average increase for the previous three calendar years for providers with GMCB oversight of 6.9%.

Total Allowed Medical Trend
The 0.0% utilization and intensity trend combined with the 6.6% unit cost trend results in total allowed medical trend of 6.6%.

2. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The generic dispensing ratio (GDR) is a measure of the percentage of pharmacy utilization attributable to generic drugs. Historically, the GDR has been increasing due to blockbuster drugs losing their patents. The Company's drug-by-drug analysis shows that the GDR will not increase at the same historical rate.

   Based on the current distribution of days supply and a list of brands expected to move to generic in the projected period, as provided by their pharmacy benefit manager, the Company projected the GDR to reach 86.3% in the projection period. This is an increase of 2.3% over the prior filing's assumption of 84.4%. The list of brand drugs used to calculate the GDR is based on a more extensive list of drugs than was used filings prior to 2014.

3. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* The Company made specific adjustments for specialty drugs that treat hepatitis C and also for PCSK9 inhibitors[4]. First, the Company recalculated the specialty drug trend after excluding the new Hepatitis C drugs (Sovaldi and Olysio) from the historical data. This reduced the 24 month regression trend from 22.0% to 12.9%. The specialty claims in the experience period, excluding hepatitis C drugs, were then trended forward at an annual rate of 12.9%. Then, the projected costs for hepatitis C treatments and PCSK9 inhibitors were added to the projected specialty claims, which resulted in a restated specialty trend of 19.0%.

   The Company projected the cost of hepatitis C treatments based on information provided by Express Scripts (ESI) in December 2014, which assumed that they would have 30 new claimants at an average cost of $154,348.

   Similarly, the projected cost of treatment using PCSK9 inhibitors was provided by ESI with an estimated 171 members likely to receive the treatment at an average cost of $12,000 per year. This estimate assumes that the drug will be only prescribed to members with familial hypercholesterolemia. However, ESI has opined that the utilization of these new drugs may increase by being prescribed to

[4] Beginning in 2014, several new treatments for hepatitis C were introduced to the market with the average cost of treatment exceeding $100,000. The PCSK9 inhibitors are expected to be approved by the FDA in August of 2015 with an average cost per patient per year of $12,000.

some members currently taking statins or to members who have untreated issues with high cholesterol due to intolerance to or lack of results from statins.

The Company reached out to key cardiologists in the State who appear to have a preference to wait until more clinical studies are available on the PCSK9 inhibitors before a wholesale move away from statins is likely to take place. Furthermore, the Company will implement clinical programs to ensure that this very expensive treatment is used appropriately. Therefore, the Company chose not to increase the utilization estimate provided by ESI for the PCSK9 inhibitors in the projected trend for 2016.

4. *Pharmacy Trend Development:* The Company is requesting a total allowed pharmacy trend of 10.0%. The pharmacy trends are calculated using 24 months of historical data, which is modeled using an exponential regression. The Company analyzed 24 months of data in order to best capture an adequate amount of the most recent history of drug costs.

   The Company modeled the cost for generic and brand drugs individually and accounted for improvements in the future contracts with the pharmacy benefit manager. However, to analyze utilization patterns, they combined the data for generic and brand drugs because of several popular brand drugs losing their patents. The combined utilization is projected to increase by 0.2%. A separate adjustment was then made to split the generic and brand utilization based on the projected GDR. The Company modeled only the total PMPM trends for specialty drugs due to their relatively low utilization and high cost nature. The following table shows the results of the Company's analysis and the requested 10.0% overall allowed pharmacy trend.

Pharmacy Trends	Cost	Utilization	Total
Generic	0.0%	1.1%	1.0%
Brand	14.2%	-4.5%	9.1%
Specialty	N/A	N/A	19.0%
Total	N/A	N/A	10.0%

5. *Leverage Adjustments to Allowed Trends:* The Company analyzed allowed trends in order to reduce the effect of benefit changes on observed trends. Therefore, adjustments for trend leveraging were made in order to convert the allowed trends into paid trends. The paid trends are what will actually be applied to large group experience to develop premiums. The leveraged trend values were calculated using the Company's Benefit Relativity models[5] by calculating the change in paid claims with and without the allowed trends. The paid trends are summarized in the table below.

[5] The Company uses the Benefit Relativity modes to calculate the impact of cost sharing for each of the plans that they offer.

Pharmacy Trends	Allowed Trends	Paid Trends
Medical	6.6%	7.4%
Drug	10.0%	11.4%
Total	7.2%	8.1%

6. *Administrative costs:* The proposed administrative costs are developed by trending forward the actual administrative costs for the year ending November 2014. The assumed trend is 2.5%, which reflects the Company's assumption that wages and benefits will increase at 3.0%, while other operating costs and membership are expected to remain at current levels. Wages and benefits make up 82.4% of administrative costs. For groups renewing in July 2015, this results in a 4.7% reduction to the previously approved administrative costs due to increased membership in 2014. The projected membership is expected to remain at the current levels.

   Similarly, the administrative charge was increased by 2.5% (or $40) to $1,665 per group per year for Experience Refund Eligible plans to offset the costs of administering the retrospective arrangement. The increase reflects the assumed increase for the direct staff cost. The proposed investment income adjustment is 0.2% of the margin applied to the settlement administrative charge.

7. *Contribution to Reserves:* The proposed CTR is 2.0% for Insured Large Groups and 0.5% for Cost Plus Groups. The Company demonstrated that a minimum CTR of 1.3% is required to maintain RBC levels at their current levels due to the impact of the 7.2% total allowed trend. The proposed CTR represents management's judgment of the appropriate margin above the minimum needed to keep pace with trend and ensure stability should a significant adverse event occur. The Company notes that regulatory action, membership growth, unusual events such as a flu epidemic or new technology may create a one-time shock to capital. The Company notes that their decision to assume that PCSK9 inhibitors will only be used to treat Familial Hypercholesterolemia (FH) in 2016 is an example of a potential one-time shock to capital.

8. *Induced Utilization Factors:* 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 total allowed charges.

   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 total allowed charges increase as the paid-to-allowed ratio increases.

Lewis & Ellis (L&E) Analysis

1. *Medical Trend Development:* To evaluate the reasonableness of the Company's approach, L&E reviewed the annual change in the total allowed medical claims for the prior 36 months. This analysis resulted in an allowed medical trend of 4.5%, which appears to be an unreasonable estimate based on the confidential support provided by the Company dated March 17, 2015. Therefore, L&E reviewed the Company's analysis in further detail.

   Utilization and Intensity
   To review the Company's assumed 0.0% utilization and intensity trend for reasonableness, L&E took a more discrete approach. L&E does not agree with the Company's assertion that a negative utilization trend is an unreasonable representation of the longer-term outlook on the use of services, given that that the 24, 36 and 46 month regressions each show a negative trend. However, L&E does agree with the Company that this is in part due to the large groups buying plans with lower actuarial value, which will reduce the impact of induced utilization.

   L&E's best estimate for the utilization and intensity trend assumption is based on the 46 month regression of -1.0% but offset by the average impact of the reduction to induced utilization over this time period of 0.7%. This results in an estimated -0.3% utilization and intensity trend.

46 Month Regression	-1.0%
Induced Utilization	0.7%
Utilization and Intensity	-0.3%

   Unit Cost
   The Company discovered errors in their calculation of the projected unit cost trend while preparing responses to requests for support. The revised projection results in a reduction to the originally requested allowed medical trend of 6.6% down to 5.8%. L&E reviewed the revised support for the unit cost trend that was provided by the Company, and it appears to be reasonable and appropriate.

   Total Allowed Medical Trend
   Incorporating the -0.3% utilization and intensity trend with the Company's revised unit cost trend of 5.8% results in a total allowed medical trend of 5.5%.

   Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. The estimated range for the actual results is 3.4% to 7.6%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.[6]

   The Company's revised proposed total allowed medical trend of 5.8% is higher than L&E's best estimate, but it fits comfortably within the estimated range of actual results. L&E considers the Company's revised allowed medical trend of 5.8% to be reasonable and appropriate.

2. *Pharmacy Trend Adjustment – Generic Dispensing Ratio:* The chart below shows the rolling 12 month average GDR from December 2011 to December 2014 as well as the projected GDR for the next 2 years.

[6] For example, the probability that the actual trend will be centered around the best estimate (between 5.4% and 5.6%) is over 50% higher than being near the low end of the range (between 3.4% and 3.6%).

The growth in the GDR has slowed considerably in recent months as the growth was only 2.0% over the last 18 months.

Historical	Rolling 12 Month GDR	Semi-Annual Increase
December 2011	78.0%	
June 2012	79.0%	1.4%
December 2012	81.2%	2.7%
June 2013	82.8%	2.0%
December 2013	83.1%	0.3%
June 2014	83.7%	0.7%
December 2014	84.5%	1.0%

Projected	Rolling 12 Month GDR	Semi-Annual Increase
June 2015	84.7%	0.2%
December 2015	85.1%	0.5%
June 2016	85.6%	0.6%
December 2016	85.9%	0.4%

While the chart shows that the historical trends have slowed, L&E believes that it is more important to focus on the approach used by the Company to project the GDR. The approach from the prior filing was improved by implementing changes based on issues that were addressed in the previous filing:

- The Company included drugs that were projected to become multi-source generics during the first 6 months of the projection period. This resolved the first issue that was addressed in the prior filing.
- The Company trended the pharmacy claims and the GDR to the same period. This appropriately addressed the last two issues from the prior filing.

L&E feels that the methodology used in the Company's analysis produces an estimate of the GDR that is reasonable and appropriate. The projected GDR represents a slowdown in the growth of the GDR, which is expected as the GDR approaches its limit of 100%.

3. *Pharmacy Trend Adjustment – Expensive Specialty Drugs:* L&E reviewed the cost per treatment for hepatitis C that the Company estimated for the projection period and determined the currently available pricing information was significantly lower than what was originally provided by ESI. Since the time that the original pricing information was provided, ESI has agreed to only include Viekira Pak on their formularies for treatment of hepatitis C.

   Based on the emerging pricing information, the Company revised their original estimated costs for treatment of hepatitis C, which resulted in a reduction to the specialty trend from 19.0% to 15.1% and the total pharmacy trend from 10.0% to 8.8%. L&E considers the Company's projection for PCSK9 inhibitors and the revised cost for hepatitis C treatment to be reasonable and appropriate.

4. *Pharmacy Trend Development:* Reviewing the historical claims data on a total PMPM basis would not produce reasonable results due to the slowing growth of the GDR, drugs losing their patents in the projection period, and the adjustments to the future contract terms with the Company's pharmacy benefit manager. Therefore, L&E used the same approach as the Company to calculate the pharmacy trend.

L&E agrees with the Company's decision to use the updated pricing information for hepatitis C treatments, since there is a significant deviation from what was originally filed. This resulted in a projected allowed pharmacy trend of 8.8%.

The estimated range for the actual results is 7.1% to 10.5%. Each of the numbers within the estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range. The Company's originally proposed trend of 10.0% would have been on the high end of the estimated range of actual results. L&E considers the Company's revised allowed pharmacy trend of 8.8% to be reasonable and appropriate.

5. *Leveraged Adjustments to Allowed Trends:* In prior filings, the Company used claims distributions based on internal claims data combined with industry data to estimate the impact of trend leveraging. For this filing, the Company used a more precise approach by modeling the impact on paid claims in the Benefit Relativity models with and without the allowed trend. The approach that the Company used to adjust allowed trends to paid trends is considered to be reasonable and appropriate. The table below shows the Company's revised allowed trends and the paid trends after leverage adjustments were made.

	Allowed Trend	**Paid Trend**
Medical	5.8%	6.5%
Pharmacy	8.8%	10.0%
Total	6.4%	7.2%

6. *Administrative costs:* The Company has experienced a decrease in the administrative costs for the year ending November 2014 due to an increase in membership. However, the Company expects the membership to remain at the current level over the projection period, so they trended the experience administrative costs forward at 2.5%. The proposed administrative costs reflect a 4.7% decrease to the previously approved administrative costs for groups that renew in July 2015. These assumptions appear to be reasonable and appropriate.

   The administrative charge for administering retrospective arrangements is based on the estimated staff time, an assumed hourly rate for direct staff cost, and a loading factor to account for overhead costs. These assumptions appear to be reasonable and appropriate

7. *Contribution to Reserves:* Using the revised allowed trend of 6.4%, a CTR of 1.1% is required to maintain RBC levels at their current levels due to the impact trend. L&E believes the proposed CTR of 2.0% is reasonable in order to maintain RBC levels in light of medical trend and provide an adequate margin over and above the minimum to keep appropriate RBC levels in the case of an adverse event without being excessive. The Company described the potential impact of PCSK9 inhibitors being used more widely than anticipated as an example for why they need to set the CTR higher than the minimum needed to cover trend.

   While L&E believes the proposed CTR of 2.0% is reasonable, reviewing the Company's current level of reserves is beyond the scope of this review. Therefore, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

8. *Induced Utilization Factors:* The new methodology chosen by BCBSVT to estimate the impact of induced utilization is based on potential enhancements that L&E cited during the previous filing. It

produces paid-to-allowed ratios with a steeper curve and better captures the impact of induced utilization. This change appears to be reasonable and appropriate.

Recommendation

After modifications, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modification:

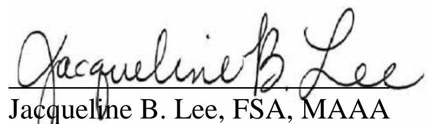
- Decrease the allowed medical trend to 5.8% which results in a reduction to the paid medical trend to 6.5%.
- Decrease the allowed drug trend to 8.8% which results in a reduction to the paid drug trend to 10.0%.

	Allowed Trends		Paid Trends	
	Original	**Revised**	**Original**	**Revised**
Medical	6.6%	5.8%	7.4%	6.5%
Drug	10.0%	8.8%	11.4%	10.0%
Total	7.2%	6.4%	8.1%	7.2%

The above changes will decrease the paid trend from 8.1% to 7.2% and change the overall average rate change from 9.7% ($44.73 PMPM) to 8.2% ($37.83 PMPM).

Sincerely,

Josh Hammerquist, ASA, MAAA
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.



Jacqueline B. Lee, FSA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

David M. Dillon, FSA, MAAA
Vice President & Principal
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ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[7], 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 Conduct[8], 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 April 6, 2015. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is March 20, 2015.

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 L&E has 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.
- L&E is 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.

[7] 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.

[8] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

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.