BlueCross BlueShield of Vermont

March 18, 2019

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

Subject: Your 03/08/2019 Questions re: Blue Cross and Blue Shield of Vermont 3Q 2019 Large Group Rating Program Filing (SERFF Tracking #: BCVT-131835151) and re: The Vermont Health Plan 3Q 2019 Large Group Rating Program Filing (SERFF Tracking #: BCVT-131835292)

Dear Mr. Ruggeberg:

In response to your requests dated March 8, 2019, here are *your questions* and our answers:

1. *Clarify the proposed total premium increase anticipated for fully-insured, manually-rated groups renewing on 1/1/2020 relative to 1/1/2019.*

   The primary quantitative impact of the filing is the 14.9 percent increase in the manual rate. We also produced sets of renewals using the same underlying experience period to illustrate the impact of both annual changes and formula and factor changes. The product of these two changes also calculates a 14.9 percent increase.

   While this filing establishes the formula that will be used to experience rate large groups, actual increases experienced by groups will vary based on the underlying experience of each group. None of our insured groups are fully manually-rated. The median large group credibility is currently 40 percent, and exceeds 50 percent for many groups. Therefore, changes in each group's underlying experience will be a primary driver of the change in premium for each group.

2. *Please split the claims underlying the manual rate base experience period into paid claims and IBNP.*

   The split in the manual rate experience period paid claims is provided in the table below:

Manual Rate Experience Paid Claims		
Incurred and Paid		$68,628,449
Estimated IBNP	+	$319,842
Completed Claims	=	$68,948,291

3. *The memorandum states that "BCBSVT will use multiple experience periods (when available)." Please clarify whether there is a maximum number of historical years (e.g. three years) used for experience rating. Is that maximum number used in all cases where it is available?*

   Three years of experience is the maximum that will be used. In the absence of extenuating circumstances, all renewals will use the maximum number of years available. In the event historical experience is not considered appropriate or reliable for rating periods (e.g. a significant change in enrollment due to an acquisition or layoff), the underwriter will use fewer years of experience and document the rationale for such a change.

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

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

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

   Particular to Vermont, we note that in their large group filing, CIGNA developed both national and Vermont-specific medical trends[2]. The Vermont trend was 7.5 percent, compared to the national trend of 6.25 percent. CIGNA filed a utilization trend of 1.7 percent and a mix trend of 2.2 percent for Vermont, for a combined utilization/mix trend of 3.9 percent.

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

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

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

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

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[1] Medical Cost Trend: Behind the Numbers 2018, page 12
https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers/reports/hri-behind-the-numbers-2018.pdf

[2] http://ratereview.vermont.gov/sites/dfr/files/2018/Objection%20Letter%201%20%26%20Response.pdf
Response to Objection 3, page 5

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

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

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

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

8. *Provide further explanation of the need for the "Manual Rate Adjustment Factor". Given the experience is trended and adjusted for demographic differences, why would using three combined experience periods have a predictable, systemic impact on the claims projection such that it must be counter-acted by an 8% reduction in the manual rate?*

The normalization factor is necessary due to the disparate experience of the groups underlying the block. When additional years of experience are added, the experience retained is not proportional to the average experience in the block, since credibility levels and experience vary across groups.

Put simply, the larger groups in the block tend to have worse experience. This is not surprising, as larger groups with good experience are more likely to self-fund, whereas smaller groups with similarly good experience might not feel that they can absorb the cashflow variation and greater risk and are therefore more likely to remain fully-insured. When greater credibility through use of multiple experience periods is assigned to these large groups with poor experience, less of their poor experience is spread across the entire block, effectively lowering the manual rate for other groups.

The magnitude of the factor is impacted by the decreasing weight placed on the manual rate. As the percentage of the rate developed from preceding years increase, the amount that is manually rated decreases. This amplifies the normalization factor, as under the three experience period method the manual rate only develops 19 percent of total projected claims.

9. *The proposed formulas and factors are to be effective as of 3Q2019, before the HIF becomes active again. Will the "Federal Insurer Fee" component of the rate calculation reflect a cost [other] than 2.2% for quotes/renewals prior to 2020?*

   The rating formula blends each year's fee proportionally to the rating months in effect. For example, a 12-month rate starting October 1, 2019 would have an effective insurer fee rate of 1.65 percent, calculated using the 0.0 percent rate for three months and the 2.2 percent rate for nine months.

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

    Please see the attached file *Response to Q3 2019 LG Filing 03.08.2019 Inquiry - Q10.xlsx* for the requested exhibits.

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

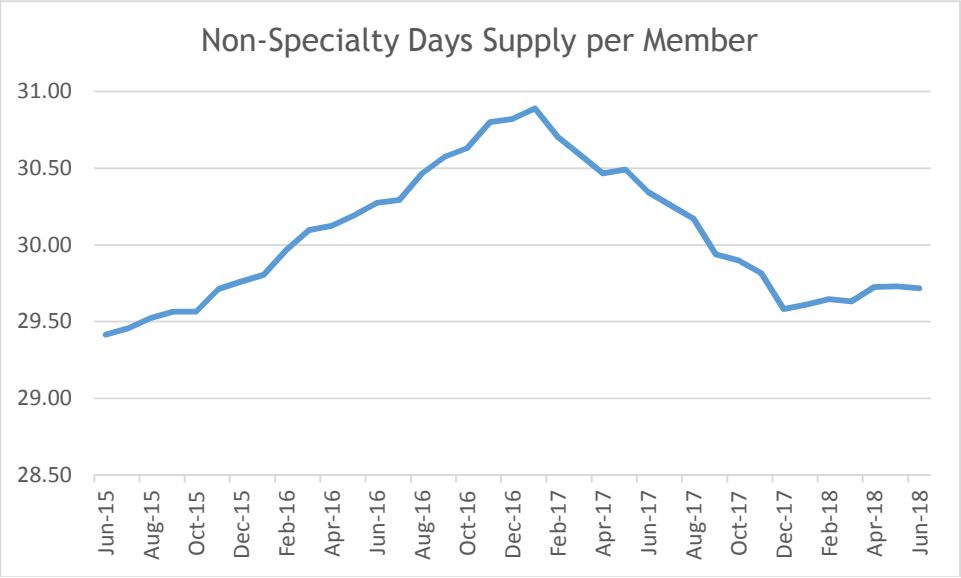
    The generic cost trend developed in the memorandum included all drugs identified as generic, including recently introduced generics in addition to drugs that have been generic for a number of years. This was the method we had used in previous filings, which included an adjustment for a projected generic dispensing rate in the ultimate trend development. This year's filing uses a new method of accounting for brands going generic, considering them separately from other generic drugs. Following this change, we agree that it would be more appropriate to use a generic cost trend that does not include the impact of new generic drugs.

    We developed a cost trend for generic drugs using drugs that were generic for the entire experience period, thereby eliminating the impact of the mix of old and new generic drugs from the cost trend. The result of a monthly 24-point regression on these drugs is a 0.0 percent generic cost trend. Using this trend in place of the filed 3.5 percent generic cost trend reduces the total pharmacy trend from 9.1 percent to 8.5 percent (before the impact of contracting changes). Please see the attached file *Response to Q3 2019 LG Filing 03.08.2019 Inquiry - Q11.xlsx* for the development of the generic and total trends.

    Note that the Exhibit 2D provided in response to Question 10 shows the generic cost trend as filed, while the Exhibit 2D in this response is the updated version.

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

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



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.