Filing at a Glance

Company:	BCBSVT
Product Name:	2015 Vermont Exchange Products Rate Filing
State:	VermontGMCB
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001C Any Size Group - Other
Filing Type:	GMCB Rate
Date Submitted:	06/02/2014
SERFF Tr Num:	BCVT-129572217
SERFF Status:	Pending State Action
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Vince Mace, Pam Young, Seth Abbene, Jude Daye, Martine Brisson-Lemieux, Andrew Proulx, Paul Shultz
Reviewer(s):	Thomas Crompton (primary), Kelly Macnee, David Dillon, Judith Henkin, Jacqueline Lee
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Other
Overall Rate Impact:

Deemer Date:
Submitted By: Jude Daye

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Explanation for Other Group Market Type:
Filing Status Changed: 07/15/2014
State Status Changed:
Created By: Jude Daye
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null
Exchange Intentions: To be sold on the Vermont Health Connect effective 01/01/2015

Filing Description:
June 2, 2014

Judith Henkin, Esq.
Health Policy Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Subject: Blue Cross and Blue Shield of Vermont - NAIC # 53295
2015 Vermont Exchange Products Rate Filing

Dear Ms. Henkin:

Attached for the Green Mountain Care Board's review and approval is Blue Cross and Blue Shield of Vermont's 2015 Vermont Exchange Products Rate Filing.

Please let me know if we can answer any questions or provide further information during your review.

Sincerely,

Kevin Goddard

cc: Tom Crompton/GMCB
Ruth Greene/BCBSVT
Vince Mace/BCBSVT
Paul Schultz/BCBSVT

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Company and Contact

Filing Contact Information

Jude Daye, Executive Assistant
445 Industrial Lane
Montpelier, VT 05601

dayej@bcbsvt.com
802-371-3244 [Phone]

Filing Company Information

BCBSVT
PO BOX 186
Montpelier, VT 05601
(802) 371-3450 ext. [Phone]

CoCode: 53295
Group Code:
Group Name:
FEIN Number: 03-0277307

State of Domicile: Vermont
Company Type: Hospital Service Corp
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Response	Jacqueline Lee	07/11/2014	07/11/2014
Pending Response	Jacqueline Lee	07/08/2014	07/08/2014
Pending Response	Jacqueline Lee	06/30/2014	06/30/2014
Pending Response	Jacqueline Lee	06/11/2014	06/11/2014

Response Letters

Responded By	Created On	Date Submitted
Martine Brisson-Lemieux	07/15/2014	07/15/2014
Martine Brisson-Lemieux	07/10/2014	07/10/2014
Martine Brisson-Lemieux	07/02/2014	07/02/2014
Martine Brisson-Lemieux	06/16/2014	06/16/2014

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Actuarial Dataset for the 2015 Vermont Exchange Products Rate Filing	Note To Reviewer	Jude Daye	06/04/2014	06/04/2014

State:	*VermontGMCB*	**Filing Company:**	*BCBSVT*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*		
Product Name:	*2015 Vermont Exchange Products Rate Filing*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	07/11/2014
Submitted Date	07/11/2014
Respond By Date	07/15/2014

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
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Scott E. Morrow, F.S.A.

Baltimore
David A. Palmer, C.F.E.

July 11, 2014

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2015 Exchange Filing
SERFF Tracking #: BCVT-129572217

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 6/2/2014. The following additional information is required for this filing.

Questions:

1. Pediatric Dental
    a. Please provide the separate communication that contains the projected allowed pediatric charges in the response to question #1a date July 2nd.
    b. Why was the benefit richness adjustment assumed to be prohibited in 2014, but not in 2015?
2. Pediatric Vision
    a. Please provide the report for pediatric vision that was provided by the vision provider VSP.
3. Transitional Reinsurance Recoveries
    a. The Final Rule (5/27/2014) suggests that the attachment point may change from $70,000 to $45,000 for 2015. Please provide a recalculated projected reinsurance recoveries PMPM (and all quantitative support for the calculation) if you were to assume that the lower attachment point was in place at the time of the filing.

b. In Table 1 in the response to question #8 dated July 2nd, please include an additional category for claims between $45,000 and $60,000.

4. Taxes and Fees
   a. Was any attempt made to estimate the impact on the insurer fee of large groups moving to self-insurance by either BCBSVT or BlueCross BlueShield Association?
5. Trend
   a. Please provide quantitative support for the unit cost increases in the table on page 19 of the Actuarial Memorandum.

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than July 15, 2014. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.
jhammerquist@lewisellis.com
(972)850-0850

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	07/08/2014
Submitted Date	07/08/2014
Respond By Date	07/10/2014

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
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Baltimore
David A. Palmer, C.F.E.

July 8, 2014

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2015 Exchange Filing
SERFF Tracking #: BCVT-129572217

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 6/2/2014. The following additional information is required for this filing.

Questions:

1. Please provide an estimate of the 2014 financial impact of the federal changes in attachment point and percentage in the 2014 transitional reinsurance compared to the assumptions you used in your 2014 rate filing.
2. Please provide a history of projected (as reflected in the rate filings) and actual incurred claims and earned premiums for the past three years for the individual and small group markets separately.
3. Please provide the allowed and incurred cost by age cohort (20 and under and 5 year increments thereafter or by age, if easier) for individual and small groups in 2013.

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than July

10, 2014. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.
jhammerquist@lewisellis.com
(972)850-0850

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/30/2014
Submitted Date	06/30/2014
Respond By Date	07/01/2014

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
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Baltimore
David A. Palmer, C.F.E.

June 30, 2014

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2015 Exchange Filing
SERFF Tracking #: BCVT-129572217

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 6/2/2014. The following additional information is required for this filing.

Questions:

1. Pediatric Dental
    a. Provide quantitative support for the $42.49 allowed charges for pediatric dental. How does this figure reconcile to the projected dental costs found in the Milliman report?
    b. We note that "there is a considerable amount of uncertainty" in the projected pediatric dental claims costs. Was any margin included in the pediatric dental claims costs to reflect this uncertainty?
    c. Provide the benefit richness adjustments used in 2015 for each pediatric dental plan. Why was this adjustment assumed to be prohibited in 2014 but not in 2015?

d. Please clarify how these projected dental amounts are representative of the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT, in light of the medical claims being applied to the deductible and out-of-pocket maximum prior to the dental claims.

2. Pediatric Vision
   a. Per the response to question 5b dated June 16th, 2014, please provide support for the projected allowed claims for pediatric vision. We have included the question below for your convenience.

      Describe the source of the each of the benefits listed below in more detail. Is the data based on insured members? Were adjustments made to the data to fit the population that will be covered?
   b. We note that it was "assumed that the paid benefits would not be materially different from the allowed charges." Please clarify if this means that zero cost sharing was assumed for pediatric vision benefits.
   c. Please provide a quantitative estimate of the cost sharing for pediatric vision benefits.
3. Pharmacy Trend
   a. Please provide quantitative and further qualitative support for the adjustment made to account for the expected May 2014 launch of generic Copaxone.
4. Medical Trend
   a. Please provide a quantitative demonstration of the expected cost shift due to the proposed 1.6% increase for Medicaid rates.
5. Base Experience Period
   a. We note that the fourth quarter of 2013 was impacted by a significant increase in utilization leading up to the implementation of Vermont Health Connect. Was any consideration given to using a different base experience period? For example, the experience from October 1, 2012 to September 30, 2013 would exclude the increased utilization leading up to the implementation of Vermont Health Connect.
6. Population Risk Morbidity
   a. Please provide quantitative support for the average age-gender factors used to calculate the factors below shown in Exhibit 5:
      i. $(1+b_9)$ The Impact of the Health Status of the Newly Insured
      ii. $(1+c_3)$ Changes in demographics (age, gender, region, etc.)
7. Other Adjustments
   a. We note that in the response to question 7a dated June 16th, 2014 that 74% of the CY 2013 pharmacy rebates were estimated. Has the company received any additional information regarding the CY 2013 rebates since the initial filing was made? Is this lag associated with the CY 2013 rebates typical for the Company?

8. Transitional Reinsurance Recoveries
    a. Please provide additional quantitative support for the expected reinsurance recoveries for individual members. The additional support should include the frequency and average allowed claims used in the calculation for both the 2014 and 2015 reinsurance recoveries split into the following categories:
        i. < $60,000
        ii. $60,000 - $70,000
        iii. $70,000 - $250,000
        iv. $250,000 +
9. Benefit Richness Adjustment
    a. Please provide further support that the "use of group data minimizes the potential for selection bias within the experience period data." To what degree do the members of the groups in the experience period data have choices between plans with different actuarial values?
10. Administrative Expenses
    a. Please provide the CY 2013 Supplemental Health Care Exhibit and reconcile to the 2013 figures provided in the previous response.
11. Taxes and Fees
    a. We note that the 2014 estimate of the Federal Insurer Fee was increased by 41.25%. Why was the increase applied to the rounded 2014 estimate, rather than the actual unrounded 2014 estimate?

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than July 1, 2014. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.
jhammerquist@lewisellis.com
(972)850-0850

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Response
Objection Letter Date	06/11/2014
Submitted Date	06/11/2014
Respond By Date	06/16/2014

Dear Jude Daye,

Introduction:

Please see the attached inquiry letter.

Conclusion:

Sincerely,
Jacqueline Lee

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
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June 11, 2014

Jude Daye, Executive Assistant
Blue Cross and Blue Shield of Vermont
445 Industrial Lane
Montpelier, VT 05601

Re: Blue Cross and Blue Shield of Vermont
2015 Exchange Filing
SERFF Tracking #: BCVT-129572217

Dear Jude Daye:

We have been retained by the Green Mountain Care Board ("GMCB") to review the above referenced group products filing submitted on 6/2/2014. The following additional information is required for this filing.

Questions:

1. General
    a. Please provide the final 2014 URRT and describe if the PMPMs are directly comparable to the 2015 URRT. If any of the PMPMs are not comparable, please describe why and include a numerical example.
2. Changes to Initially Filed Rates in 2014
    a. Please provide a breakdown of the changes that happened during the interrogatories with the actuaries or due to a decision made by the Board to the assumptions and rates that were initially filed in 2014.
3. Reason for Rate Increase
    a. Please provide the percentage of the increase that is due to changes in the amounts providers are paid that are projected to occur before the end of 2014 beyond the original assumptions for 2014. In other words, please split the 2.9% increase from the top of page 5 of the Actuarial Memorandum into those that have already occurred and those that are projected to occur.

b. Please reconcile the 4.8% increase in 2015 due to amounts providers are paid with the trend exhibits provided.
c. Please provide the calculation of the 2.5% decrease due to "new members" who have or will enroll in the qualified health plans who will be significantly healthier on average than those previously insured in individual and small group products.
d. Provide a more detailed quantitative breakdown of the other adjustments used in the 2014 rate development that cumulatively have the effect of reducing the required rate increase by 1.8%.
e. Provide quantitative and qualitative support for the 4.0% increase in rates that is attributed to the reduction in the transitional reinsurance program. How many member months were used to develop this estimate?
f. Provide quantitative and qualitative support for the 0.8% increase in rates that is attributed to benefit leveraging.

4. Changes in the Morbidity of the Population Insured
   a. Provide a comparison of the 2014 enrollment by age, gender and plan to the projected 2015 membership by age, gender and plan.
   b. Describe the year to date paid claims and earned premiums that are available and discuss whether or not they should be considered in the rate development.
5. Changes in Benefits
   a. In Exhibit 5, should the change in the Benefit Adjustment factor ($1+c_1$) from the 2014 to 2015 filings be shown in the "Reason for Rate Increase" illustration? If so, please demonstrate the impact.
   b. Describe the source of the each of the benefits listed below in more detail. Is the data based on insured members? Were adjustments made to the data to fit the population that will be covered?
      i. Pediatric Vision Benefit
      ii. Pediatric Dental Benefit
6. Changes in Demographics
   a. In Exhibit 5, please explain the necessity of the Changes in demographics ($1+c_3$) after adjustments were made for Impact of the Health Status of the newly insured ($1+b_3$) and Changes in pool morbidity ($1+b_9$).
7. Other Adjustments
   a. From Exhibit 5, how much of the pharmacy rebates (e_1) in the experience period is estimated? How do the estimated experience period pharmacy rebates compare to the actual 2012 pharmacy rebates?
   b. Provide quantitative support for the cost of the Vermont Vaccine Purchasing Program Payments for children and adults.
   c. Please provide an exhibit with the information below for private reinsurance in 2011, 2012 and 2013.
      i. Terms of private reinsurance
      ii. Premiums PMPM
      iii. Recoveries PMPM
      iv. Number of claims
   d. In Exhibit 5, provide the calculation of the net cost of reinsurance (e_5). Were any adjustments made to the claims data used in the BCBSVT Large Claims and Stop Loss Filing (BCVT-129374060)?

8. Contract Conversion Factor
    a. From Exhibit 5, please discuss the appropriateness of reducing the projected index rate by the Changes in Family Tiering ($1+c_6$) and/or any guidance provided by CCIIO about this adjustment factor. Was any consideration given to making this adjustment in the 'cost-sharing design of the plan' to avoid reducing the allowed costs? Demonstrate compliance with the definition of the projected index rate in the Part I Instructions.
9. Projected Risk Adjustments PMPM:
    a. Based on the support provided, the risk adjustment in cell V35 on WS 1 of the URRT should be -$0.08. If this is correct, please update the URRT accordingly.
10. Benefit Richness Adjustment
    a. Provide qualitative and quantitative support for the benefit richness adjustment factors for medical and pharmacy in Exhibit 6C.
    b. Please discuss the changes in the benefit richness adjustments from the prior filing.
    c. Were any steps taken to assure that the benefit richness adjustments did not include any differences in utilization due to differing health status of people with different cost-sharing designs, per page 26 of the Part I Instructions?
11. Impact of Specific Eligibility Categories for the Catastrophic Plan
    a. Please elaborate on which adjustment for the catastrophic plan causes the method described on the bottom of page 24 in the Actuarial Memorandum to skew the Plan Adjusted Index Rate.
12. Taxes and Fees
    a. Please provide the calculation of the Federal Insurer Fee of 2.83% of premium.
13. Administrative Expense Load
    a. Please provide the total administrative costs and member months for the combined BCBSVT individual members, BCBSVT small group members and TVHP small group members for the prior 5 years.
    b. Please provide a comparison of the 2014 and 2015 administrative expenses, and justify the differences.
14. Profit (or Contribution to Surplus) & Risk Margin
    a. Provide quantitative support for the requested contribution to reserve.
15. Medical Trend Development
    a. What is the projected change in utilization and unit cost for providers outside the service area?
16. Exhibit 6A
    a. We note that several exhibits use the Plan Level Adjusted Index Rate as the average premium. Please discuss if the Plan Level Adjusted Index Rate is the expected premium or if it is 3.6% lower than the actual expected premium due to the Changes in Family Tiering adjustment discussed above.
17. Exhibit 6B
    a. Please discuss the difference between the AV Metal Value and the Paid to Allowed Ratio for EHB Portion in Exhibit 6B for the plans listed below. Note that we are not suggesting that the AV Metal Values and the Paid to Allowed Ratios should reconcile. However, large discrepancies merit further review.
        i. Standard Bronze CDHP
        ii. Standard Silver CDHP

Please be aware that we expect to have further questions regarding the filing as the review continues.

To ensure that the review of your filing has been completed before statutory deadlines, we expect you to respond as expeditiously as possible to every objection in our letter, but no later than June 16, 2014 at noon EST. Note that the responses can be submitted separately and do not have to be submitted all at the same time.

We trust that you understand these forms may not be used in Vermont until they are formally approved by the GMCB.

Sincerely,

Josh Hammerquist A.S.A., M.A.A.A.
Assistant Vice President & Consulting Actuary
Lewis & Ellis, Inc.
jhammerquist@lewisellis.com
(972)850-0850

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/15/2014
Submitted Date	07/15/2014

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2015 Exchange Filing.

Response 1

Comments:

Resquested documentation for objection

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.11.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.11.2014.pdf VTX28_2015_Ped_Dental_Claims_2014-07-15.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/10/2014
Submitted Date	07/10/2014

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2015 Exchange Filing.

Response 1

Comments:

Resquested documentation for objection

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	esponses to BCBSVT 2015 Exchange Filing Inquiries - 07.08.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.08.2014.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/02/2014
Submitted Date	07/02/2014

Dear Thomas Crompton,

Introduction:

Attached please find the responses from BCBSVT to the Actuarial Inquiries to the 2015 Exchange Filing.

Response 1

Comments:

Resquested documentation for objection

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014.pdf Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014.xlsx Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014 - Excel Document.pdf Supplemental Health Care Exhibit Filed BCBSVT 2013.pdf Supplemental Health Care Exhibit Filed TVHP 2013.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/16/2014
Submitted Date	06/16/2014

Dear Thomas Crompton,

Introduction:

Attach please find the response from BCBSVT to the Actuarial Inquiries to the 2015 Exchange Filing.

Response 1

Comments:

Resquested documentation for objection

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014
Comments:	
Attachment(s):	BCBSVT 2014 Exchange Filing - Method for applying the GMCB corrected Order.pdf Exhibits for Detail Explanation of Order Calculation - 2014 Exchange Filing.pdf Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.11.2014.xlsx Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014 - Excel Documents.pdf Unified_Rate_Review_Template_BCBSVT_2014_Final_Amended_Rates.pdf Unified_Rate_Review_Template_BCBSVT_2014_Final_Amended_Rates.xlsm Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Martine Brisson-Lemieux

State: *VermontGMCB* **Filing Company:** *BCBSVT*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001C Any Size Group - Other*
Product Name: *2015 Vermont Exchange Products Rate Filing*
Project Name/Number: */*

Note To Reviewer

Created By:

Jude Daye on 06/04/2014 03:21 PM

Last Edited By:

Jude Daye

Submitted On:

06/04/2014 03:21 PM

Subject:

Actuarial Dataset for the 2015 Vermont Exchange Products Rate Filing

Comments:

Attached please find the Actuarial Dataset for the 2015 Vermont Exchange Products Rate Filing. We are including both the PDF version and an Excel version of the document.

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Attachment BCBSVT - 2015 Exchange - Actuarial Dataset.xlsx is not a PDF document and cannot be reproduced here.

Please provide Company specific inputs for any cells shaded in blue that currently has dummy variables.

Purpose, Scope, and Reason for Rate Increase

Insurance Company Name	Blue Cross and Blue Shield of Vermont
HIOS ID	13627
SERFF Filing Number	BCVT-129572217
Date of Submission	6/2/2014
Proposed Effective Date	1/1/2015

	Before Rate Increase	After Rate Increase
Average annual premium per policy	$8,190	$8,993

Proposed Overall Rate Change	9.81%
Proposed Minimum Rate Change	4.80%
Proposed Maximum Rate Change	11.79%

Relationship of Proposed Rate Scale to Current Rate Scale Due to:

	Description	Relativity
Claims Experience	The experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. We combined both	1.0798
Age / Gender	We applied Milliman's Health Cost Guidelines (2013) age/gender factors both the experience membership for continuing members and the projected membership and compared the average factors	0.9918
Tier	The mandated tier factors remained unchanged	1.0000
Geography	N/A	1.0000
Tobacco	N/A	1.0000
Benefit Plan Relativities	As overall costs increase and the amounts that members pay in cost-sharing contributions stays the same, more of the total cost is transferred to premiums	1.0080
Mandated Benefit Changes	The Green Mountain Care Board approved a change to enhance coverage for dental services for children. The change provides that children covered through the Exchange product will have access to cleanings and other services with no	1.0050
Non-Mandated Benefit Changes	N/A	1.0000
Other	This includes Transitional Reinsurance, Federal Insurer Fee, changes in pool morbidity, cost trend, changes in administrative charges and other items	1.0121
	Total Average Relativity of Proposed vs. Current Scale	1.0981

Annual Rate Change Distribution

	Impacted # of Contracts	Impacted # of Members	Impacted # of Groups
Reduction of 15.00% or more	0	0	0
Reduction of 10.01% to 14.99%	0	0	0
Reduction of 5.01% to 10.00%	0	0	0
Reduction of 0.01% to 5.00%	0	0	0
No Change	0	0	0
Increase of 0.01% to 5.00%	1,654	2,792	224
Increase of 5.01% to 10.00%	13,515	22,815	1,558
Increase of 10.01% to 14.99%	19,302	32,583	2,581
Increase of 15.00% or more	0	0	0
Total	34,471	58,190	4,363

History of Rate Changes

Rate Effective Month and Year:	Average Annual Proposed Rate Change	Average Annual Approved Rate Change
2012	N/A	N/A
2013	N/A	N/A
2014	N/A	N/A

Experience Period Used in Rate Development

General Description of Experience Used in Rate Development (may be different than experience shown in URRT)	The experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. We combined both companies since all their members will be migrating to the Exchange and Small
Does experience include pools/blocks of business not affected by proposed rate change?	No (Yes or No)

	Incurred From Month/Year	Incurred To Month/Year
Time period used for Experience Data in Rate Development	1/1/2013	12/31/2013

Total Written Premium in Experience Period	$287,929,163
Total Earned Premium in Experience Period	$287,929,163
Total Incurred Claims in Experience Period	$268,391,883
Loss Ratio	93.21%
Paid Through Date For Claims	3/31/2014
IBNR as % of Incurred Claims	0.39%
IBNR as # of Months of Paid Claims	0.05
Number of Contracts/Policyholders	464,343
Number of Covered Lives	729,421

Service Category	Incurred Claims $ PMPM	% Incurred
Inpatient Facility	$66.65	14.7%
Outpatient Facility	$141.15	31.2%
Professional	$81.04	17.9%
Prescription Drugs	$72.62	16.0%
Capitation and Other Provider Payments	$76.48	16.9%
Other	$14.81	3.3%
Total	$452.75	

Credibility Analysis

Assumed Experience Credibility %	100.00%
Description of Credibility Formula and the Theoretical Basis for Use	N/A

Alternative Data Sources

Description of Any Alternative Experience Data Used in Rate Development	N/A
Description of Any Manual Rate Data Used in Rate Development	N/A

Retention

	PMPM in effect during the experience period	PMPM from Most Recent Approved Rate Filing	Proposed PMPM for Effective Date	Proposed Change in PMPM Compared to Prior 12 months	Proposed Change in PMPM Compared to Most Recently Approved Filing
Payroll and Benefits	$14.31	$14.40	$12.79	-10.58%	-11.17%
Outsourced Services (EDP, claims, etc.)	$6.07	$6.10	$6.92	13.94%	13.38%
Auditing and consulting	$2.61	$2.21	$1.81	-30.83%	-18.19%
Marketing & Advertising	$0.84	$0.49	$0.33	-61.13%	-33.13%
Legal Expenses	$0.21	$0.22	$0.11	-48.81%	-50.16%
Other General Admin Expense	$5.32	$5.70	$4.82	-9.44%	-15.47%
Commissions & Brokers Fees	$7.19	$0.00	$0.00	-100.00%	
Taxes, Licenses & Fees	$0.44	$0.50	$0.45	2.15%	-10.83%
Reinsurance	$0.00	$0.00	$0.00		
Profit/Risk Margin	-$14.84	$2.02	$4.44	-129.92%	119.62%

	As % of Premium during the experience period	As % of Premium from Most Recent Approved Rate Filing	Proposed As % of Premium for Effective Date	Proposed Change in % of Premium Compared to Prior 12 months	Proposed Change in % of Premium Compared to Most Recently Approved Filing
Payroll and Benefits	3.62%	3.32%	2.88%	-20.49%	-13.07%
Outsourced Services (EDP, claims, etc.)	1.54%	1.41%	1.56%	1.30%	10.95%
Auditing and consulting	0.66%	0.51%	0.41%	-38.50%	-19.94%
Marketing & Advertising	0.21%	0.11%	0.07%	-65.44%	-34.56%
Legal Expenses	0.05%	0.05%	0.02%	-54.49%	-51.23%
Other General Admin Expense	1.35%	1.31%	1.08%	-19.48%	-17.28%
Commissions & Brokers Fees	1.82%	0.00%	0.00%	-100.00%	
Taxes, Licenses & Fees	0.11%	0.12%	0.10%	-9.18%	-12.74%
Reinsurance	0.00%	0.00%	0.00%		
Profit/Risk Margin	-3.76%	0.50%	1.00%	-126.61%	100.00%

Trend & Projection Assumptions

Adjustments from Experience Period to Current Calendar Year

Start Period	End Period
1/1/2014	12/31/2014

	Util. Adjustments to Current Rate					Unit Cost Adj to Current Rate			
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Total Util Factor	Provider Payment Change	Other Factor	Total Unit Cost Factor	Trend
Inpatient Facility	1.0000	1.0000	1.0000	1.0000	1.00000	1.0403	1.0000	1.04028	1.04028
Outpatient Facility	1.0000	1.0000	1.0000	1.0000	1.00000	1.0403	1.0000	1.04028	1.04028
Professional	1.0000	1.0000	1.0000	1.0000	1.00000	1.0403	1.0000	1.04028	1.04028
Prescription Drugs	1.0187	1.0000	1.0000	1.0000	1.01870	1.0681	1.0000	1.06810	1.08807
Capitation and Other Provider Payments	1.0000	1.0000	1.0000	1.0000	1.00000	1.0403	1.0000	1.04028	1.04028
Other	1.0000	1.0000	1.0000	1.0000	1.00000	1.0403	1.0000	1.04028	1.04028

	Adjustments from Current Calendar Year to Projection Year								
	Start Period	End Period							
	1/1/2015	12/31/2015							
	Util. Adjustments to Current Rate					Unit Cost Adj to Current Rate			
Service Category	Util/1000 Trend	Benefit Plan Change	Population Change	Other Factor	Total Util Factor	Provider Payment Change	Other Factor	Total Unit Cost Factor	Trend
Inpatient Facility	1.0000	1.0000	1.0000	1.0000	1.00000	1.0480	1.0000	1.04805	1.04805
Outpatient Facility	1.0000	1.0000	1.0000	1.0000	1.00000	1.0480	1.0000	1.04805	1.04805
Professional	1.0000	1.0000	1.0000	1.0000	1.00000	1.0480	1.0000	1.04805	1.04805
Prescription Drugs	1.0187	1.0000	1.0000	1.0000	1.01870	1.0597	1.0000	1.05970	1.07952
Capitation and Other Provider Payments	1.0000	1.0000	1.0000	1.0000	1.00000	1.0480	1.0000	1.04805	1.04805
Other	1.0000	1.0000	1.0000	1.0000	1.00000	1.0480	1.0000	1.04805	1.04805

Service Category	Incurred Claims $ PMPM	Medical Trend
Inpatient Facility	$66.65	1.09026
Outpatient Facility	$141.15	1.09026
Professional	$81.04	1.09026
Prescription Drugs	$72.62	1.17459
Capitation and Other Provider Payments	$76.48	1.09026
Other	$14.81	1.09026
Aggregate	$452.75	1.103789607

Monthly Trend Analysis Based on Experience Data Time Period used for Rate Development

Month	Member Months	Monthly Incurred Claims $ PMPM	Rolling 12 Mo Trend	Annualized Rolling 6 Mo Trend	Annualized Rolling 3 Mo Trend
January-2011	40,728	$413.95			
February-2011	41,137	$368.10			
March-2011	41,544	$462.88			
April-2011	41,847	$410.30			
May-2011	42,167	$413.85			
June-2011	42,279	$445.38			18.48%
July-2011	42,536	$396.09			12.89%
August-2011	42,651	$432.58			2.08%
September-2011	42,862	$458.97			11.86%
October-2011	42,747	$452.39			36.82%
November-2011	42,728	$482.76			47.37%
December-2011	42,763	$497.84		23.27%	54.19%
January-2012	60,442	$428.30		43.22%	93.88%
February-2012	60,483	$433.67		51.82%	129.53%
March-2012	60,785	$467.83		71.07%	199.07%
April-2012	60,990	$440.67		82.38%	109.19%
May-2012	60,929	$485.15		93.56%	78.71%
June-2012	60,891	$420.38		95.69%	7.55%
July-2012	60,850	$422.29		68.07%	-3.34%
August-2012	60,836	$443.20		50.34%	-27.72%
September-2012	61,055	$385.61		24.51%	-25.54%
October-2012	60,917	$483.07		15.91%	-4.48%
November-2012	61,059	$469.18		2.03%	18.32%
Dec-2012	61,186	$479.15	47.66%	1.24%	72.99%
Jan-2013	60,791	$478.60	43.25%	5.74%	40.72%
Feb-2013	60,577	$427.63	36.53%	3.47%	13.90%
Mar-2013	60,635	$473.62	31.62%	16.93%	-15.79%
Apr-2013	60,560	$490.18	27.78%	13.59%	-12.06%
May-2013	60,431	$500.52	22.35%	17.05%	22.20%
Jun-2013	60,739	$452.80	20.06%	9.45%	18.98%
Jul-2013	61,204	$477.18	17.59%	5.18%	13.17%
Aug-2013	61,332	$471.60	14.87%	10.31%	-12.94%
Sep-2013	61,148	$488.68	15.50%	5.13%	2.67%
Oct-2013	60,840	$565.08	13.34%	10.50%	31.89%
Nov-2013	60,849	$518.13	11.39%	10.02%	56.57%
Dec-2013	60,315	$544.14	9.72%	19.04%	58.34%

Solvency

	Most Recent Quarterly Financial Statement	Most Recent Annual Financial Statement
Total Adjusted Capital		
Authorized Control Level		
RBC Ratio		

Loss Ratio

Time Period	Period Beginning Date	Period Ending Date	Member Months	Incurred Claims	Earned Premium	Loss Ratio	Expected Incurred Claims	A-to-E Claims Ratio
Historical Year -4	1/1/2009	12/31/2009						
Historical Year -3	1/1/2010	12/31/2010						
Historical Year -2	1/1/2011	12/31/2011						
Historical Year -1	1/1/2012	12/31/2012						
Historical Year 0	1/1/2013	12/31/2013						
Historical Totals			0	0	0		0	
Interim Time Period	1/1/2014	12/31/2014	758,664	243,093,245	278,842,852	87.2%	243,093,245	100.0%
Future Year 1	1/1/2015	12/31/2014	698,280	273,590,826	310,011,258	88.3%	273,590,826	100.0%

Anticipated Federal loss ratio standard in market: 80%

Justification for relationship of Federal MLR standard and the projected future loss ratio including detailed break down of adjustments

Please see the Actuarial Memorandum and Exhibit 8 for details about the adjustments. Our projected Loss Ratio is much higher than the anticipated 80% Federal MLR Standard.

Note:
The historical time periods should represent calendar years since the inception date of the plan type through the most recent date available allowing for the appropriate amount of run-out.
In instances where the start dates and end dates do not line up with a calendar year, partial years should be used.
The interim time period the time between the end date of the "Most Recent Date Available" and the rate effective date.
The future year should represent the 12 months immediately following the rate effective date.

Consumer Adjusted Premium Rate Development

Index Rate for Projected Period PMPM	$503.40
Risk Adjustment PMPM	$0.08
Net Reinsurance Contributions PMPM	($10.29)
Exchange User Fees PMPM	$0.00
Market Adjusted Index Rate PMPM	$493.19

Product	BCBSVT EPO Standard (Individual)		BCBSVT EPO Standard (Indiv	EPO Accountable Blue (B	SVT EPO Standard (Indiv	EPO-CDHP Standard (B	VT EPO Standard (Indiv	VT EPO-CDHP Standard (Ind	EPO Standard (I
Product ID	13627VT034		13627VT034	13627VT038	13627VT034	13627VT035	13627VT034	13627VT035	13627VT034
Plan ID	13627VT0340002		13627VT0340003	13627VT0380001	13627VT0340004	13627VT0350001	13627VT0340005	13627VT0350002	3627VT0340006
Metal Tier	Platinum (with highest Metal AV)	Platinum (with lowest Metal AV)	Gold (with highest Metal AV)	Gold (with lowest Metal AV)	Silver (with highest Metal AV)	Silver (with lowest Metal AV)	Bronze (with highest Metal AV)	Bronze (with lowest Metal AV)	Catastrophic
Metal AV Value	0.881		0.802	0.799	0.715	0.685	0.615	0.609	0.654
Pricing AV Value	1.173		1.002	0.909	0.849	0.794	0.711	0.690	0.414
Projected Member Months	45276		31884	9564	76560	42960	12072	13104	1056
Market Adjusted Index Rate PMPM	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19
Plan Adjustments (in multiplicative format)									
Actuarial value and cost-sharing design of the plan	1.062		0.899	0.810	0.753	0.701	0.622	0.602	0.573
Provider network, delivery system characteristics and utilization management practices	1.000		1.000	1.000	1.000	1.000	1.000	1.000	1.000
Plan benefits in addition to EHB	1.000		1.000	1.000	1.000	1.000	1.000	1.000	1.000
Expected impact of special eligibility categories (only for catastrophic plans)	1.000		1.000	1.000	1.000	1.000	1.000	1.000	0.592
Plan Adjustments (in % format)									
Distribution and administration costs	9.5%		10.3%	10.9%	11.3%	11.7%	12.5%	12.8%	18.1%
Plan Adjusted Index Rate	$578.46	$493.19	$494.10	$448.40	$418.56	$391.37	$350.65	$340.37	$204.02
Age Calibration Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Geography Calibration Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Aggregate Calibration Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Consumer Adjusted Premium Rate PMPM	$578.46	$493.19	$494.10	$448.40	$418.56	$391.37	$350.65	$340.37	$204.02

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: Experience Rated
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision: 01/01/2014
Filing Method of Last Filing: Experience Rated

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
BCBSVT	Increase	9.811%	9.811%	$27,698,314	35,037	$282,312,944	11.787%	4.797%

Rate Review Detail

COMPANY:

Company Name: BCBSVT
HHS Issuer Id: 13627

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
BCBSVT EPO Accountable Blue (Individual)	13627VT038		4188
BCBSVT EPO Accountable Blue (Small Group)	13627VT036		2603
BCBSVT EPO Standard (Individual)	13627VT034		15415
BCBSVT EPO Standard (Small Group)	13627VT032		19654
BCBSVT EPO-CDHP Standard (Individual)	13627VT035		5114
BCBSVT EPO-CDHP Standard (Small Group)	13627VT033		8090
BCBSVT EPO-CDHP-Accountable Blue (Individual)	13627VT039		1519
BCBSVT EPO-CDHP-Accountable Blue (Small Group)	13627VT037		1284

Trend Factors:

FORMS:

New Policy Forms: N/A
Affected Forms: N/A
Other Affected Forms: N/A

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 729,421
Benefit Change: Increase
Percent Change Requested: Min: 4.797 Max: 11.787 Avg: 9.811

PRIOR RATE:

Total Earned Premium: 282,312,944.00
Total Incurred Claims: 201,268,377.00
Annual $: Min: 190.94 Max: 521.20 Avg: 404.30

REQUESTED RATE:

Projected Earned Premium: 310,011,258.00
Projected Incurred Claims: 248,643,841.00
Annual $: Min: 204.02 Max: 578.46 Avg: 443.96

Supporting Document Schedules

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	BCBSVT 2015 Exchange Filing - Actuarial Memorandum.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	Part III Actuarial Memorandum is the same as the Actuarial Memorandum in the previous section.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Civil Union Rating Requirements
Bypass Reason:	Not required.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Consumer Disclosure Form
Comments:	
Attachment(s):	BCBSVT 2015 Exchange Filing - Plain Language Summary.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Filing Compliance Certification
Comments:	
Attachment(s):	Filing Compliance Certification.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Filing Authorization
Bypass Reason:	BCBSVT does not use a Third Party to submit filings.
Attachment(s):	
Item Status:	
Status Date:	

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Satisfied - Item:	Unified Rate Review Template
Comments:	PDF and 2 Excel Versions attached.
Attachment(s):	Unified_Rate_Review_Template_2015_BCBSVT_13627.xlsm Unified Rate Review Template - BCBSVT - Issuer 13627.pdf UnifiedRateReviewSubmission_BCBSVT_Issuer13627_201406028570.xml
Item Status:	
Status Date:	

Satisfied - Item:	Exhibits
Comments:	Excel and PDF Versions attached.
Attachment(s):	BCBSVT 2015 Exchange Filing - Exhibits.xlsx BCBSVT 2015 Exchange Filing - Exhibits.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Attachments
Comments:	
Attachment(s):	Attachment A - Standard Plans AV Certification - Part 1.pdf Attachment A - Standard Plans AV Certification - Part 2.pdf Attachment B - Blue Rewards (Non-Standard) Plans AV Certification.pdf Attachment C.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Rate Data Template
Comments:	Excel (xlsx) Version was too big for SERFF so only PDF and Excel xml versions are attached.
Attachment(s):	Rate Data Template - BCBSVT - Issuer 13627.pdf RateDateTemplateSubmission_BCBSVt_Issuer13627.xml
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014
Comments:	

State: VermontGMCB **Filing Company:** BCBSVT
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001C Any Size Group - Other
Product Name: 2015 Vermont Exchange Products Rate Filing
Project Name/Number: /

Attachment(s):	BCBSVT 2014 Exchange Filing - Method for applying the GMCB corrected Order.pdf Exhibits for Detail Explanation of Order Calculation - 2014 Exchange Filing.pdf Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.11.2014.xlsx Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014 - Excel Documents.pdf Unified_Rate_Review_Template_BCBSVT_2014_Final_Amended_Rates.pdf Unified_Rate_Review_Template_BCBSVT_2014_Final_Amended_Rates.xlsm Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014.pdf Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014.xlsx Responses to BCBSVT 2015 Exchange Filing Inquiries - 06.30.2014 - Excel Document.pdf Supplemental Health Care Exhibit Filed BCBSVT 2013.pdf Supplemental Health Care Exhibit Filed TVHP 2013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	esponses to BCBSVT 2015 Exchange Filing Inquiries - 07.08.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.08.2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.11.2014
Comments:	
Attachment(s):	Responses to BCBSVT 2015 Exchange Filing Inquiries - 07.11.2014.pdf VTX28_2015_Ped_Dental_Claims_2014-07-15.pdf
Item Status:	
Status Date:	

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2015 VERMONT EXCHANGE PRODUCTS RATE FILING
ACTUARIAL MEMORANDUM

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1. GENERAL INFORMATION

1.1. Company Identifying Information

Company Legal Name: Blue Cross and Blue Shield of Vermont
State: Vermont
HIOS Issuer ID: 13627
Market: Combined
Effective Date: January 1, 2015

1.2. Company Contact Information

Primary Contact Name: Paul Schultz, FSA, MAAA
Primary Contact Telephone Number: 1-(802)-371-3763
Primary Contact Email Address: schultzp@bcbsvt.com

1.3. Scope and Purpose

The purpose of this rate filing is to provide the rates and a description of the rate development for the products that Blue Cross and Blue Shield of Vermont (BCBSVT) proposes to offer on Vermont Health Connect (VHC).

This filing is intended to comply with the following laws:

- Vermont State Law 8 V.S.A. § 4062
- Vermont State Law 8 V.S.A. § 4512
- Vermont State Law 33 V.S.A. § 1806
- Vermont State Law 33 V.S.A § 1811
- Vermont State Law 33 V.S.A. § 1812.
- DFR Order establishing tier rate structure and multipliers (Docket No. 13-002-I)
- Vermont Department for Children and Families Health Benefits Eligibility and Enrollment Rule, Sections 2.04 and 13.00
- Federal Regulation 45 C.F.R. Part 153
- Federal Regulation 45 C.F.R. Part 154
- Federal Regulation 45 C.F.R. Part 155
- Federal Regulation 45 C.F.R. Part 156
- Federal Regulation 45 C.F.R. Part 158
- Federal Regulation 26 IRC § 223

1.4. Proposed Rate Increase(s)

BCBSVT proposes an average increase of 9.8 percent.

1.5. Reason for Rate Increase(s)

Significant medical price increases were partially offset by favorable membership assumptions and reductions in BCBSVT administrative expenses. Combined, these factors produced a 3.3 percent increase in rates. The remainder of the 9.8 percent increase was driven by changes related to federal and state health care reforms, including an increase in the federal fee that is included in Exchange pricing, a reduction in federal subsidies of the premiums on Vermont's Exchange, and a modest expansion of dental benefits for children.

- The federal government assesses a charge on all health plans to subsidize Exchange coverage for the three year-period between 2014 and 2016, through its Transitional Reinsurance Program. The subsidy is reduced in 2015 and 2016, before being eliminated entirely in 2017. Because the premium subsidy is being reduced from an estimated seven percent to an estimated three percent in 2015, it will require groups and members to pay 4.0 percent more for their coverage.

- The federal insurer fee established by the Affordable Care Act is used to provide subsidies to low-income people to help them afford to purchase Exchange products. This fee is increasing by more than 40 percent, resulting in a 0.9 percent increase in premium for Exchange products.

- The Green Mountain Care Board approved a change to enhance coverage for dental services for children. The change provides that children covered through the non-CDHP Exchange products will have access to cleanings and other services with no cost-sharing requirement. The enhancement in coverage raises the premium by 0.5 percent.

- Most deductibles, out-of-pocket maximums and co-pays in Exchange plans remain unchanged from 2014 to 2015. As overall costs increase and the amounts that members pay in cost-sharing contributions stays the same, more of the total cost is transferred to premiums. This had an impact of 0.8 percent on premium.

These four items drive an increase of 6.3 percent required solely because of mandated changes associated with the Affordable Care Act and Vermont benefit decisions.

In the absence of mandated changes associated with the Affordable Care Act and Vermont benefit decisions, a 3.3 percent increase would have been requested:

- An estimate of increases in the amounts providers are paid was included in 2014 Exchange rates. Increases beyond those assumptions that have already

occurred in 2014, or that are projected to occur before the end of 2014, drive a premium increase of 2.9 percent. This primarily includes hospital payments under budgets approved by the Green Mountain Care Board and prescription drug prices.

- Amounts providers are paid are expected to increase by 4.8 percent in 2015. This increase flows directly to premium.

- BCBSVT assumes that "new members" who have or will enroll in our qualified health plans will prove to be significantly healthier on average than those previously insured in individual and small group products. This assumption creates a premium decrease of 2.5 percent.

- Other adjustments to the assumptions used in the 2014 rate development cumulatively have the effect of reducing the required rate increase by 1.8 percent. These include items such as updating the experience base to calendar year 2013 and observing the mix of membership actually enrolled on the Exchange in 2014. Notably, BCBSVT has:

    - Reduced the projected medical utilization "trend" (the expected increases in overall medical use) to zero,
    - Reduced its administrative expense fees, and
    - Included a one percent contribution to reserves, an amount that is lower than it would normally require for the protection of Exchange members.

2. PROPOSED BENEFITS

2.1. Description of Benefits

BCBSVT Standard Plans: BCBSVT is providing rates for the Standard Plans with benefits as approved by the Green Mountain Care Board, which are outlined in Exhibit IA – (State of Vermont Standard Plan Designs). The plans are on the EPO network and offer members access to a nationwide network of providers. These plans include coverage for all Essential Health Benefits (EHBs). The Form filings for these products can be found under BCVT-129432892 for Non-CDHP plans and BCVT-129433224 for CDHP Plans.

BCBSVT Blue Rewards (Non-Standard) Plans: BCBSVT is providing rates for two health and wellness-based non-standard plan types that we have named Blue Rewards and CDHP Blue Rewards. Please see Exhibit IB – (BCBSVT Blue Rewards (Non-Standard) Plan Designs) for details on the benefit structure. The Form filings for these products can be found under BCVT-129433009 for Non-CDHP plans and BCVT-129433137 for CDHP Plans. BCBSVT Blue Rewards plans also offer a Wellness program with incentives up to

$300 per year for each adult member for completing a health assessment, having a physical exam, setting a personal health goal and having a routine eye or dental exam

2.2. AV Metal Values

BCBSVT will be offering two types (Standard and Non-Standard) of plans on Vermont Health Connect in 2015. Standard plans are designed by the State of Vermont and offered by all issuers on the Exchange. Please see Attachment A – Standard Plans AV Certification (Parts 1 and 2) for the certification provided by the State.

Non-Standard plans are designed by BCBSVT. The metal values included in the URRT were calculated using an alternate methodology, as allowed by 45 CFR §156.135. Multiple benefit designs offered in BCBSVT's Non-Standard plans are not supported by the AV Calculator.
Please see Attachment B – Blue Rewards (Non-Standard) Plans AV Certification, for the actuarial certification, which includes the process used to develop the AV Metal Values.

3. EXPERIENCE RATING

3.1. Experience Period Premium and Claims

The experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. TVHP is a fully owned subsidiary of BCBSVT. We combined both companies since all their members will be migrating to the Exchange and Small Group products are no longer offered under TVHP. This population will be the Single Risk Pool. Members with Medicare as their primary insurance or members without a pharmacy benefit were excluded.

We used claims incurred January 1, 2013 through December 31, 2013 and paid through March 31, 2014. Both the paid claims and the allowed charges were completed using BCBSVT's monthly reserving models that underlie the financial statement reserves (best estimates before margin). These methods are subject to review by independent auditors and examination by Vermont Department of Financial Regulation (DFR). The claims used to develop the completion factors include a larger block of business than the experience period block. For the purpose of calculating completion factors the reserving method categorizes claims by reporting/payment process (Local, BlueCard, Pharmacy, Medicare Supplement, etc.). Completion factors are calculated separately for each category. Using the larger block to calculate the Incurred But Not Reported (IBNR) claims reduces the variability of the projection.

The paid claims and allowed charges come directly from claim records in BCBSVT's data warehouse. For Fee-for-Service claims, we combined plan payment with member cost sharing to calculate the allowed charges. For claims under a capitation arrangement, we combined capitation paid to the provider with the member cost sharing to generate allowed charges.

The table below shows details underlying the Incurred Claims and Allowed Claims (from URRT, Section 1 of Worksheet 1) for the Experience Period.

Claims	Incurred Claims	Allowed Claims
Claims incurred and paid through December 31, 2013	$267,341,514	$329,118,227
Estimate of IBNR as of March 31, 2013	$1,050,342	$1,127,369
Total Claims	$268,391,883	$330,245,595
Member Months	729,421	729,421
Total PMPM	$367.95	$452.75

The experience period total allowed charges PMPM is $452.75.

In the experience period, the earned premium was $287,929,163. Neither BCBSVT nor TVHP is required to pay MLR rebates for the 2013 calendar year.

3.2. Benefit Categories

Medical claims are initially categorized into 2 categories based on the type of claim form the provider submitted: UB-04/CMS 1450 (Facility Inpatient/Outpatient) or HCFA/CMS 1500 (Professional/Other). Facility claims are then divided into the Inpatient and Outpatient categories in Worksheet 1, Section II by the place of service listed on the UB-04 claim form.

Professional and Other medical claims are subdivided based on whether the provider is a medical professional or medical supplier as submitted on the HCFA 1500 claim form.

The prescription drug benefit category was populated for claims processed through our pharmacy benefit manager.

The capitation benefit category was populated with claims that run through our internal capitation system. The capitation category uses "other" as a utilization description and the units represent the number of capitations in a given year.

3.3. Index Rate

The Index Rate is equal to the experience period allowed charges for EHB.

To calculate the Experience Period Index Rate (line A of Exhibit 5), we first excluded pharmacy rebates, Blue Card fees, and payments to the BluePrint program. These claims are not dependent on benefits and should not be subject to the projection factors described in the following sections. They will be added back into the Projected Index Rate (as described in section 3.4.5.).

BCBSVT has access to the detailed claims information underlying capitated claims and since the majority of the capitation arrangement will no longer be in place in the projection period, using the FFS equivalent represents the expected payment better than the capitation.

These adjustments are included in the "Other" factor in the section 2 of worksheet 1 of the URRT.

	Total Dollars	PMPM
Allowed Claims in section 1 of worksheet 1 of URRT	$330,245,595	$452.75
Remove Blue Card Fees	- $1,308,412	-$1.79
Remove Pharmacy Rebates	+ $2,509,837	+$3.44
Remove Payments to BluePrint Program	- $1,522,003	-$2.09
Remove Payments to the Vermont Vaccine Purchasing Program	- $903,474	-$1.24
Replace Capitation with FFS equivalent	- $4,275,610	-$5.86
Experience Period Index Rate Claims	$324,745,934	$445.21

The Experience Period Index Rate is $445.21.

3.4. Projection Factors

3.4.1. Membership Projections

As of late April, BCBSVT had 55,045 members enrolled in a QHP product, either through Vermont Health Connect or directly. BCBSVT also had 3,145 Small Groups members with renewal dates of May 2014 and beyond. These groups are expected to sign up in QHP products upon renewal.

We used this information to project the 2015 Exchange enrollment and the distribution by plan. Small Groups that have yet to make the move to a QHP plan are expected to choose plans in proportion to other members from our Small Group lines of business. The total member months expected to be covered by this filing is 698,280.

This projected membership was also used to adjust our Index Rate for demographics, morbidity, benefit changes, and other allowable adjustments described below.

Details of the projected membership breakdown are on Exhibit 2A.

3.4.2. Changes in the Morbidity of the Population Insured

Our experience period is based on calendar year 2013. It includes members that enrolled in a QHP with BCBSVT during 2014, are expected to enroll in a QHP with BCBSVT upon the renewal date of their small group plan, or cancelled.

Based on these different categories, we split the experience claims cost and compared the different populations. We used the allowed charges from the experience and adjusted for the change in network (see section 3.4.5 for details on this adjustment). Using the average claims cost of the members expected to enroll with BCBSVT in 2015, we adjusted the experience period claims cost.

	"Cancelled" Members	Continuing Members	Total
Experience Period Allowed (adjusted for change in Network)	$139,840,024	$218,710,557	$358,550,580
Member Months	257,381	472,040	729,421
PMPM	$543.32	$463.33	$491.56

The factor ($1+b_9$ on Exhibit 5) to adjust for the change in pool morbidity is $463.33/$491.56 = 0.9426.

We also adjusted the experience for the new entrants. As of late April, 15,689 members that were not previously enrolled with BCBSVT or TVHP had enrolled in one of our QHP Products. All that is known at this time are the members' age and gender. Using Milliman's Health Cost Guidelines (2013) age-gender factors (AGF), we compared the expected claims cost of our existing members to the expected claims cost of the new entrants.

Again, we started with the experience claims adjusted for the network and split the continuing members into the market they joined (Individual Non-Subsidized, Individual Subsidized and Small Group). We adjusted the PMPM of the new members within each market by the ratio of the resulting AGF for new and continuing members. The weighted average PMPM of new and continuing members was compared to the PMPM for existing members alone in order to derive the adjustment for new member morbidity.

See Exhibit 2B for details.

3.4.3. Changes in Benefits

We included two factors to account for the change in benefits. The first one, ($1+c_1$ line on Exhibit 5), represents the anticipated change in the average utilization of services due to the change in average cost sharing in QHP products compared to the experience period products. To calculate this factor, we first calculated the average modeled paid to allowed ratio for the benefits in the experience. The model used to re-adjudicate each benefit and assign an induced utilization factor is described in BCBSVT Benefit Relativity Values Filing (BCVT- 129370654).

Calculation of the Impact of the change in benefits ($1+c_1$)	
Experience Period Average Utilization Factor (for "old" products)	0.9633
Projected Period Average Utilization Factor (for QHP products)	0.9725
Benefit Adjustment ($1+c_1$) = 0.9725 / 0.9633	1.0096

The second factor is for additional Essential Health Benefits that now have to be included. This includes Pediatric Vision and Pediatric Dental Benefits. These benefits are for members age 21 and younger. Neither of these benefits was in our experience. We therefore used claims estimates provided by outside vendors.

For the Pediatric Vision benefit, the expected allowed claims cost per child, as calculated by our vision vendor, VSP, is $3.10 per month. This translates to $0.58 per member per month based on the experience period split between adult and child. This cost is included in the buildup of the Projected Index Rate (Exhibit 5, line e_6). We assumed that the paid benefits would not be materially different from the allowed charges.

For the Pediatric Dental benefit, Milliman performed the calculation of the expected claims cost for each benefit. The overall expected allowed charges per child are $42.49 per month, which becomes $7.99 per member per month. This cost is included in the built up of the Projected Index rate (Exhibit 5, line e_7). Attachment C details Milliman's method to calculate the expected paid claims for each proposed plan.

3.4.4. Changes in Demographics

To develop the change in demographic factor (factor $1+c_3$ on Exhibit 5), we again used Milliman's Health Cost Guidelines (2013) age-gender factors. We applied these factors to both the experience membership for continuing members and the projected membership and compared the average factors.

Calculation of the Demographic Adjustment ($1+c_3$)	
Experience Period Average Age-Sex Factor	1.22250
Projected Period Average Age-Sex Factor	1.21986
Demographic Adjustment ($1+c_3$) = 1.21986 / 1.22250	0.9978

3.4.5. Other Adjustments

The buildup of the Projected Index Rate also includes a factor for the change in provider networks and adjustments for non-system claims[1].

We adjusted our experience period for the change in provider networks (factor $1+c_2$ on Exhibit 5). BCBSVT's 2015 Exchange plans are offered on our EPO Network. This is a new network, as of January 1, 2014. Our experience period claims came from four different networks, BCBSVT's Non-Managed network (PPO/Indemnity), BCBSVT's Managed network (VHP), BCBSVT's Catamount network and TVHP's network. All four of these networks have different contracts with different reimbursement schedules. Using the historical contracted reimbursement schedules, we calculated network factors that represent the different contracts. Using these factors, we can adjust our projected allowed changes to represent the contract that will be effective in 2015. This factor also includes Pharmacy reimbursement changes between the experience period and the projection period. In the experience, pharmacy claims were subject to two discount schedules. In the projection period, all Exchange pharmacy claims will process on one discount schedule. See details on Exhibit 2C.

Other costs were added in the buildup of the Projected Index Rate to account for non-system claims (Items e_1-e_5 on Exhibit 5). As previous explained in section 3.3, these non-system claims are claims that are independent from the benefits.

- Pharmacy Rebates (e_1):
  The experience period pharmacy rebates is estimated to be $3.44 PMPM. This number is estimated since we have not yet received the details underlying the rebate payment for the later part of CY 2013. Pharmacy rebates are expected to trend at the same rate as Brand Drugs. As shown on Exhibit 3E, the projected trend for Brand drugs is 8.0 percent, which brings our projected pharmacy rebates to $4.01 PMPM.

- BluePrint Payments (e_2):
  BCBSVT participates in the Vermont BluePrint for Health[2] program. The experience period payments for this program were $2.09 PMPM. We do not expect this PMPM to change in 2015.

[1] Non-system claims are payments that are not processed through the claims adjudication system.
[2] http://hcr.vermont.gov/blueprint

- Interplan Teleprocessing System (ITS) (e_3):
  The BlueCard® Program gives BCBSVT members healthcare coverage wherever they go across the country and around the world. The fees associated with this program are independent of the amount of the claims and therefore solely dependent on utilization of BlueCard participating providers. As described below, we believe that the medical utilization trend is flat and therefore these fees are expected to remain at the $1.79 PMPM experienced in 2013 throughout 2015.

- Vermont Vaccine Purchasing Program Payments (e_4):
  The Vermont Vaccine Purchasing Program[3] offers health care providers state-supplied vaccines at no charge by collecting payments from Health plans, insurers and other payers. This is based on the actual claims from Vermont providers where the vaccine is indicated as having been supplied by the state. Based on the individual vaccine cost rates provided by the program and the charges assessed by the program we estimate an imputed charge for each claim where the vaccine is provided by the state. The average PMPM ($1.24) for the experience period was used as the expected cost for the projection period.

- Net Cost of Reinsurance (e_5): BCBSVT uses reinsurance to protect itself against very high claims. Included in the Projected Index Rate is the net cost (reinsurance premium less expected reinsurance claims) of reinsurance. This PMPM cost was calculated in BCBSVT Large Claims and Stop Loss Filing (BCVT-129374060).

3.4.6. Contract Conversion Factor

Vermont has defined the following tier structure:

Tier	Definition	Tier Ratio
Tier One	Single	1.00
Tier Two	Couple	2.00
Tier Three	Single Head of Household with one or more children	1.93
Tier Four	Family : Two Parents with one or more children	2.81

These mandated tier factors do not represent the expected relationships between tiers. An adjustment is necessary so that the premium produced using the state tier factors matches the premium required for the plan based on the BCBSVT tier factors which reflect the plan benefits.

[3] http://healthvermont.info/hc/imm/VaccinePurchasingPoolPilotProgram.aspx

Based on the experience period claims, trended to 2015 and adjusted for the changes in network, we created a model to calculate the expected payments for benefits where more than one member accumulates to a combined out-of-pocket. Using the same base, we calculated and convolved expected claims payments for children, adults, and combinations of both.

For all benefits, tiers three and four were modeled with each of one through five children. We also modeled seven children as a proxy for six or more children. The expected claims cost were then weighted based on the distribution of children in those tiers in our experience period. For aggregate benefits, we also modeled two adults.

Using our projected membership and contracts by tier, we calculated an average tier factor of 1.5011 and the average members per subscriber at 1.6881.

Since the Tier factors are different from the expected claims cost, we adjusted our projected PMPM to account for this difference. The adjustment is shown on line $1+c_6$ of Exhibit 5. The details are on Exhibit 2D.

3.4.7. Trend Factors (cost/utilization):

Pharmacy Trend Development

The source of the data is BCBSVT's data warehouse, except where noted below. To ensure accuracy of claims information, the data used has been reconciled against internal reserving, enrollment and other financial reports. We combined the pharmacy experience of BCBSVT and TVHP small groups and individual products to develop the pharmacy trend. We used claims incurred from October 1, 2011 to September 30, 2013, with payments through March 31, 2014. Note that the fourth quarter of 2013 was excluded from the analysis due to a significant increase in utilization leading up to the implementation of Vermont Health Connect. We believe that this was a one-time phenomenon, and not the beginning of a pattern of higher utilization. Drug card and HSA drug experience is combined, and completion factors, based on the total drug card and HSA pharmacy experience for both companies, were applied to estimate the ultimate incurred claims. Allowed charges are used rather than claim payments, in order to mitigate the effect of benefit changes on observed trends. The data includes claims from the single risk pool.

ESI has been the pharmacy benefits manager for BCBSVT and TVHP since July 2009. The initial ESI contract was for a period of 3 years; a new contract became effective July 2012. We have adjusted the historical pharmacy claims data, as well as the projected pharmacy claims, to normalize for the various guarantees within these contracts. Specifically, all historical experience has been restated to the provisions for the contract year ending in 2014. The initial selections of brand and generic cost

trends based on historical analysis are then reduced by a factor equal to the contracted future improvement in pricing guarantees.

With the emergence of new and expensive specialty drugs, as well as the increasing shift to generics as more brand drugs come off patent, we analyzed the components of trend (cost and utilization) separately for Brands, Generics, and Specialty drugs. We have projected the generic dispensing rate (GDR) based on the brand drugs that are scheduled to lose patent in the next few years. Specialty drugs are very high cost drugs with low utilization. Because of their relative infrequency, it is more appropriate to look at the overall PMPM trends for these drugs rather than separate cost and utilization components. The overall pharmacy trend is then calculated by combining the separate projections.

Exhibit 3A provides the monthly and the 12-month rolling data, along with the corresponding year-over-year and exponential regression trends, for non-specialty drugs. These are shown separately for the generic cost, brand cost, and overall non-specialty utilization categories. The number of days supply, rather than the number of scripts, is used to normalize for changes in the days supply per script (e.g. increased use of 90-day fills). Because there are several popular brand drugs that have become generic during the experience period, or will become generic during the projection period, we have combined the data for generic and brand drugs for the purpose of analyzing utilization patterns (the separate GDR projection is applied to the total projected utilization to arrive at brand and generic components). The regressions use 24 data points on the monthly data, in order to best capture an adequate amount of the most recent history of drug costs.

Exhibit 3B provides the historical generic dispensing rates (GDR). The period from January 2011 to December 2012 experienced a 4.4 percent increase in GDR. This is primarily due to blockbuster drugs such as Lipitor, Seroquel, Plavix and Lexapro losing their patents. (Note that we make an assumption as to changes in GDR due to plan design elsewhere in the development; therefore, it would be inappropriate to include it here.) Although several popular drugs, such as Nexium and Lunesta, are expected to lose their patents in the upcoming year, our drug-by-drug analysis shows that GDR will not increase at the same historical rate. Based on our current distribution of days supply and a list of brands expected to move to generic in the period during which these trend rates will be in effect, as provided by ESI, we estimate that GDR will reach 86.6 percent in the projected period.

It is important to note that care must be taken in projecting the GDR to avoid the simplifying assumption that generic shift will continue at historical levels. Generic conversion is a very discrete function – while specific dates for generic launches may be impacted by ongoing litigation, the list of brand drugs losing their patent protection is well-recognized in the industry. Furthermore, generic substitution protocols have increased generic substitution rates to well over 99 percent where

such switches are clinically viable. For the above reasons, it would be actuarially inappropriate to base a future GDR assumption on a linear projection of past increases, which is why we have chosen to take a far more detailed, and more discrete, approach. Exhibit 3C lists the brand drugs that are expected to lose their patent protection through the end of the projection period and their prevalence in our experience.

Exhibit 3D shows the calculation of the 86.6 percent GDR in the projection period. Utilization for brand drugs losing or expected to lose their patent protection from calendar year 2013 through the projection period is summarized by month. Because Average Wholesale Price (AWP) and effective discounts do not change significantly for most new generic drugs until the six-month exclusivity period has closed (that is, when the generic becomes "multi-source"), average 2013 utilization is projected through six months following each generic launch date. After that time, all utilization is expected to shift to generic.

Exhibit 3E summarizes the trends for non-specialty drugs and calculates our total non-specialty allowed drug trend as 7.1 percent.

Exhibit 3F provides the monthly and the 12-month rolling data, along with the corresponding year-over-year trend and exponential regression trends, for Specialty drugs. These regression criteria were chosen in order to best capture the most recent history of drug costs. Rolling 12-months regression is more appropriate for Specialty Drugs because of the low-frequency, high-cost nature of these drugs. We made a further adjustment to specialty trends to reflect the expected May 2014 launch of generic Copaxone. This drug accounts for nearly 10 percent of allowed specialty cost during the experience period. We assumed that generic Copaxone would be priced 10 percent below the price of Copaxone during the six-month exclusivity period and 30 percent below the price of Copaxone thereafter. This results in a 2 percent dampening of expected specialty trend. We used a relatively short period of rolling PMPMs due to the rapidly emerging nature of the specialty drug market.

Using the PMPM claims as weights between Non-Specialty and Specialty claims for the 12 months ending December 2013, adjusted to the contract in place as of December 2013, we calculate the following:

Category	PMPM	Overall Trend
Generic	$21.94	5.6%
Brand	$33.30	8.0%
Specialty	$20.67	11.8%
Total	$75.91	8.4%

Medical Trend Development

The source of the data is BCBSVT's data warehouse, except where noted below. To ensure accuracy of claims information, the data used has been reconciled against internal reserving, enrollment, and other financial reports. Claims incurred between January 1, 2010 and December 31, 2013, completed through March 31, 2014, were used in the analysis. Completion factors are applied to estimate the ultimate incurred claims for each period shown in the exhibits. The regressions for medical trend used claims incurred through December 31, 2013.

The data includes claims from the single risk pool.

Using the historical contracted reimbursement schedules, we calculated network factors that represent the different contracts. Using these factors, we can modify the claims to reflect only one contract. From there, we can observe the historical cost increases using all claims information for the single risk pool.

Medical Trend is composed of three pieces: cost, utilization and intensity. In our analysis, we combine utilization and intensity within the utilization metric and analyze the unit cost separately. Historical experience is normalized for contract changes and then analyzed to derive a utilization trend in the absence of unit cost changes. Future unit cost trends are developed on a discrete basis, using the most recent round of contract negotiations as a starting point. The overall trend is the product of these two components.

Utilization

Contract changes for the entirety of the experience period were measured explicitly for each facility within our service area, as well as the three largest physician groups.

Increases were measured for fee schedules and other chargemasters by applying each schedule to a market basket of services. The market basket was defined by using Current Procedural Terminology (CPT) codes & CPT modifier combinations that were present in each of the effective periods the schedules covered. Using the same experience period data used throughout the trend analysis, total allowed costs for the selected CPT & CPT modifier combinations were compared under each schedule to estimate the percentage increase. For contracts under DRG arrangements, we compared the charge for the 1.000 DRG service for each period. Finally, for services under a discount of charge arrangement, we used the contracted chargemaster increase provided by our Provider Contracting department.

This accounted for over 90 percent of allowed claims dollars during the experience period. Costs for other claims are primarily for out-of-area services. Contracting changes for these claims were derived from the Fall 2013 Blue Trend Survey, which is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

Claims were normalized to the December 2013 contract at each unique provider by applying a factor equal to the product of the impact of each contracting change from the experience month through December 2013. The derived trend for other claims was assumed to be continuous. Please see Exhibit 3G for an illustration of this approach.

Shown on Exhibit 3H is the resulting array of allowed PMPM claims costs, before and after normalization for contract changes. We performed regressions on a number of periods, including 24 and 36 months of monthly PMPM costs, both including and excluding the fourth quarter of 2013. Results can also be seen on Exhibit 3H. Results vary from -3.1 percent (most recent 24 months through September 2013) to +3.3 percent (most recent 24 months through December 2013). Using the longer 36-month time period produces results that are closer to zero.

Using regressions on a longer period will help reduce the effect of high claims, as well as short-term oscillations due to the low-frequency, high-intensity nature of the services. We believe that the best estimate is produced by using the 36-month period ended December 2013. While there may have been a “rush to services” in advance of moving to Vermont Health Connect, this effect would be more profound on prescription drugs where claims are more frequent and the timing of which is more subject to manipulation. We believe that this impact is overshadowed by the effect of the clear seasonal pattern of lower medical claims in Q3 and higher medical claims in Q4. (Using a period beginning in Q4 and ending in Q3 will artificially skew trends downward.) For these reasons, we have treated the 36-month result through December 2013 of 0.7 percent as our most credible data point. However, because of the potential increased utilization in Q4, we have chosen a flat utilization trend assumption of 0.0 percent.

As a check and for further information, we also performed our analysis in the same way we calculated utilization trend in our most recent large group trend filing (see BCVT-129403752, which was approved without amendment by the GMCB). It is important to note that this methodology includes intensity as a component of the unit cost trend, rather than the utilization trend. Nonetheless, results tracked very closely to those produced by the technique described above. This indicates that intensity has been essentially flat over the length of the experience period. Results can be seen in Exhibit 3I.

The alternate methodology addresses trend by provider type. Inpatient utilization is observed by modeling the number of admissions per thousand members per month. Since inpatient admissions are very volatile, using a long range regression will reduce the impact of this volatility. The three year regression on monthly admissions is 2.1 percent increase on Inpatient Utilization. While there is a national trend toward fewer inpatient admissions, that does not appear to be the case in Vermont. We

conjecture that the rural nature of the state and relative unavailability of alternative outpatient services may be leading to an absence of declining inpatient trends in the state.

Outpatient utilization is observed by modeling the number of services per thousand members per month. The three year regression on monthly visits yields a zero percent trend in Outpatient utilization. This result seems more intuitive when observed in conjunction with the positive trend in inpatient admissions, and appears to represent a subtle shift from outpatient to inpatient services.

"Professional and Other" claims include all claims that are on a HCFA form, such as professional visits, DME, Ancillary, Labs, etc. Professional utilization is observed by modeling the number of visits per thousand members per month. The number of professional visits has been very stable over the past three years. The three year regression on monthly claims results in a 0.4 percent professional utilization trend.

Each of the above results is calculated on a 36-month regression of monthly data through December 2013. The overall utilization trend for this period is 0.6 percent. Using a period ended September 2013 yields a negative trend of -1.5 percent. Both of these results are very close to those produced for these time periods, using our preferred methodology.

Category	YE Dec 2013 PMPM	Regression Results using 36 month – Excluding Q4 2013	Regression Results using 36 month – Including Q4 2013
Inpatient	$90.99	-0.1%	2.1%
Outpatient	$188.87	-2.0%	0.0%
Professional and Other	$134.88	-1.8%	0.4%
Total	$414.74	-1.5%	0.6%

Again, we feel that the period ended December 2013 represents the best point estimate. But in order to mitigate the impact of a potential rush to services in the final quarter of 2013 and to better represent our longer-term outlook on the use of services, we have chosen zero percent as our utilization trend.

Unit Cost

Unit cost trends were largely derived from observations of recent contracting and provider budgetary changes.

During calendar 2013, roughly 55 percent of total claims dollars were provided by Vermont facilities and providers impacted by the hospital budget review process of the Green Mountain Care Board (GMCB). We have assumed that the GMCB would approve hospital budgets for October 1, 2014 and October 1, 2015 that support identical commercial increases as that approved for October 1, 2013. Based upon that assumption, Provider Contracting and Actuarial worked together to assess the impact such an increase would have on contract negotiations specific to the EPO network used for Qualified Health Plans.

It should be noted that the State legislature recently proposed a compromise 1.6 percent increase for Medicaid rates within their budget proposal. This would increase the cost shift toward commercial coverage, as the GMCB has established an overall system net patient revenue cap of 3.0 percent over 2014 budgets, which matches both last year's patient revenue cap and the fiscal 2014 increase in Medicaid rates. We have chosen not to further increase our trends for the potential upward impact this proposed greater cost shift would have on commercial rates.

Similarly, we assumed for other providers within the BCBSVT service area that overall 2014 and 2015 budget increases would be identical to those implemented during calendar 2013. Again, Provider Contracting and Actuarial worked together to assess the impact these increases would have on contract negotiations specific to the EPO network used for Qualified Health Plans.

Finally, unit cost increases for providers outside the BCBSVT service area were derived from the Fall 2013 Blue Trend Survey, which is a proprietary and confidential dissemination of the BlueCross BlueShield Association.

The results of the analysis are summarized in the below chart:

Annual Reimbursement Changes due to Budget Increases and Contracting Season

	Percent of Total Allowed Claims	FY 2014 Unit Cost Increases	Assumption to 2015
Vermont facilities and providers impacted by GMCB's Hospital Budget Review	55.6%	4.7%	5.7%
Other facilities and providers	44.4%	2.4%	3.4%
Total	100.0%	3.7%	4.7%

As a check and for further information, we also performed our analysis in the same way we calculated cost trend in our most recent large group trend filing (see BCVT-

129403752, which was approved without amendment by the GMCB). It is important to note that this methodology includes intensity as a component of the unit cost trend, rather than the utilization trend. Nonetheless, results tracked very closely to those produced by the technique described above. This indicates that intensity has been essentially flat over the length of the experience period. Results can be seen in Exhibit 3J.

For inpatient claims, we assessed the cost per admission and the cost per day. The monthly costs per admission and per day are very dependent on the type of inpatient claim. Using regressions on a longer period will help reduce the effect of high claims, as well as short-term oscillations due to the low-frequency, high-intensity nature of the services. The 36-month regression on monthly admissions results in an Inpatient cost increase of 7.8 percent to 8.0 percent. For outpatient claims, we looked at the cost per service. The 36-month regression on monthly claims yields an Outpatient cost increase of 7.2 percent to 7.5 percent.

We examined the cost per visit for Professional and Other claims, with a visit being defined as a unique combination of member, date, and provider. The majority of these services are on fee schedules, and BCBSVT has been able to control cost efficiently. The 36-month regression on monthly claims results in a 3.8 percent to 4.1 percent increase on Professional cost.

Overall Medical Trend

As a final check for reasonability, we performed a 36-month regression on monthly PMPM figures during the experience period described above. This analysis, which is shown in Exhibit 3K, yields a 4.5 percent trend estimate on claims through September 2013 and a higher estimate of 7.0 percent for the period ended December 2013.

We believe that the more discrete view of unit cost changes, as introduced on page 17, yields the more accurate analysis, and we believe a result that is toward the lower end of the range given by the 36-month regression analysis is entirely reasonable. Our selected trend assumptions are 0.0 percent for utilization (including intensity) and 4.4 percent for unit cost increases, resulting in an overall medical trend assumption of 4.4 percent. This overall medical trend rate is comfortably within the bottom quartile of medical trends reported in the Oliver Wyman Carrier Trend Report, January 2014 Analysis.

Overall Total Trend

To adjust the Experience Period Index Rate for the trend factors described above, we started with the experience period claims, adjusted for changes in network and applied cost and utilization to both Medical and Pharmacy claims. The resulting factors ($1+d_1$ and $1+d_2$ on Exhibit 5) are calculated on Exhibit 3L.

3.5. Credibility of Experience

BCBSVT's experience period had 729,421 member months and is therefore fully credible.

3.6. Credibility manual rate development

Since BCBSVT's experience is fully credible, no manual rate was needed in the development of rates for the experience period EHB. For additional EHB that BCBSVT does not currently have in its experience, the projected claims were based on manual rates produced by consultants. See Attachment C for details.

3.6.1. Source and Appropriateness of Experience Data Used: Not Applicable

3.6.2. Adjustments Made to the Data: Not Applicable

3.6.3. Inclusion of Capitation Payments: Not Applicable

3.7. Market Adjusted Index Rate

The Market Adjusted Index Rate (line H of Exhibit 5) is $493.19. This is calculated by adjusting the Projected Index Rate (line F of Exhibit 5, $503.40) for allowable market-wide modifiers described below.

3.7.1. Projected Risk Adjustments PMPM:

BCBSVT does not expect any risk adjustment transfer for 2015. BCBSVT covers at least 90 percent of the members enrolled in QHP products[4] and therefore would closely track with the average risk of the market. We also have no information or experience on which to base an estimate of a risk adjustment amount.

As described in the Final Notice of Benefits and Payment Parameters rule (79 F.R. 13743), the per capita risk adjustment user fee, used to fund the HHS-risk adjustment program, is $0.96 per enrollee per year, or $0.08 per month (line g_1 of Exhibit 5)

3.7.2. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

To estimate the expected recoveries from the transitional reinsurance, BCBSVT adjusted its CY 2013 experience period by the network and trend factors ($1+c_2$, $1+d_1$,

[4] This was calculated by comparing our enrollment as of April 30, 2014 to the VHC Enrollment Update dated April 30, 2014.
http://info.healthconnect.vermont.gov/sites/hcexchange/files/Vermont%20Health%20Connect%20Enrollment%20Update_4.30.14.pdf

$1+d_2$ of Exhibit 5) and then re-adjudicated claims for each of the proposed benefits to model the expected claims that would be included in the Transitional Reinsurance Program.

The Final Notice of Benefits and Payment Parameters rule (79 F.R. 13743) defined the 2015 Transitional Reinsurance Program parameters as:

- $70,000 claims attachment point
- 50 percent coinsurance
- $250,000 reinsurance cap

Using these parameters, BCBSVT estimated the expected recoveries for each plan design offered on the Exchange. The expected recoveries were then weighted based on projected membership by plan. The recoveries only apply to members in the individual market. The projected recoveries must therefore be spread across all members, as Vermont has a combined market. The expected recoveries PMPM are $13.96. See Exhibit 4 for details.

The Final Notice of Benefits and Payment Parameters rule (79 F.R. 13743) also established the Uniform Reinsurance Contribution rate at $44 annually per capita, or $3.67 PMPM.

The market-wide adjustment for the Transitional reinsurance program is therefore -$10.29 (-$13.96+$3.67), as shown on line g_2 of Exhibit 5.

3.7.3. Exchange User Fees

BCBSVT does not expect Vermont Health Connect to charge a user fee for 2015.

3.8. Plan Adjusted Index Rates

3.8.1. Plan Adjustment – Actuarial Value and Cost Sharing adjustment

This plan adjustment, as shown on Exhibit 6A, is reflected by three factors:

- Paid to Allowed Ratio
- Benefit Richness Adjustment
- Changes in Family Tiers

3.8.1.1. Paid to Allowed Ratio

The Paid to Allowed ratios were calculated by first, calculating the paid to allowed ratio for projected EHB claims for services that were present in the experience period. This was done by taking the same starting point described in section 3.7.2 and re-adjudicating every plan. We then added the additional EHB paid and allowed, and

the non-system claims and market-wide adjustment amounts in both paid and allowed. We then calculated the overall expected paid to allowed ratio. Please see details in Exhibit 6B.

The Paid to Allowed Average Factor is the weighted average Expected Claims Cost without Market Wide Adjustments ($393.77+$5.73+$2.18) divided by Projected Index Rate ($503.40). As shown in Section 3 of Worksheet 1 of the URRT, the paid to allowed average factor is 79.8 percent.

3.8.1.2. Benefit Richness Adjustment

The Benefit Richness Adjustment is the counterpart of the Change in Benefit projection factor ($1+c_1$ line on Exhibit 5) described in Section 3.4.3. This factor represents the different projected utilization for each plan based solely on benefit design. These factors were normalized using the projected membership to ensure that the total adjustment was 1.000. See Exhibit 6C for details.

3.8.1.3. Change in Family Tier

The Change in Family Tier Adjustment is the counterpart of the Contract Conversion Factor (line $1+c_6$ on Exhibit 5) described in Section 3.4.6. This factor represents the adjustment by plan needed to ensure that the premium produced using the state tier factors matches the premium required for the plan based on the BCBSVT tier factors which reflect the plan benefits. These factors were normalized using the projected membership to ensure that the total adjustment was 1.000. See Exhibit 6D for details.

3.8.2. Provider Network, Delivery System and Utilization Management adjustment: Not Applicable

3.8.3. Adjustment for benefits in addition to the EHBs: Not Applicable

3.8.4. Impact of specific eligibility categories for the catastrophic plan

This plan adjustment includes two components of the impact of the specific eligibility categories for the catastrophic plan. Both of these adjustments are based on the eligible population. The eligible population includes Vermont residents that are under age 30 and residents age 30 and over who would find the lowest cost plan to be more than 8 percent of their income. This analysis on the eligible population was conducted by Neela Associates for our 2014 Exchange filing. Since the census data used for this analysis was not updated, BCBSVT will use the same population distribution as in its 2014 Exchange Filing.

Below is a summary of the analysis performed by Neela Associates:

The under 30 population was identified by applying census data that shows that 36.7 percent of Vermont's population is between 0 and 30. We applied this percentage to eligible populations to arrive at the number of individuals under age 30 in each population. Eligible populations included currently non-subsidized Catamount members, individuals dropped from their employer plans (either community pool, association pool or large business pools), the currently uninsured who would not be eligible for a subsidy, and those currently in groups of one.

We also assumed that those individuals insured via group plans would stay with their group plans unless the groups were to drop coverage.

The second population is individuals for whom the lowest cost plan would be more than 8 percent of their income. To estimate this group, we started with Vermont census data by income and bronze plan costs. Using the 8 percent of income data, we grossed up the bronze plan costs and interpolated the census data to identify the percentage of individuals falling between 400 percent of FPL and the 8 percent of income threshold. We then applied this percentage to the following populations: non-subsidy eligible catamount members over the age of 30; individuals dropped from group plans over the age of 30; non-subsidy eligible uninsured individuals over the age of 30; and, groups of one over the age of 30. We did not include any members of VHAP, ESIA, subsidized Catamount members, or group insured members in the analysis unless the group was to drop coverage.

The number of eligible individuals age 30 and above is dependent on the cost of the lowest bronze plan. BCBSVT assumed that this would be its Non-Standard Bronze plan. At a single premium of $357.52, the estimated number of individuals age 30 and above for whom this represents more than 8 percent of income is 1,736. We also estimate that the population under age 30 is 6,125, for a total of 7,861 individuals eligible for the Catastrophic Plan.

To adjust for the eligible population, we first calculated the adjustment for the impact on the pricing actuarial value of the expected lower allowed charges of the group eligible to enroll in the catastrophic plan. This was calculated by splitting the experience used to calculate the Pricing Actuarial Value into two populations (Under and Over 30) and re-adjudicating for the catastrophic benefit. Using the projected eligible members as weights, we calculated that the overall expected allowed charges are 0.6581 of the total allowed charges.

We then adjusted the paid to allowed ratio, based on the weighted average paid to allowed ratio from both populations. This factor is 0.9137.

Finally, we noticed that the normalization and order of operation required by the plan level adjustments described above were skewing the expected Plan Adjusted Index Rate for the catastrophic plan. To check our calculations, we calculated the plan

level adjustment two ways. First, by applying paid to allowed ratio, benefit richness factors and tier adjustment to only claims that they applied to, and then adding non-system claims and market-wide adjustments. Second, we calculated the Plan Adjusted Index Rate by applying the normalized paid to allowed ratio, benefit richness factor and tier factors to the Market Adjusted Index Rate. For all plans, except the catastrophic, this resulted in the same expected claims cost. We added an adjustment to the catastrophic plan to account for this difference. This adjustment is 0.9846.

The total adjustment for the specific eligibility categories for the catastrophic plan is 0.5920. See Exhibit 6E for details.

3.8.5. Adjustment for distribution of the administrative costs

3.8.5.1. Administrative Expense Load:

BCBSVT Administrative Expense load was not initially calculated as a percent of premium adjustment. This adjustment is the sum of the following fees:

- BCBSVT Base Administrative Charges
  To develop the Base Administrative Expenses PMPM, we used the data underlying the Q4 2014-Q3 2015 BCBSVT Administrative Charges and Contribution to Reserves filing (BCVT-129486744). The experience period used in this filing is calendar year 2013.

  We combined the expenses for the members expected to be in the Exchange in 2015. These members are from BCBSVT Small Group, BCBSVT Nongroup, BCBSVT Safety Net, BCBSVT Catamount and TVHP Small Group. The experience period PMPM is $29.37.

  While the specific functions differ in some respects, the cost of the administrative functions associated with the Exchange in 2015 is expected to be comparable to the cost of administering coverage for the eligible populations in 2013.

  We have not trended costs forward from 2013 to 2015, as we expect increases in membership across our book of business to provide a broader base over which to spread fixed costs, offsetting any increase in underlying cost due to expected inflation and wage increases.

  BCBSVT experienced one-time expenses in 2013 with the startup of VHC and the associated member outreach campaign. We do not believe that these will be recurring expenses and we removed them from the projected period expenses. The projected period PMPM is $25.78.

- Charges for Outside Vendors
  - Vermont Collaborative Care

This is the amount PMPM to be paid to VCC for utilization review and management of mental health and substance abuse claims.

- CBA Dental and VSP Vision
  These benefits are being administered by third party administrators. The administrative fees are charged for eligible members only. The ratio of eligible members to total members, based on the projected exchange population split between adult and child, was applied to get the per member per month charge.
- Health Equity
  All Exchange members are eligible for HRA and/or HSA Integration service. For plans with an HSA-compatible benefit design, we offer a service to integrate with the mechanics of depositing monies into Health Savings Accounts (HSA). All plans are also eligible for this service with Health Reimbursement Accounts (HRA). To calculate these fees, we used the experience of members that are already enrolled in this program and compared it to all members enrolled in a QHP plan in the first quarter of 2014.
- Blue for You Program
  Under this program, BCBSVT will reward members with credits via a debit card for the following wellness activities:
  - Completing an online health assessment
  - Setting personal health goals online
  - Having a physical exam
  - Having a routine eye or dental exam

  We believe that this program will contribute to improvement in the health of Exchange members over time. In support of our mission of commitment to the health of Vermonters, BCBSVT management has decided to not make an explicit charge for this program in the Exchange plan rates.

The total of these charges adds up to 6.13 percent of premium. The details of the administrative charges are on Exhibit 7A.

3.8.5.2. Profit (or Contribution to Surplus) & Risk Margin:

The filed rates include a one percent contribution to reserves. BCBSVT included one percent for contribution to reserves because it is the minimum required to avoid depleting Risk Based Capital (RBC). Investment income is taken into account in the calculation of the minimum required contribution to reserve (CTR). This calculation does not consider the potential impact of exceptional one-time events (e.g. a flu epidemic). In normal circumstances, CTR would include some additional margin to protect member reserves against the occurrence of such an event. Because of the already-significant rate increase in this newly-established market, BCBSVT has

intentionally lowered its CTR requirement for the Exchange to only that necessary to avoid depletion of RBC through inadequately funded rates.

Details of Contribution to Reserve are on Exhibit 7B.

3.8.5.3. Taxes and Fees:

The proposed rates include on average 3.77 percent in Taxes and Fees. These taxes and fees are both from the State Government and the Federal Government.

The Vermont Information Technology Leaders (VITL) tax and the Health Care Claims Assessment (HCCA) are levied by the State of Vermont. They total 0.999 percent of claims, with 0.199 percent for VITL and 0.8 percent for HCCA.

The fees collected by the Federal Government include Patient Centered Outcomes Research Institute Fee (PCORI) and the Federal Insurer Fee. The PCORI fee is estimated at $2.11 per member per year, or $0.18 per member per month. The Federal Insurer Fee is estimated at 2.83 percent of premium.

Details of the Taxes and Fees are on Exhibit 7C.

3.8.6. AV Pricing Values

As described in the Part I Unified Rate Review Template Instructions dated April 30, 2014, the AV Pricing Value "represents the cumulative effect of adjustments made by the issuer to move from the Market Adjusted Index Rate to the Plan Adjusted Index Rate". These adjustments are described in detail in preceding parts of Section 3.8. See Exhibit 7D for details.

3.8.7. Calibration

Age, Tobacco, and Geographic factors are not allowed in Vermont. Therefore no calibration is required.

3.8.8. Projected Loss Ratio

We assume that, since the transitional reinsurance recoveries are required to be spread across the combined market for premium determination, the MLR calculation will be done at the combined market level with a minimum requirement of 80 percent. We project that the overall Loss Ratio, using the federally prescribed MLR methodology for the combined market will be 94.2 percent, well above the minimum 80 percent required. See Exhibit 8 for details.

3.9. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium rates are displayed on Exhibit 9. Since rate factors for age and geography are not allowed in Vermont, the only adjustment is the application of rating factors. As explained in section 3.4.6., Vermont has predetermined the tier factors for QHP plans. Using those tier factors, our projected membership by tier and the average members per subscriber, we calculate that the contract conversion factor to convert from PMPM to Single Rate is 1.125.

Rate Structure	Single	Couple	Adult + child(ren)	Family	Average
Exchange Tiers	1.000	2.000	1.930	2.810	1.501
Tier weights	61.9%	19.6%	3.4%	15.1%	100.0%

Average Members per Subscriber	1.688
Contract Conversion Factor	= 1.688/1.501 = 1.125

The Consumer Adjusted Premium Rates are shown on Exhibit 9.

3.10. Small Group Plan Premium Rates

All Small Groups must renew on 1/1/2015 according to the combined market rules. BCBSVT will not file small group rates for Q2-Q4 2015.

4. ADDITIONAL INFORMATION

4.1. Terminated Products

The following products will be terminated prior to 1/1/2015.

Product ID	Product Name	Product Type	Description	Market
13627VT001	CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT002	Vermont Freedom Plan	PPO	PPO	Small Group
13627VT003	Vermont Health Partnership	POS	Point of Service	Small Group
13627VT004	Comprehensive	Indemnity	Comprehensive	Small Group

13627VT005	Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT006	Individual HSA	PPO	PPO High Deductible Health Plan	Individual
13627VT007	Vermont Freedom Plan	PPO	PPO	Individual
13627VT008	Catamount Blue	PPO	PPO	Individual
13627VT009	Individual Comp	Indemnity	Comprehensive	Individual
13627VT010	CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT011	PPO	PPO	PPO	Small Group
13627VT012	POS	POS	Point of Service	Small Group
13627VT013	Comprehensive	Indemnity	Comprehensive	Small Group
13627VT014	Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT015	Individual HSA	PPO	PPO High Deductible Health Plan	Individual
13627VT016	Vermont Freedom Plan	PPO	PPO	Individual
13627VT017	Catamount Blue	PPO	PPO	Individual
13627VT018	Individual Comp	Indemnity	Comprehensive	Individual
13627VT019	AIVIS - CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT020	AIVIS - PPO	PPO	PPO	Small Group
13627VT021	AIVIS - POS	POS	Point of Service	Small Group
13627VT022	AIVIS - Plan J	Indemnity	Wrap-around major medical	Small Group
13627VT023	VACE - CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT024	VACE - PPO	PPO	PPO	Small Group
13627VT025	VSAA - CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT026	VSAA - PPO	PPO	PPO	Small Group
13627VT027	VSAA - POS	POS	Point of Service	Small Group

13627VT028	VSDS - CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT029	VSDS - PPO	PPO	PPO	Small Group
13627VT030	VHSG - CDHP Comprehensive	Indemnity	Comprehensive High-Deductible Health Plan	Small Group
13627VT031	VHSG - PPO	PPO	PPO	Small Group

4.2. Plan Type

Our plan type is EPO.

4.3. Warning Alerts

There are no warning alerts in the Unified Rate Review Template.

5. RELIANCE AND ACTUARIAL CERTIFICATION

5.1. Reliance

We relied upon the services of Susan Stock, Managing Director with Neela Associates, Shelburne, Vermont, to assist in the analysis of the expected population eligible for the Catastrophic Plan. The results of this analysis appear reasonable.

For the metallic AV values of the standard plans we relied upon the certification provided by Julie A. Peper, FSA, MAAA, Director and Senior Consulting Actuary with Wakely Consulting. (Attachment A)

We relied upon pricing information from George N. Berry, FSA, MAAA, Principal and Consulting Actuary with Milliman, for the projected net claims costs for the pediatric dental benefits that will be offered in the Exchange plans. We provided the parameters of the pediatric dental plans to Mr. Berry, and relied on his expertise in the pricing of those benefits. (Attachment B)

We relied on vision claim estimates provided by VSP, our vision administrator. These estimates appear reasonable and consistent with costs under our current vision plans.

5.2. Actuarial Certification

The purpose of this rate filing is to provide the rates and a description of the rate development for the products that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to be offered on Vermont Health Connect (VHC). These calculations are not intended to be used for any other purpose. This memorandum documents the methodology used to calculate the AV Metal Value for each Qualified Health Plan offered by BCBSVT in 2015, the appropriateness of the essential health benefit portion of premium upon which advanced payment of premium tax credits (APTCs) are based, that the Index Rate is developed in accordance with federal regulations, and that the Index Rate along with allowable modifiers are used in the development of plan specific premium rates.

I, Paul A. Schultz, am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work described herein.

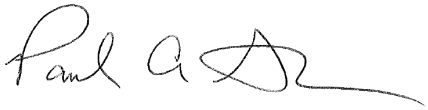
In my opinion, the projected Index Rate is in compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)), developed in compliance with the applicable Actuarial Standards of Practice, reasonable in relation to the benefits provided and the population anticipated to be covered, and neither excessive nor deficient. The calculations and results are appropriate for the purpose intended.

The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV was calculated in accordance with actuarial standards of practice.

I have relied upon the certification of AV Metal Value provided by the State for Standard Plans, and attached hereto. Metal AVs for Blue Rewards (Non-Standard) Plans were determined using the AV calculator, or in accordance with the requirements of 45 CFR 156.135(b)(3), as described in the attached actuarial certification.

This filing was prepared in accordance with generally accepted actuarial principals and methodologies, Actuarial Standards of Practice established by the Actuarial Standards Board, and applicable Federal and State laws and regulations concerning the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally facilitated exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers.



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Paul Schultz, F.S.A., M.A.A.A.
Actuarial Director
Blue Cross and Blue Shield of Vermont
June 2, 2014

BLUE CROSS BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING
PLAIN LANGUAGE SUMMARY

Blue Cross and Blue Shield of Vermont (BCBSVT) is committed to the health of Vermonters, outstanding member experiences and responsible cost management for all of the people whose lives we touch. By pooling the populations covered by our products, we protect individuals from the unaffordable and potentially ruinous costs associated with significant illnesses or injuries. Our products promote preventive care, health maintenance and health improvement, and we have in place strong utilization management programs that support members who require medical care and assure that they have access to high value care while avoiding unnecessary costs.

BCBSVT also works with providers to dampen cost increases through reimbursement strategies that include incentives to both provide and properly manage care. BCBSVT's vision is a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care. None of this work is possible unless BCBSVT remains financially strong, and that requires that we be allowed to charge rates that cover the medical expenses of the populations we serve.

The purpose of this rate filing is to provide the rates and a description of the rate development for the products that Blue Cross and Blue Shield of Vermont (BCBSVT) is proposing to be offered in the Vermont Exchange, effective January 1, 2015.

- BCBSVT is proposing an average rate increase of 9.8 percent across all Exchange plans. This ranges from a 4.8 percent increase to an 11.8 percent increase.
- There are an estimated 35,037 contracts (57,867 members) currently enrolled with BCBSVT in a Qualified Health Plan.

Significant medical price increases were partially offset by favorable membership assumptions and reductions in BCBSVT administrative expenses. Combined, these factors produced a 3.3 percent increase in rates. The remainder of the 9.8 percent increase was driven by changes related to federal and state health care reforms, including an increase in the federal fee that is included in Exchange pricing, a reduction in federal subsidies of the premiums on Vermont's new Exchange, and a modest expansion of dental benefits for children.

- The federal government assesses a charge on all health plans to subsidize Exchange coverage for the three year-period between 2014 and 2016, through its Transitional Reinsurance Program. The subsidy is reduced in 2015 and 2016, before being eliminated entirely in 2017. Because the premium subsidy is being reduced from an estimated seven percent to an estimated three percent in 2015, it will require groups and members to pay 4.0 percent more for their coverage.

- The federal insurer fee established by the Affordable Care Act is used to provide subsidies to low-income people to help them afford to purchase Exchange products. This fee is increasing by more than 40 percent, resulting in a 0.9 percent increase in premium for Exchange products.

- The Green Mountain Care Board approved a change to enhance coverage for dental services for children. The change provides that children covered through the non-CDHP Exchange products will have access to cleanings and other services with no cost-

sharing requirement. The enhancement in coverage raises the premium by 0.5 percent.

- Most deductibles, out-of-pocket maximums and co-pays in Exchange plans remain unchanged from 2014 to 2015. As overall costs increase and the amounts that members pay in cost-sharing contributions stays the same, more of the total cost is transferred to premiums. This had an impact of 0.8 percent on premium.

These four items drive an increase of 6.3 percent required solely because of mandated changes associated with the Affordable Care Act and Vermont benefit decisions.

In the absence of mandated changes associated with the Affordable Care Act and Vermont benefit decisions, a 3.3 percent increase would have been requested:

- An estimate of increases in the amounts providers are paid was included in 2014 Exchange rates. Increases beyond those assumptions that have already occurred in 2014, or that are projected to occur before the end of 2014, drive a premium increase of 2.9 percent. This primarily includes hospital payments under budgets approved by the Green Mountain Care Board and prescription drug prices.

- Amounts providers are paid are expected to increase by 4.8 percent in 2015. This increase flows directly to premium.

- BCBSVT assumes that "new members" who have or will enroll in our qualified health plans will prove to be significantly healthier on average than those previously insured in individual and small group products. This assumption creates a premium *decrease* of 2.5 percent.

- Other adjustments to the assumptions used in the 2014 rate development cumulatively have the effect of *reducing* the required rate increase by 1.8 percent. These include items such as updating the experience base to calendar year 2013 and observing the mix of membership actually enrolled on the Exchange in 2014. Notably, BCBSVT has:

    - Reduced the projected medical utilization "trend" (the expected increases in overall medical use) to zero,
    - Reduced its administrative expense fees, and
    - Included a one percent contribution to reserves, an amount that is lower than it would normally require for the protection of Exchange members.

BCBSVT understands the importance of adequately funding our health care system, to keep it strong and accessible. Since the factors driving this rate increase are almost entirely related to federal policy changes and increases in prices paid to medical providers in Vermont, we believe that there is no way to further reduce these rates without underfunding the health care coverage on which Vermonters rely.

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and, to the best of my knowledge, the filing complies with all applicable statutory and regulatory provisions for the State of Vermont.

Kevin Goddard
Vice President, External Affairs and Sales

6/2/14
Date

Unified Rate Review v2.0.2

Company Legal Name:	**Blue Cross and Blue Shield of V**	State:	**VT**
HIOS Issuer ID:	**13627**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2015**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2013 to 12/31/2013

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$287,929,163	$394.74	100.00%
Incurred Claims in Experience Period	$268,391,883	367.95	93.21%
Allowed Claims:	$330,245,595	452.75	114.70%
Index Rate of Experience Period		$445.00	
Experience Period Member Months	729,421		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2015 to 12/31/2015 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	116.63	$6,857.57	$66.65	0.935	1.090	1.044	1.000	109.04	$8,151.48	$74.07	0.00	$0.00	$0.00
Outpatient Hospital	Services	5,160.26	328.25	141.15	0.935	1.090	1.044	1.000	4,824.27	390.06	156.81	0.00	0.00	0.00
Professional	Visits	16,497.81	58.94	81.04	0.935	1.086	1.044	1.000	15,423.61	69.79	89.71	0.00	0.00	0.00
Other Medical	Visits	2,634.33	67.48	14.81	0.935	0.997	1.044	1.000	2,462.80	73.37	15.06	0.00	0.00	0.00
Capitation	Other	32,598.00	28.15	76.48	0.935	0.979	1.044	1.000	30,475.49	30.05	76.31	0.00	0.00	0.00
Prescription Drug	Prescriptions	14,464.88	60.24	72.62	0.935	1.147	1.064	1.019	14,033.54	78.19	91.44	0.00	0.00	0.00
Total				$452.75							$503.40			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$503.40	$351,514,152
Paid to Allowed Average Factor in Projection Period			0.798	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$401.71	$280,508,293
Projected Risk Adjustments PMPM			0.08	55,862
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$401.63	$280,452,431
Projected ACA reinsurance recoveries, net of rein prem, PMPM			10.29	7,185,301
Projected Incurred Claims			$391.34	$273,267,130
Administrative Expense Load		6.13%	26.92	18,800,533
Profit & Risk Load		1.00%	4.39	3,066,971
Taxes & Fees		3.77%	16.56	11,562,481
Single Risk Pool Gross Premium Avg. Rate, PMPM			$439.22	$306,697,115
Index Rate for Projection Period			$503.40	
% increase over Experience Period			11.27%	
% Increase, annualized:			5.48%	
Projected Member Months				698,280

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**Blue Cross and Blue Shield of Vermont**	State:	**VT**
HIOS Issuer ID:	**13627**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2015**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Products	BCBSVT EPO Standard (Small Group)				CBSVT EPO-CDHP Standard (Small Grou		BCBSVT EPO Standard (Individual)					BCBSVT EPO-CDHP Standard (Individual		BSVT EPO Accountable Blue (Small Grou		HP-Accountable Bl	CBSVT EPO Accountable Blue (Individua		DHP-Accountable Bl
Product ID:	13627VT017	13627VT032				13627VT033		13627VT034					13627VT035		13627VT036		13627VT037	13627VT038		13627VT039
Metal:	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze	Gold	Silver	Bronze	Gold	Silver	Bronze
AV Metal Value	0.000	0.881	0.802	0.715	0.615	0.685	0.609	0.654	0.881	0.802	0.715	0.615	0.685	0.609	0.799	0.711	0.613	0.799	0.711	0.613
AV Pricing Value	0.000	1.173	1.002	0.849	0.711	0.794	0.690	0.414	1.173	1.002	0.849	0.711	0.794	0.690	0.909	0.776	0.645	0.909	0.776	0.645
Plan Type:	PPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	Terminated Products	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1	BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	BCBSVT EPO Catastrophic Plan	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1	BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Bronze CDHP	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Bronze CDHP
Plan ID (Standard Component ID):	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390003
Exchange Plan?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	-6.67%	0.00%				0.00%		0.00%					0.00%		0.00%		0.00%	0.00%		0.00%
Historical Rate Increase - Calendar Year - 1	8.10%	0.00%				0.00%		0.00%					0.00%		0.00%		0.00%	0.00%		0.00%
Historical Rate Increase - Calendar Year 0	0.00%	0.00%				0.00%		0.00%					0.00%		0.00%		0.00%	0.00%		0.00%
Effective Date of Proposed Rates	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)	0.00%	11.62%	11.79%	10.70%	9.70%	6.61%	5.64%	7.37%	11.62%	11.79%	10.70%	9.70%	6.61%	5.64%	9.53%	8.90%	4.80%	9.53%	8.90%	4.80%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	11.62%	11.79%	10.70%	9.70%	6.61%	5.64%	7.37%	11.62%	11.79%	10.70%	9.70%	6.61%	5.64%	9.53%	8.90%	4.80%	9.53%	8.90%	4.80%
Proj'd Per Rate Change % (over Exper. Period)	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	#DIV/0!	11.31%				6.30%		11.16%					6.40%		9.35%		4.79%	9.06%		4.79%

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390003
Inpatient	$0.00	$0.00	$7.43	$6.55	$5.14	$3.99	$3.03	$2.28	$2.16	$7.43	$6.55	$5.14	$3.99	$3.03	$2.28	$4.92	$4.00	$1.83	$4.92	$4.00	$1.83
Outpatient	$0.00	$0.00	$15.74	$13.89	$10.88	$8.45	$6.40	$4.84	$4.57	$15.74	$13.89	$10.88	$8.45	$6.40	$4.84	$10.41	$8.46	$3.87	$10.41	$8.46	$3.87
Professional	$0.00	$0.00	$9.00	$7.94	$6.23	$4.83	$3.66	$2.76	$2.61	$9.00	$7.94	$6.23	$4.83	$3.66	$2.76	$5.96	$4.84	$2.21	$5.96	$4.84	$2.21
Prescription Drug	$0.00	$0.00	$9.18	$8.09	$6.35	$4.92	$3.73	$2.82	$2.66	$9.18	$8.09	$6.35	$4.92	$3.73	$2.82	$6.07	$4.94	$2.25	$6.07	$4.94	$2.25
Other	$0.00	$0.00	$1.51	$1.33	$1.05	$0.81	$0.62	$0.46	$0.44	$1.51	$1.33	$1.05	$0.81	$0.62	$0.46	$1.00	$0.81	$0.37	$1.00	$0.81	$0.37
Capitation	$0.00	$0.00	$7.66	$6.75	$5.30	$4.11	$3.12	$2.35	$2.22	$7.66	$6.75	$5.30	$4.11	$3.12	$2.35	$5.06	$4.12	$1.88	$5.06	$4.12	$1.88
Administration	$0.00	$0.00	-$3.14	-$3.24	-$3.25	-$3.21	-$3.36	-$3.30	-$3.28	-$3.14	-$3.24	-$3.25	-$3.21	-$3.36	-$3.30	-$2.92	-$3.20	-$3.39	-$2.92	-$3.20	-$3.39
Taxes & Fees	$0.00	$0.00	$6.70	$5.49	$4.35	$3.42	$3.20	$2.57	$0.65	$6.70	$5.49	$4.35	$3.42	$3.20	$2.57	$4.16	$3.29	$2.28	$4.16	$3.29	$2.28
Risk & Profit Charge	$0.00	$0.00	$3.18	$2.72	$2.29	$1.90	$1.99	$1.72	$1.05	$3.18	$2.72	$2.29	$1.90	$1.99	$1.72	$2.34	$1.99	$1.59	$2.34	$1.99	$1.59
Total Rate Increase	$0.00	$0.00	$57.26	$49.52	$38.34	$29.22	$22.39	$16.50	$13.08	$57.26	$49.52	$38.34	$29.22	$22.39	$16.50	$37.00	$29.25	$12.89	$37.00	$29.25	$12.89
Member Cost Share Increase	$0.00	$0.00	$3.52	$8.42	$10.06	$12.77	$10.23	$12.02	$7.34	$3.52	$8.42	$10.06	$12.77	$10.23	$12.02	$6.56	$10.63	$11.86	$6.56	$10.63	$11.86
Average Current Rate PMPM	$406.54	$0.00	$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$190.94	$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$411.40	$353.52	$305.02	$411.40	$353.52	$305.02
Projected Member Months	698,280	0	109,008	53,172	75,096	20,460	70,308	36,516	1,056	45,276	31,884	76,560	12,072	42,960	13,104	23,616	10,464	17,340	9,564	33,660	16,164

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390003
OK	$ 394.74	Premium Information	Average Rate PMPM	$394.74	$394.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OK	729,421		Member Months	729,421	729,421	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OK	$287,929,163		Total Premium (TP)	$287,931,646	$287,931,646	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			EHB Percent of TP, [see instructions]	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OK	$330,245,595	Claims Information	Total Allowed Claims (TAC)	$330,245,595	$330,245,595	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			EHB Percent of TAC, [see instructions]	99.98%	99.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.02%	0.02%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Allowed Claims which are not the issuer's obligation:	$61,853,712	$61,853,712	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS on behalf of insured person, as %	0.00%		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
OK	$268,391,883		Total Incurred claims, payable with issuer funds	$268,391,883	$268,391,883	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OK	$ 367.95		Incurred Claims PMPM	$367.95	$367.95	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
OK	$ 452.75		Allowed Claims PMPM	$452.75	$452.75	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
			EHB portion of Allowed Claims, PMPM	$452.66	$452.66	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Product-Plan Data Collection

Company Legal Name:	**Blue Cross and Blue Shield of Vermont**	State:	**VT**
HIOS Issuer ID:	**13627**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2015**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	BCBSVT EPO Standard (Small Group)				CBSVT EPO-CDHP Standard (Small Grou		BCBSVT EPO Standard (Individual)					BCBSVT EPO-CDHP Standard (Individual		BSVT EPO Accountable Blue (Small Grou		HP-Accountable Bl	CBSVT EPO Accountable Blue (Individua		DHP-Accountable Bl
Product ID:	13627VT017	13627VT032				13627VT033		13627VT034					13627VT035		13627VT036		13627VT037	13627VT038		13627VT039
Metal:	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze	Gold	Silver	Bronze	Gold	Silver	Bronze
AV Metal Value	0.000	0.881	0.802	0.715	0.615	0.685	0.609	0.654	0.881	0.802	0.715	0.615	0.685	0.609	0.799	0.711	0.613	0.799	0.711	0.613
AV Pricing Value	0.000	1.173	1.002	0.849	0.711	0.794	0.690	0.414	1.173	1.002	0.849	0.711	0.794	0.690	0.909	0.776	0.645	0.909	0.776	0.645
Plan Type:	PPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	Terminated Products	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1	BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	BCBSVT EPO Catastrophic Plan	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1	BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Bronze CDHP	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Bronze CDHP
Plan ID (Standard Component ID):	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390003

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390003
OK	$ 439.22	Premium Information	Plan Adjusted Index Rate	$443.96	$0.00	$578.46	$494.10	$418.56	$350.65	$391.37	$340.37	$204.02	$578.46	$494.10	$418.56	$350.65	$391.37	$340.37	$448.40	$382.77	$317.91	$448.40	$382.77	$317.91
OK	698,280		Member Months	698,280	-	109,008	53,172	75,096	20,460	70,308	36,516	1,056	45,276	31,884	76,560	12,072	42,960	13,104	23,616	10,464	17,340	9,564	33,660	16,164
OK	$306,697,115		Total Premium (TP)	$310,011,258	$0	$63,056,891	$26,272,216	$31,432,329	$7,174,363	$27,516,374	$12,429,123	$215,448	$26,190,406	$15,753,843	$32,045,103	$4,233,085	$16,813,213	$4,460,270	$10,589,345	$4,005,327	$5,512,604	$4,288,469	$12,884,108	$5,138,739
			EHB Percent of TP, [see instructions]	99.97%		99.98%	99.98%	99.97%	99.97%	99.97%	99.97%	99.94%	99.98%	99.98%	99.97%	99.97%	99.97%	99.97%	99.98%	99.97%	99.96%	99.98%	99.97%	99.96%
			state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.03%	100.00%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.06%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.02%	0.03%	0.04%	0.02%	0.03%	0.04%
OK	351,514,152	Claims Information	Total Allowed Claims (TAC)	$351,514,492	$0	$54,874,680	$26,766,811	$37,803,363	$10,299,574	$35,393,081	$18,382,172	$531,591	$22,791,960	$16,050,421	$38,540,341	$6,077,051	$21,626,085	$6,596,560	$11,888,306	$5,267,583	$8,728,964	$4,814,522	$16,944,460	$8,136,965
			EHB Percent of TAC, [see instructions]	99.97%		99.98%	99.98%	99.97%	99.97%	99.97%	99.97%	99.94%	99.98%	99.98%	99.97%	99.97%	99.97%	99.97%	99.98%	99.97%	99.96%	99.98%	99.97%	99.96%
			state mandated benefits portion of TAC that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.03%	100.00%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.06%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%	0.02%	0.03%	0.04%	0.02%	0.03%	0.04%
			Allowed Claims which are not the issuer's obligation	$77,920,932		-$3,314,047	$2,649,605	$9,143,344	$3,814,851	$10,384,689	$7,168,885	$357,873	$240,331	$2,677,964	$11,980,333	$2,653,354	$7,844,049	$3,010,536	$2,212,134	$1,631,113	$3,773,562	$1,227,358	$6,407,279	$4,057,718
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0																				
			Portion of above payable by HHS on behalf of insured person, as %	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OK	273,267,130		Total Incurred claims, payable with issuer funds	$273,593,559	$0	$58,188,727	$24,117,205	$28,660,019	$6,484,723	$25,008,392	$11,213,287	$173,718	$22,551,629	$13,372,457	$26,560,008	$3,423,696	$13,782,036	$3,586,024	$9,676,172	$3,636,469	$4,955,402	$3,587,165	$10,537,182	$4,079,248
OK	7,185,301		Net Amt of Rein	$7,186,745		-$400,059	-$195,141	-$275,602	-$75,088	-$258,030	-$134,014	$9,729	$1,450,643	$972,143	$2,377,764	$358,176	$1,341,073	$389,844	-$86,671	-$38,403	-$63,638	$296,388	$1,036,874	$480,757
			Net Amt of Risk Adj	$0																				
OK	$ 391.34		Incurred Claims PMPM	$391.81	#DIV/0!	$533.80	$453.57	$381.65	$316.95	$355.70	$307.08	$164.51	$498.09	$419.41	$346.92	$283.61	$320.81	$273.66	$409.73	$347.52	$285.78	$375.07	$313.05	$252.37
OK	$ 503.40		Allowed Claims PMPM	$503.40	#DIV/0!	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40	$503.40
			EHB portion of Allowed Claims, PMPM	$503.27	#DIV/0!	$503.30	$503.29	$503.27	$503.24	$503.26	$503.23	$503.10	$503.30	$503.29	$503.27	$503.24	$503.26	$503.23	$503.28	$503.25	$503.22	$503.28	$503.25	$503.22

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

STATE OF VERMONT STANDARD PLAN DESIGNS

	Platinum	Gold	Silver	Silver	Bronze	Bronze
	Standard	Standard	Standard	Standard	Standard	Standard
Deductible/OOP Max	**Deductible**	**Deductible**	**Deductible**	**CDHP**	**Deductible**	**CDHP**
Medical Ded	$150	$750	$1,900	$1,550	$3,500	$2,000
Rx Ded	$0	$50	$100	Combined	$300	Combined
Integrated Ded	No	No	No	Yes	No	Yes
Medical OOPM	$1,250	$4,250	$5,100	$5,750	$6,350	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,300	$1,250	$1,300
Integrated OOPM	No	No	No	Yes	Yes	Yes
Family Deductible / OOP	Stacked	Stacked	Stacked	Aggregate	Stacked	Aggregate
Medical Deductible waived for:	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Emergency Room, Dental Class I, Vision	Preventive Care, Office Visits, Urgent Care, Ambulance, Dental Class I, Vision	Preventive Care	Preventive Care, Dental Class I	Preventive Care
Drug Deductible waived for:	N/A	Generic Scripts	Generic Scripts	Wellness Scripts	N/A	Wellness Scripts
Service Category						
Preventive	$0	$0	$0	0%	$0	0%
PCP Office Visit	$10	$15	$25	10%	$35	50%
MH/SA Office Visit	$10	$15	$25	10%	$35	50%
Specialist Office Visit	$20	$25	$45	20%	$80	50%
Urgent Care	$40	$45	$60	20%	$100	50%
Ambulance	$50	$50	$100	20%	$100	50%
DME	10%	20%	40%	20%	50%	50%
ER	$100	$150	$250	20%	50%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	20%	50%	50%
Outpatient	10%	20%	40%	20%	50%	50%
Inpatient	10%	20%	40%	20%	50%	50%
Rx Generic	$5	$5	$12	$10	$20	$12
Rx Preferred Brand	$40	$40	$50	$40	$80	40%
Rx Non-Preferred Brand	50%	50%	50%	50%	60%	60%
Pediatric Vision (Exam and Materials)	$20	$25	$45	20%	$80	50%
Pediatric Dental Class I	0%	0%	0%	0%	0%	0%
Pediatric Dental Class II	30%	30%	30%	30%	30%	30%
Pediatric Dental Class III	50%	50%	50%	50%	50%	50%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

BLUE REWARDS (NON-STANDARD) PLAN DESIGNS

	GOLD	SILVER	BRONZE	CATASTROPHIC
	Blue Rewards	Blue Rewards	Blue Rewards	Blue Rewards
Deductible/OOP Max	**Deductible**	**Deductible**	**CDHP**	**Deductible**
Medical Ded	$1,250	$2,000	$5,000	$6,600
Rx Ded	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$6,250	$6,250	$6,600
Rx OOPM	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate	Aggregate	Aggregate	Aggregate
Medical Deductible waived for:	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care	Preventive Care, 3 PCP/MH Office Visits
Drug Deductible waived for:	N/A	N/A	Wellness Scripts	N/A
Service Category				
Preventive	$0	$0	$0	$0
PCP Office Visit	3 visits per member combined PCP/MH at no cost share before deductible then $20 copay	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	50%	3 visits per member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit			50%	
Specialist Office Visit	$30	$50	50%	0%
Urgent Care	$30	$50	50%	0%
Ambulance	$30	$50	50%	0%
DME	$30	$50	50%	0%
ER	$250	$250	50%	0%
Radiology (MRI, CT, PET)	$500	$1,750	50%	0%
Outpatient	$500	$1,750	50%	0%
Inpatient	$500	$1,750	50%	0%
Rx Generic	$5	$5	$25	0%
Rx Preferred Brand	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	0%
Pediatric Vision (Exam and Materials)	$30	$50	50%	0%
Pediatric Dental Class I	0%	0%	0%	0%
Pediatric Dental Class II	30%	30%	30%	0%
Pediatric Dental Class III	50%	50%	50%	0%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

PROJECTED MEMBERSHIP BY PLAN AND MARKET

Product	Individual Market	Small Group Market	TOTAL
Catastrophic	88	0	88
Non-Standard Gold	797	1,968	2,765
Non-Standard Gold - CSR 100%	0	0	0
Non-Standard Silver	847	872	1,719
Non-Standard Silver - CSR 100%	0	0	0
Non-Standard Silver - CSR 73%	350	0	350
Non-Standard Silver - CSR 77%	593	0	593
Non-Standard Silver - CSR 87%	828	0	828
Non-Standard Silver - CSR 94%	187	0	187
Non-Standard Bronze CDHP - CSR 100%	1	0	1
Non-Standard Bronze CDHP	1,346	1,445	2,791
Standard Platinum	3,773	9,084	12,857
Standard Platinum - CSR 100%	0	0	0
Standard Gold	2,657	4,431	7,088
Standard Gold - CSR 100%	0	0	0
Standard Silver	2,115	6,258	8,373
Standard Silver - CSR 100%	2	0	2
Standard Silver - CSR 73%	767	0	767
Standard Silver - CSR 77%	1,264	0	1,264
Standard Silver - CSR 87%	1,708	0	1,708
Standard Silver - CSR 94%	524	0	524
Standard Silver CDHP	1,698	5,859	7,557
Standard Silver CDHP - CSR 100%	1	0	1
Standard Silver CDHP - CSR 73%	393	0	393
Standard Silver CDHP - CSR 77%	555	0	555
Standard Silver CDHP - CSR 87%	722	0	722
Standard Silver CDHP - CSR 94%	211	0	211
Standard Bronze	1,006	1,705	2,711
Standard Bronze - CSR 100%	0	0	0
Standard Bronze CDHP	1,092	3,043	4,135
Standard Bronze CDHP - CSR 100%	0	0	0
Total	**23,525**	**34,665**	**58,190**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

ADJUSTMENT FOR IMPACT OF THE HEALTH STATUS OF NEWLY INSURED

	Continuing			New Entrants		
	Individual Non-Subsidized	Individual Subsidized	Small Group	Individual Non-Subsidized	Individual Subsidized	Small Group
Projected Membership	7,457	7,148	27,896	2,987	5,933	6,769
AGF Factors	1.3901	1.4199	1.1296	1.2684	1.2250	1.0448
PMPM	$553.67	$584.18	$409.76	=1.2684 / 1.3901 x $553.67 = $505.18	=1.225 / 1.4199 x $584.18 = $503.98	=1.0448 / 1.1296 x $409.76 = $379.00
Average PMPM			$464.34			$450.29

Weighted Average of Continuing Members and New Entrants	$460.55
Impact of New Entrants (Line 1+b3 on Exhibit 5) = $460.55 / $464.34	**0.9918**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

IMPACT OF THE CHANGE IN PROVIDER NETWORK

MEDICAL CLAIMS

Coverage Category in the Experience	CY 2013 Allowed Claims	Experience Membership	CY 2013 Allowed PMPM	Network Adjustment	CY 2013 Allowed PMPM Adjuted for Network
Catamount	$72,577,613	196,948	$368.51	1.4217	$523.92
Indemnity/PPO	$98,692,581	261,297	$377.70	0.9753	$368.37
Point-of-Service	$1,492,960	3,893	$383.50	1.0000	$383.50
HMO	$96,502,594	267,283	$361.05	1.0527	$380.08
Weighted Average PMPM			$369.15	1.1235	$414.74

PHARMACY CLAIMS

Coverage Category in the Experience	CY 2013 Allowed Claims	Experience Membership	CY 2013 Allowed PMPM	Network Adjustment	CY 2013 Allowed PMPM Adjuted for Network
Catamount	$21,005,498	196,948	$106.66	1.0099	$107.71
Indemnity/PPO	$15,865,129	261,297	$60.72	1.0099	$61.32
Point-of-Service	$291,627	3,893	$74.91	1.0099	$75.65
HMO	$18,317,931	267,283	$68.53	1.0099	$69.21
Weighted Average PMPM			$76.06	1.0099	$76.81
Total Average PMPM			**$445.21**		**$491.56**

Impact of Change in Provider Network (Line 1+c2 on Exhibit 5) = $491.56 / $445.21 **1.1041**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

PLAN LEVEL ADJUSTMENT
CHANGE IN FAMILY TIER FACTOR

	NON-STANDARD PLANS			STANDARD PLANS								
	GOLD Blue Rewards	SILVER Blue Rewards	BRONZE Blue Rewards CDHP	PLATINUM Deductible	GOLD Deductible	SILVER Deductible	SILVER CDHP	BRONZE Deductible	BRONZE CDHP	Catastrophic Blue Rewards	TOTAL	
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190	
Projected Contracts	1,638	2,178	1,654	7,616	4,199	7,487	5,592	1,606	2,450	52	34,471	
											Mandated Tier Factors	Membership Split by Tier
Modeled Tier Factor - Single Tier	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.00	61.9%
Modeled Tier Factor - Couple Tier	1.8362	1.7875	1.7199	2.0000	2.0000	2.0000	1.7686	2.0000	1.7416	1.7156	2.00	19.6%
Modeled Tier Factor - Adult + Child(ren) Tier	1.4549	1.4026	1.3173	1.6547	1.6416	1.6076	1.3764	1.5489	1.3398	1.3410	1.93	3.4%
Modeled Tier Factor - Family Tier	2.5397	2.4689	2.4529	2.8331	2.8163	2.7790	2.4353	2.7118	2.4406	2.4500	2.81	15.1%
Average Tier Factor	1.5011	1.5011	1.5011	1.5011	1.5011	1.5011	1.5011	1.5011	1.5011	1.5011		
Family Multiplier PMPM Adjustment	0.9405	0.9259	0.9135	0.9960	0.9940	0.9895	0.9194	0.9814	0.9156	0.9132	**0.9644**	*$1+c_6$ on Exh 5*

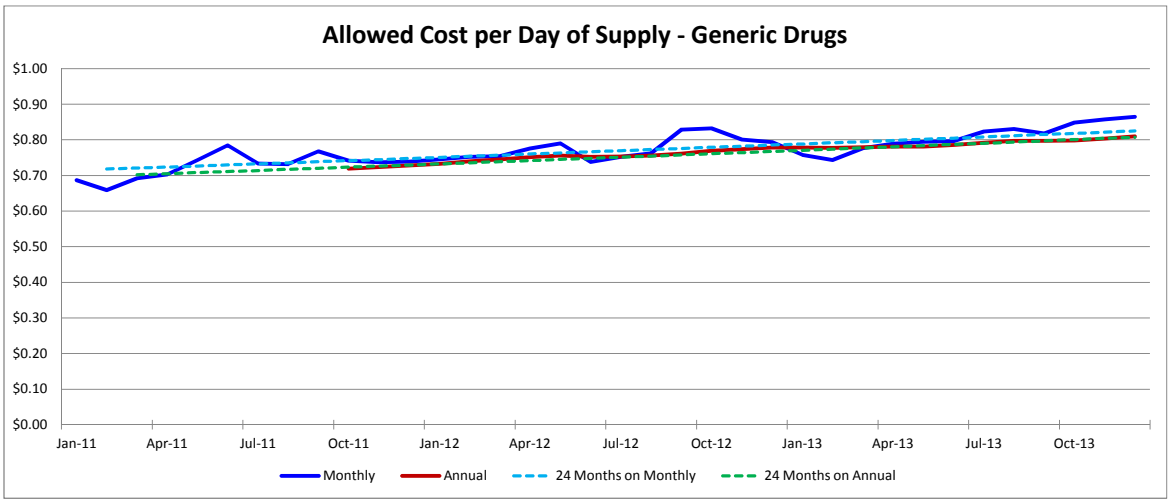
Average Members per Subsriber 1.6881

PHARMACY TREND DEVELOPMENT

GENERIC DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Adjusted Allowed Charge	Cost/ Supply	Monthly Cost Trend	Supply	Adjusted Allowed Charge	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Nov-10	920,218	$630,210	$0.68							
Dec-10	1,000,610	$686,956	$0.69							
Jan-11	925,045	$635,074	$0.69							
Feb-11	881,246	$580,303	$0.66						$0.72	$0.70
Mar-11	1,041,142	$720,518	$0.69						$0.72	$0.70
Apr-11	973,064	$684,200	$0.70						$0.72	$0.71
May-11	1,032,652	$767,153	$0.74						$0.73	$0.71
Jun-11	1,039,107	$815,357	$0.78						$0.73	$0.71
Jul-11	1,006,219	$738,113	$0.73						$0.73	$0.72
Aug-11	1,074,522	$785,810	$0.73						$0.74	$0.72
Sep-11	1,039,852	$798,320	$0.77						$0.74	$0.72
Oct-11	1,046,981	$776,204	$0.74		11,980,658	$8,618,220	$0.72		$0.74	$0.73
Nov-11	1,070,404	$788,534	$0.74		12,130,844	$8,776,544	$0.72		$0.74	$0.73
Dec-11	1,182,843	$874,212	$0.74	7.7%	12,313,077	$8,963,800	$0.73		$0.75	$0.73
Jan-12	1,397,551	$1,041,628	$0.75	8.6%	12,785,583	$9,370,354	$0.73		$0.75	$0.74
Feb-12	1,378,249	$1,036,779	$0.75	14.2%	13,282,587	$9,826,830	$0.74		$0.75	$0.74
Mar-12	1,496,653	$1,128,033	$0.75	8.9%	13,738,098	$10,234,345	$0.74		$0.76	$0.74
Apr-12	1,474,371	$1,143,434	$0.78	10.3%	14,239,404	$10,693,579	$0.75		$0.76	$0.74
May-12	1,525,284	$1,204,989	$0.79	6.3%	14,732,036	$11,131,414	$0.76		$0.76	$0.75
Jun-12	1,513,837	$1,117,272	$0.74	-5.9%	15,206,766	$11,433,329	$0.75		$0.77	$0.75
Jul-12	1,501,210	$1,129,344	$0.75	2.6%	15,701,758	$11,824,559	$0.75		$0.77	$0.75
Aug-12	1,585,472	$1,208,263	$0.76	4.2%	16,212,708	$12,247,012	$0.76		$0.77	$0.76
Sep-12	1,474,009	$1,221,695	$0.83	8.0%	16,646,864	$12,670,387	$0.76		$0.78	$0.76
Oct-12	1,657,532	$1,379,503	$0.83	12.3%	17,257,415	$13,273,686	$0.77		$0.78	$0.76
Nov-12	1,585,258	$1,268,780	$0.80	8.6%	17,772,269	$13,753,932	$0.77	7.0%	$0.78	$0.77
Dec-12	1,650,984	$1,310,212	$0.79	7.4%	18,240,409	$14,189,931	$0.78	6.9%	$0.79	$0.77
Jan-13	1,622,082	$1,229,147	$0.76	1.7%	18,464,940	$14,377,450	$0.78	6.2%	$0.79	$0.77
Feb-13	1,505,731	$1,119,047	$0.74	-1.2%	18,592,422	$14,459,719	$0.78	5.1%	$0.79	$0.78
Mar-13	1,595,847	$1,239,104	$0.78	3.0%	18,691,617	$14,570,790	$0.78	4.6%	$0.79	$0.78
Apr-13	1,637,320	$1,291,562	$0.79	1.7%	18,854,566	$14,718,918	$0.78	4.0%	$0.80	$0.78
May-13	1,642,085	$1,305,092	$0.79	0.6%	18,971,367	$14,819,021	$0.78	3.4%	$0.80	$0.79
Jun-13	1,561,029	$1,243,082	$0.80	7.9%	19,018,560	$14,944,831	$0.79	4.5%	$0.80	$0.79
Jul-13	1,665,495	$1,370,567	$0.82	9.4%	19,182,845	$15,186,054	$0.79	5.1%	$0.81	$0.79
Aug-13	1,679,210	$1,393,695	$0.83	8.9%	19,276,583	$15,371,486	$0.80	5.6%	$0.81	$0.80
Sep-13	1,624,735	$1,328,373	$0.82	-1.4%	19,427,309	$15,478,164	$0.80	4.7%	$0.81	$0.80
Oct-13	1,740,110	$1,475,802	$0.85	1.9%	19,509,888	$15,574,462	$0.80	3.8%	$0.82	$0.80
Nov-13	1,633,526	$1,399,987	$0.86	7.1%	19,558,156	$15,705,669	$0.80	3.8%	$0.82	$0.81
Dec-13	1,861,265	$1,609,063	$0.86	8.9%	19,768,438	$16,004,521	$0.81	4.1%	$0.82	$0.81

Exponential Trend:	5.0%	5.2%
Adjustment for Future ESI Contract Terms:	0.9771	0.9771
Adjusted Trend:	2.6%	2.8%

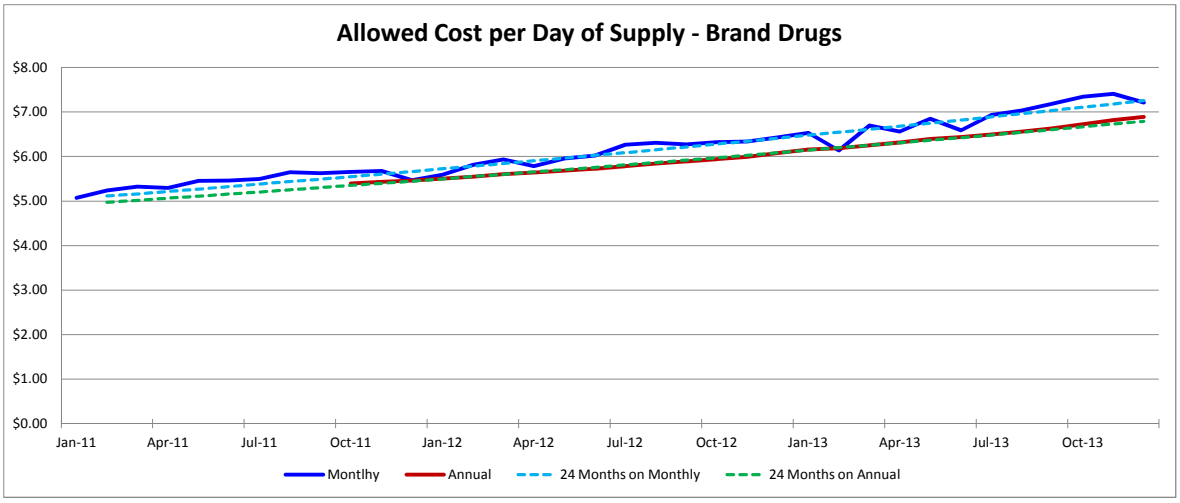


PHARMACY TREND DEVELOPMENT

BRAND DRUGS - COST TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Supply	Adjusted Allowed Charge	Cost/ Supply	Monthly Cost Trend	Supply	Adjusted Allowed Charge	Cost/ Supply	Rolling 12 Cost Trend	Monthly Data	Rolling 12 Data
Nov-10	272,711	$1,428,771	$5.24							
Dec-10	296,486	$1,541,569	$5.20							
Jan-11	246,553	$1,249,967	$5.07							
Feb-11	228,999	$1,199,926	$5.24						$5.11	$4.97
Mar-11	273,235	$1,454,052	$5.32						$5.16	$5.02
Apr-11	267,201	$1,415,254	$5.30						$5.22	$5.06
May-11	267,249	$1,457,656	$5.45						$5.27	$5.11
Jun-11	267,887	$1,463,365	$5.46						$5.32	$5.16
Jul-11	260,463	$1,431,819	$5.50						$5.38	$5.20
Aug-11	274,590	$1,551,494	$5.65						$5.44	$5.25
Sep-11	277,214	$1,559,458	$5.63						$5.49	$5.30
Oct-11	284,978	$1,612,245	$5.66		3,217,567	$17,365,576	$5.40		$5.55	$5.35
Nov-11	281,464	$1,597,751	$5.68		3,226,320	$17,534,556	$5.43		$5.61	$5.40
Dec-11	320,153	$1,750,482	$5.47	5.2%	3,249,987	$17,743,469	$5.46		$5.66	$5.45
Jan-12	326,502	$1,825,144	$5.59	10.3%	3,329,936	$18,318,646	$5.50		$5.72	$5.50
Feb-12	320,206	$1,860,277	$5.81	10.9%	3,421,143	$18,978,997	$5.55		$5.78	$5.55
Mar-12	338,751	$2,011,266	$5.94	11.6%	3,486,659	$19,536,211	$5.60		$5.84	$5.60
Apr-12	318,546	$1,842,709	$5.78	9.2%	3,538,005	$19,963,667	$5.64		$5.90	$5.65
May-12	326,612	$1,944,799	$5.95	9.2%	3,597,367	$20,450,810	$5.68		$5.96	$5.70
Jun-12	288,247	$1,734,466	$6.02	10.2%	3,617,727	$20,721,911	$5.73		$6.03	$5.76
Jul-12	290,804	$1,822,164	$6.27	14.0%	3,648,067	$21,112,255	$5.79		$6.09	$5.81
Aug-12	296,639	$1,870,442	$6.31	11.6%	3,670,116	$21,431,203	$5.84		$6.15	$5.86
Sep-12	276,196	$1,733,133	$6.28	11.5%	3,669,097	$21,604,878	$5.89		$6.22	$5.92
Oct-12	311,987	$1,972,557	$6.32	11.8%	3,696,107	$21,965,190	$5.94		$6.28	$5.97
Nov-12	301,841	$1,912,065	$6.33	11.6%	3,716,485	$22,279,504	$5.99	10.3%	$6.35	$6.03
Dec-12	329,328	$2,117,420	$6.43	17.6%	3,725,659	$22,646,442	$6.08	11.3%	$6.41	$6.08
Jan-13	286,375	$1,870,149	$6.53	16.8%	3,685,533	$22,691,447	$6.16	11.9%	$6.48	$6.14
Feb-13	272,888	$1,675,341	$6.14	5.7%	3,638,215	$22,506,511	$6.19	11.5%	$6.55	$6.20
Mar-13	277,613	$1,859,861	$6.70	12.8%	3,577,077	$22,355,107	$6.25	11.5%	$6.61	$6.25
Apr-13	285,432	$1,873,270	$6.56	13.5%	3,543,962	$22,385,667	$6.32	11.9%	$6.68	$6.31
May-13	288,059	$1,973,235	$6.85	15.0%	3,505,410	$22,414,103	$6.39	12.5%	$6.75	$6.37
Jun-13	275,013	$1,811,613	$6.59	9.5%	3,492,176	$22,491,250	$6.44	12.4%	$6.82	$6.43
Jul-13	291,050	$2,018,172	$6.93	10.7%	3,492,421	$22,687,259	$6.50	12.2%	$6.89	$6.48
Aug-13	301,634	$2,121,051	$7.03	11.5%	3,497,416	$22,937,868	$6.56	12.3%	$6.96	$6.54
Sep-13	290,921	$2,090,145	$7.18	14.5%	3,512,141	$23,294,880	$6.63	12.6%	$7.03	$6.61
Oct-13	320,570	$2,352,785	$7.34	16.1%	3,520,724	$23,675,108	$6.72	13.2%	$7.10	$6.67
Nov-13	295,173	$2,187,317	$7.41	17.0%	3,514,056	$23,950,359	$6.82	13.7%	$7.18	$6.73
Dec-13	340,655	$2,458,218	$7.22	12.2%	3,525,383	$24,291,157	$6.89	13.4%	$7.25	$6.79

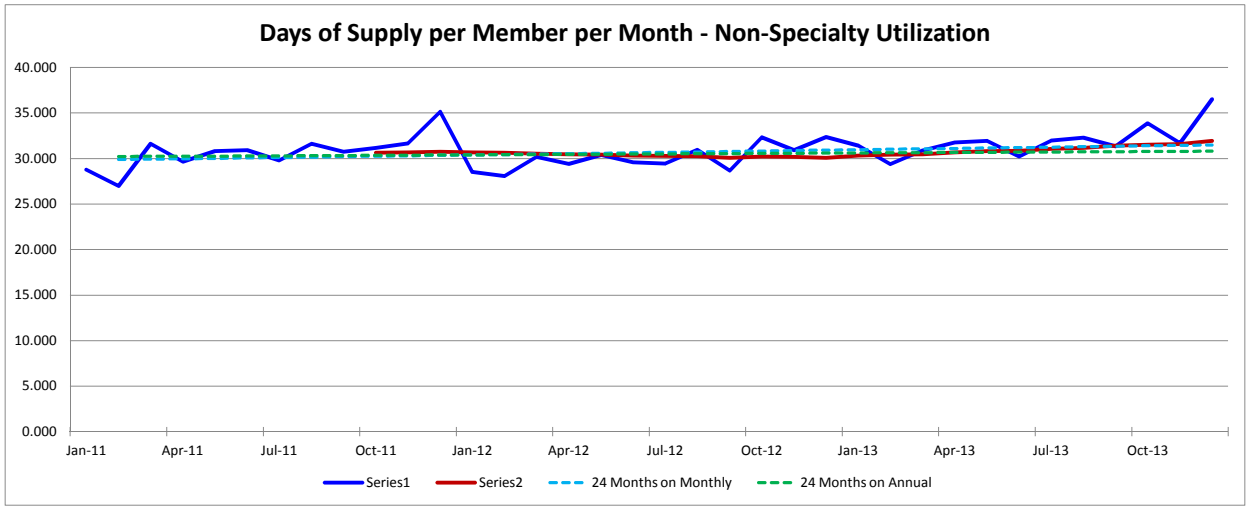
Exponential Trend:	13.1%	11.6%
Adjustment for Future ESI Contract Terms:	0.9973	0.9973
Adjusted Trend:	12.8%	11.3%



PHARMACY TREND DEVELOPMENT

NON-SPECIALTY DRUGS - UTILIZATION TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Membership	Supply	Supply per Member	Monthly Utilization Trend	Membership	Supply	Supply per Member	Rolling 12 Utilization Trend	Monthly Data	Rolling 12 Data
Nov-10	37,896	1,192,929	31.479							
Dec-10	37,708	1,297,096	34.398							
Jan-11	40,728	1,171,598	28.766							
Feb-11	41,137	1,110,245	26.989						29.883	30.218
Mar-11	41,544	1,314,377	31.638						29.925	30.234
Apr-11	41,847	1,240,265	29.638						29.972	30.251
May-11	42,167	1,299,901	30.827						30.018	30.268
Jun-11	42,279	1,306,994	30.914						30.065	30.286
Jul-11	42,536	1,266,682	29.779						30.111	30.303
Aug-11	42,651	1,349,112	31.631						30.158	30.320
Sep-11	42,862	1,317,067	30.728						30.205	30.338
Oct-11	42,747	1,331,959	31.159		496,102	15,198,225	30.635		30.251	30.355
Nov-11	42,728	1,351,868	31.639		500,934	15,357,164	30.657		30.299	30.372
Dec-11	42,763	1,502,997	35.147	2.2%	505,989	15,563,065	30.758		30.345	30.389
Jan-12	60,442	1,724,053	28.524	-0.8%	525,703	16,115,520	30.655		30.393	30.407
Feb-12	60,483	1,698,455	28.082	4.0%	545,049	16,703,729	30.646		30.441	30.424
Mar-12	60,785	1,835,404	30.195	-4.6%	564,290	17,224,757	30.525		30.485	30.441
Apr-12	60,990	1,792,917	29.397	-0.8%	583,433	17,777,409	30.470		30.533	30.458
May-12	60,929	1,851,895	30.394	-1.4%	602,195	18,329,403	30.438		30.580	30.475
Jun-12	60,891	1,802,084	29.595	-4.3%	620,807	18,824,493	30.323		30.628	30.493
Jul-12	60,850	1,792,014	29.450	-1.1%	639,121	19,349,825	30.276		30.674	30.510
Aug-12	60,836	1,882,111	30.937	-2.2%	657,306	19,882,824	30.249		30.723	30.528
Sep-12	61,055	1,750,205	28.666	-6.7%	675,499	20,315,961	30.075		30.771	30.545
Oct-12	60,917	1,969,519	32.331	3.8%	693,669	20,953,521	30.207		30.818	30.562
Nov-12	61,059	1,887,099	30.906	-2.3%	712,000	21,488,753	30.181	-1.6%	30.866	30.580
Dec-12	61,186	1,980,312	32.365	-7.9%	730,423	21,966,068	30.073	-2.2%	30.913	30.597
Jan-13	60,791	1,908,457	31.394	10.1%	730,772	22,150,473	30.311	-1.1%	30.962	30.615
Feb-13	60,577	1,778,619	29.361	4.6%	730,866	22,230,637	30.417	-0.7%	31.011	30.633
Mar-13	60,635	1,873,460	30.897	2.3%	730,716	22,268,693	30.475	-0.2%	31.055	30.649
Apr-13	60,560	1,922,752	31.750	8.0%	730,286	22,398,528	30.671	0.7%	31.103	30.666
May-13	60,431	1,930,145	31.940	5.1%	729,788	22,476,777	30.799	1.2%	31.151	30.684
Jun-13	60,739	1,836,042	30.228	2.1%	729,636	22,510,735	30.852	1.7%	31.200	30.701
Jul-13	61,204	1,956,545	31.968	8.5%	729,990	22,675,266	31.062	2.6%	31.247	30.718
Aug-13	61,332	1,980,844	32.297	4.4%	730,486	22,773,999	31.177	3.1%	31.296	30.736
Sep-13	61,148	1,915,656	31.328	9.3%	730,579	22,939,450	31.399	4.4%	31.346	30.754
Oct-13	60,840	2,060,681	33.870	4.8%	730,502	23,030,612	31.527	4.4%	31.393	30.771
Nov-13	60,849	1,928,700	31.696	2.6%	730,292	23,072,212	31.593	4.7%	31.443	30.789
Dec-13	60,315	2,201,920	36.507	12.8%	729,421	23,293,820	31.935	6.2%	31.491	30.806
								Exponential Trend:	1.9%	0.7%



BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

EXHIBIT 3B

PHARMACY TREND DEVELOPMENT
HISTORICAL GENERIC DISPENSING RATES

Brand	EFFEXOR	LIPOFEN	CONCERTA	FLOMAX	COZAAR	LIPITOR	LEXAPRO	SEROQUEL	PLAVIX	ACTOS	Other					
Generic	VENLAFAXINE	FENOFIBRATE	METHYLPHENIDATE	TAMSULOSIN	LOSARTAN	ATORVASTATIN	ESCITALOPRAM	QUETIAPINE	CLOPIDOGREL	PIOGLITAZONE	Generic	Brand	Specialty	Total	Generic Dispensing Rate	
Incurred Date	# DAYS SUPPLY BY INCURRED DATE														Monthly	Rolling 12
201001	1,696	870	1,183	0	0	0	0	0	0	0	805,465	269,549	11,710	1,090,473	74.2%	
201002	1,590	690	1,050	0	0	0	0	0	0	0	751,184	262,850	11,486	1,028,850	73.3%	
201003	1,876	960	1,175	2,042	0	0	0	0	0	0	896,453	298,148	13,323	1,213,977	74.3%	
201004	1,903	630	1,259	4,156	5,835	0	0	0	0	0	854,528	279,266	13,323	1,160,900	74.8%	
201005	1,892	957	1,121	4,479	10,725	0	0	0	0	0	820,656	258,075	13,276	1,111,181	75.6%	
201006	2,248	960	1,147	3,508	10,939	0	0	0	0	0	889,348	277,494	12,614	1,198,258	75.8%	
201007	7,509	840	1,316	4,181	9,937	0	0	0	0	0	853,433	253,859	13,088	1,144,163	76.7%	
201008	10,762	840	1,358	4,077	10,960	0	0	0	0	0	873,422	267,628	13,319	1,182,366	76.2%	
201009	10,082	930	1,451	4,055	10,072	0	0	0	0	0	874,522	262,005	12,079	1,175,196	76.7%	
201010	9,698	990	1,480	4,601	10,610	0	0	0	0	0	864,899	267,758	12,510	1,172,546	76.1%	
201011	11,337	1,170	1,423	4,648	10,549	0	0	0	0	0	891,091	272,711	12,515	1,205,444	76.3%	
201012	11,772	2,825	1,230	5,352	12,243	0	0	0	0	0	967,188	296,486	13,377	1,310,473	76.4%	75.6%
201101	11,068	2,338	1,496	4,465	10,160	0	0	0	0	0	895,518	246,553	11,536	1,183,134	78.2%	75.9%
201102	10,553	2,758	1,196	4,455	11,313	0	0	0	0	0	850,971	228,999	11,144	1,121,389	78.6%	76.3%
201103	12,903	2,698	1,934	5,914	11,064	0	0	0	0	0	1,006,629	273,235	12,961	1,327,338	78.4%	76.7%
201104	12,474	2,668	2,362	4,946	10,340	0	0	0	0	0	940,274	267,201	10,962	1,251,227	77.8%	76.9%
201105	12,925	2,938	2,936	4,938	12,775	0	0	0	0	0	996,140	267,249	14,134	1,314,035	78.6%	77.2%
201106	13,611	2,548	4,409	5,943	11,451	0	0	0	0	0	1,001,145	267,887	12,903	1,319,897	78.7%	77.4%
201107	12,676	3,028	4,153	5,733	12,184	0	0	0	0	0	968,445	260,463	13,132	1,279,814	78.6%	77.6%
201108	12,732	3,388	5,361	5,696	12,415	0	0	0	0	0	1,034,930	274,590	13,498	1,362,610	78.9%	77.8%
201109	12,995	2,368	6,746	5,065	12,220	0	0	0	0	0	1,000,458	277,214	13,068	1,330,135	78.2%	77.9%
201110	13,582	2,758	7,360	6,881	14,155	0	0	0	0	0	1,002,245	284,978	13,555	1,345,514	77.8%	78.0%
201111	14,156	3,386	6,754	5,875	12,620	0	0	0	0	0	1,027,612	281,464	12,380	1,364,248	78.5%	78.2%
201112	14,276	3,287	8,131	5,766	14,022	7,182	0	0	0	0	1,130,179	320,153	14,324	1,517,321	78.0%	78.3%
201201	16,771	3,686	10,170	7,929	18,584	10,852	0	0	0	0	1,329,558	326,502	16,127	1,740,180	80.3%	78.6%
201202	18,961	3,894	10,328	6,926	19,272	12,646	0	0	0	0	1,306,221	320,206	15,217	1,713,672	80.4%	78.8%
201203	19,874	3,326	11,050	8,520	19,878	13,222	9,577	0	0	0	1,411,204	338,751	17,020	1,852,425	80.8%	79.0%
201204	19,138	5,029	11,256	7,502	20,939	12,512	11,634	4,466	0	0	1,381,892	318,546	16,718	1,809,635	81.5%	79.3%
201205	21,828	4,134	11,108	7,578	20,871	18,563	12,697	3,123	3,145	0	1,422,236	326,612	18,782	1,870,678	81.5%	79.6%
201206	19,212	4,378	10,707	8,116	19,192	33,815	13,967	3,770	8,659	0	1,392,021	288,247	18,361	1,820,445	83.2%	80.0%
201207	18,295	4,014	10,589	7,053	23,098	33,820	13,202	4,897	8,703	0	1,377,538	290,804	18,031	1,810,045	82.9%	80.4%
201208	23,234	4,106	11,052	9,045	21,153	34,659	14,587	4,041	7,217	750	1,455,628	296,639	18,231	1,900,342	83.4%	80.8%
201209	19,733	4,659	10,740	7,677	19,937	33,388	14,986	3,900	8,386	1,980	1,348,623	276,196	16,834	1,767,038	83.4%	81.2%
201210	21,692	4,619	12,195	8,777	22,849	38,155	16,041	4,183	8,051	2,700	1,518,269	311,987	19,313	1,988,832	83.3%	81.6%
201211	21,464	4,949	11,799	8,763	22,576	35,438	15,401	3,300	7,905	2,430	1,451,234	301,841	17,010	1,904,109	83.3%	81.9%
201212	21,424	6,084	12,245	8,632	23,964	39,557	17,952	4,622	8,866	2,100	1,505,538	329,328	18,769	1,999,081	82.6%	82.3%
201301	21,374	4,497	11,576	8,490	23,455	37,408	15,768	3,804	7,410	2,731	1,485,571	286,375	18,757	1,927,215	84.2%	82.6%
201302	20,397	5,549	11,499	8,398	21,434	34,895	14,008	3,368	7,202	2,070	1,376,912	272,888	16,282	1,794,901	83.9%	82.8%
201303	22,123	7,298	11,542	8,281	24,255	41,275	16,702	4,366	7,451	1,770	1,450,783	277,613	18,983	1,892,443	84.3%	83.1%
201304	21,526	4,477	11,579	7,951	25,343	39,357	16,802	4,406	7,654	2,953	1,495,270	285,432	18,695	1,941,446	84.3%	83.4%
201305	21,587	6,195	12,744	8,621	24,042	42,402	15,651	3,718	9,049	2,536	1,495,541	288,059	19,655	1,949,799	84.2%	83.6%
201306	21,505	5,911	10,140	9,731	25,181	42,038	14,700	3,507	7,894	1,972	1,418,451	275,013	18,473	1,854,515	84.2%	83.7%
201307	22,227	5,361	11,906	8,169	26,869	43,272	18,509	3,366	8,266	2,461	1,515,089	291,050	19,637	1,976,182	84.3%	83.8%
201308	22,819	7,063	12,098	8,450	24,130	42,121	18,606	4,256	8,005	1,966	1,529,694	301,634	19,293	2,000,137	84.0%	83.8%
201309	21,684	5,753	12,103	9,345	26,221	44,417	17,256	3,780	9,063	2,102	1,473,011	290,921	18,760	1,934,416	84.0%	83.9%
201310	24,505	5,664	12,614	9,955	26,430	45,079	16,967	4,116	8,341	2,283	1,584,157	320,570	19,967	2,080,648	83.6%	83.9%
201311	20,836	5,515	12,005	7,666	25,607	40,593	18,554	4,071	8,471	2,378	1,487,832	295,173	19,850	1,948,549	83.8%	83.9%
201312	25,192	7,085	13,094	10,463	29,033	53,382	20,088	4,896	9,678	2,383	1,685,971	340,655	24,039	2,225,959	83.6%	84.0%
201401	21,018	4,483	11,033	9,165	23,328	38,955	15,504	3,686	7,506	2,022	1,370,263	236,901	15,390	1,759,253	85.7%	84.1%
201402	19,702	4,910	10,385	6,676	23,410	43,244	16,712	1,933	6,347	2,634	1,311,656	229,395	17,567	1,694,571	85.4%	84.3%
201403	20,862	6,555	11,419	9,879	29,414	49,410	17,314	4,187	7,283	3,003	1,574,276	255,513	16,159	2,005,275	86.5%	84.4%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

EXHIBIT 3C

PHARMACY TREND DEVELOPMENT
BRAND GOING OFF PATENT IN THE PROJECTION PERIOD

Brand Name	Patent Expiration Date	Percent of Total Brand Days Supply
DIOVAN	March 2014	0.91%
EVISTA	March 2014	0.32%
DETROL	March 2014	0.13%
NEXIUM	May 2014	1.53%
RESTASIS	May 2014	0.47%
LUNESTA	May 2014	0.47%
LUMIGAN	August 2014	0.23%
COMBIPATCH	August 2014	0.11%
OXYCONTIN	October 2014	0.77%
INTUNIV	December 2014	0.16%
NAMENDA	January 2015	0.16%
WELCHOL	March 2015	0.14%
ABILIFY	April 2015	1.04%
EPIPEN	June 2015	0.14%
ANDROGEL	August 2015	0.69%
ORTHO EVRA PATCH	November 2015	0.34%
CELEBREX	December 2015	1.50%
ORTHO TRI-CYCLEN LO TABLE	December 2015	1.04%
PATANOL	December 2015	0.15%
AVODART	December 2015	0.13%
Others		1.33%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

PHARMACY TREND DEVELOPMENT
GENERIC DISPENSING RATE DEVELOPMENT

date	rx_cat	_201301	_201302	_201303	_201304	_201305	_201306	_201307	_201308	_201309	_201310	_201311	_201312	CY Average	_201401	_201402	_201403	_201404	_201405	_201406
201301	ALL	747	133	68	143	61	63	142	31	68	103	63	102	144						
201302	ALL	30	30	0	0	0	0	0	0	0	0	0	0	5						
201303	ALL	445	637	577	593	607	485	650	537	601	372	758	823	591						
201304	ALL	246	120	129	94	3	32	262	57	82	145	74	126	114						
201305	ALL	489	655	332	616	798	173	192	304	39	207	83	175	339						
201306	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0						
201307	ALL	510	464	895	420	420	810	330	480	494	344	548	601	527						
201308	ALL	180	150	210	90	90	90	70	60	0	0	0	0	78	78					
201309	ALL	2,253	2,033	2,490	2,193	2,801	2,323	2,506	2,961	1,780	571	451	225	1,882	1,882	1,882				
201310	ALL	192	123	185	196	132	110	121	161	106	109	62	0	125	125	125	125			
201311	ALL	3,493	3,864	3,777	4,364	4,467	3,734	3,372	4,183	3,576	4,484	2,010	779	3,509	3,509	3,509	3,509	3,509		
201312	ALL	8,479	9,035	10,079	8,732	9,597	8,161	8,757	10,097	8,532	9,800	8,972	6,614	8,904	8,904	8,904	8,904	8,904	8,904	
201401	ALL	2,072	1,932	1,310	1,737	1,669	1,721	2,243	1,729	1,169	533	651	623	1,449	1,449	1,449	1,449	1,449	1,449	1,449
201402	ALL	90	0	0	90	0	90	0	0	0	0	0	0	23	23	23	23	23	23	23
201403	ALL	3,666	4,520	4,601	3,461	4,429	4,026	3,261	4,625	3,993	3,553	3,803	4,774	4,059	4,059	4,059	4,059	4,059	4,059	4,059
201404	ALL	457	406	170	399	583	248	435	335	511	261	584	726	426	426	426	426	426	426	426
201405	ALL	6,912	6,092	6,502	6,780	7,331	6,777	7,480	8,089	6,350	7,699	7,696	9,480	7,266	7,266	7,266	7,266	7,266	7,266	7,266
201406	ALL	409	60	141	173	248	174	605	322	332	246	131	550	283	283	283	283	283	283	283
201407	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201408	ALL	776	562	1,014	1,035	1,060	915	1,201	682	1,376	1,304	734	1,382	1,004	1,004	1,004	*1,004*	1,004	1,004	1,004
201409	ALL	344	456	444	389	210	220	313	190	259	388	192	493	325	325	325	325	325	325	325
201410	ALL	2,907	2,552	2,906	2,748	2,916	2,813	3,035	2,501	3,003	2,969	2,724	3,085	2,847	2,847	2,847	2,847	2,847	2,847	2,847
201411	ALL	0	0	0	5	0	5	0	0	0	0	0	40	4	4	4	4	4	4	4
201412	ALL	360	296	490	660	480	480	690	358	731	449	519	268	482	482	482	482	482	482	482
201501	ALL	462	360	330	600	360	525	330	330	508	511	631	601	462	462	462	462	462	462	462
201502	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201503	ALL	480	360	285	420	330	330	450	450	240	390	300	811	404	404	404	404	404	404	404
201504	ALL	2,835	2,956	2,498	2,945	3,207	2,621	4,046	3,153	3,129	3,428	3,106	3,052	3,081	3,081	3,081	3,081	3,081	3,081	3,081
201505	ALL	14	10	58	60	21	10	10	14	10	28	21	23	23	23	23	23	23	23	23
201506	ALL	336	193	414	496	595	336	410	1,044	449	531	383	274	455	455	455	455	455	455	455
201507	ALL	210	150	150	60	270	242	120	32	126	61	211	121	146	146	146	146	146	146	146
201508	ALL	1,950	1,775	2,028	2,152	1,740	2,052	2,058	1,927	1,797	2,153	2,234	2,521	2,032	2,032	2,032	2,032	2,032	2,032	2,032
201509	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201510	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201511	ALL	1,208	953	972	678	1,182	1,310	839	1,781	850	1,125	1,532	1,348	1,148	1,148	1,148	1,148	1,148	1,148	1,148
201512	ALL	8,496	7,253	8,326	8,216	8,011	10,150	8,906	8,091	9,343	9,187	8,031	9,540	8,629	8,629	8,629	8,629	8,629	8,629	8,629
	Brand	235,333	224,768	226,266	234,914	234,469	223,984	238,244	247,136	241,526	269,764	248,744	291,585	243,061	243,061	243,061	243,061	243,061	243,061	243,061
	Generic	1,622,076	1,505,719	1,595,813	1,637,290	1,642,055	1,561,029	1,665,465	1,679,180	1,624,675	1,739,963	1,633,451	1,861,177	1,647,325	1,649,043	1,649,122	1,651,004	1,651,129	1,654,637	1,663,542
	Total	**1,908,457**	**1,778,619**	**1,873,460**	**1,922,752**	**1,930,145**	**1,836,042**	**1,956,545**	**1,980,844**	**1,915,656**	**2,060,681**	**1,928,700**	**2,201,920**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**
Monthly GDR		85.0%	84.7%	85.2%	85.2%	85.1%	85.0%	85.1%	84.8%	84.8%	84.4%	84.7%	84.5%		85.0%	85.0%	85.1%	85.1%	85.2%	85.7%
Rolling 12													84.9%		84.9%	84.9%	84.9%	84.9%	84.9%	84.9%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

PHARMACY TREND DEVELOPMENT
GENERIC DISPENSING RATE DEVELOPMENT

date	rx_cat	_201407	_201408	_201409	_201410	_201411	_201412	_201501	_201502	_201503	_201504	_201505	_201506	_201507	_201508	_201509	_201510	_201511	_201512
201301	ALL																		
201302	ALL																		
201303	ALL																		
201304	ALL																		
201305	ALL																		
201306	ALL																		
201307	ALL																		
201308	ALL																		
201309	ALL																		
201310	ALL																		
201311	ALL																		
201312	ALL																		
201401	ALL																		
201402	ALL	23																	
201403	ALL	4,059	4,059																
201404	ALL	426	426	426															
201405	ALL	7,266	7,266	7,266	7,266														
201406	ALL	283	283	283	283	283													
201407	ALL	0	0	0	0	0	0												
201408	ALL	1,004	1,004	1,004	1,004	1,004	1,004	1,004											
201409	ALL	325	325	325	325	325	325	325	325										
201410	ALL	2,847	2,847	2,847	2,847	2,847	2,847	2,847	2,847	2,847									
201411	ALL	4	4	4	4	4	4	4	4	4	4								
201412	ALL	482	482	482	482	482	482	482	482	482	482	482							
201501	ALL	462	462	462	462	462	462	462	462	462	462	462	462						
201502	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0					
201503	ALL	404	404	404	404	404	404	404	404	404	404	404	404	404	404				
201504	ALL	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081	3,081			
201505	ALL	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23	23		
201506	ALL	455	455	455	455	455	455	455	455	455	455	455	455	455	455	455	455	455	
201507	ALL	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146	146
201508	ALL	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032
201509	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201510	ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201511	ALL	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148	1,148
201512	ALL	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629	8,629
	Brand	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061	243,061
	Generic	1,664,991	1,665,013	1,669,073	1,669,499	1,676,765	1,677,047	1,677,047	1,678,051	1,678,376	1,681,222	1,681,227	1,681,708	1,682,171	1,682,171	1,682,575	1,685,656	1,685,679	1,686,135
	Total	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**	**1,941,152**
Monthly GDR		85.8%	85.8%	86.0%	86.0%	86.4%	86.4%	86.4%	86.4%	86.5%	86.6%	86.6%	86.6%	86.7%	86.7%	86.7%	86.8%	86.8%	86.9%
Rolling 12		85.0%	85.1%	85.1%	85.3%	85.4%	85.6%	85.7%	85.9%	86.0%	86.1%	86.2%	86.3%	86.4%	86.4%	86.5%	86.6%	86.6%	**86.6%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

EXHIBIT 3E

PHARMACY TREND DEVELOPMENT
NON-SPECIALTY DRUG TREND

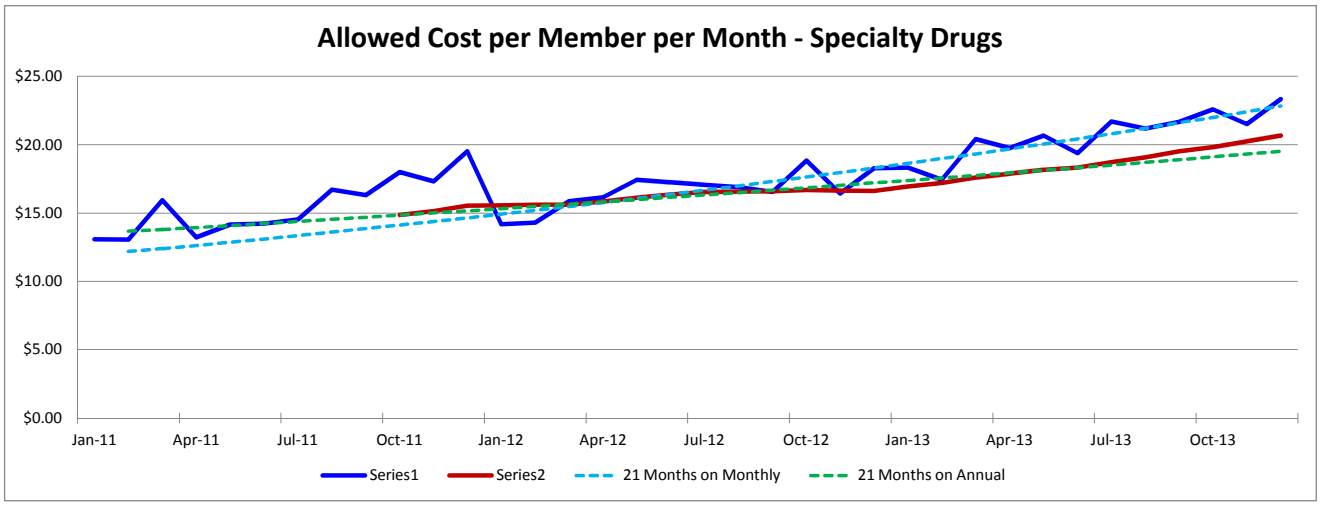
For the 12 months ending December 2013:		**Generic**	**Brand**	**Non-Specialty Total**
# Days Supply	a	19,768,438	3,525,383	23,293,820
Allowed Charge per Supply	b	$0.81	$6.89	
Total Allowed Charges	c=a*b	$16,004,521	$24,291,157	$40,295,678
Utilization Trends	d			**3.8%**
Projected # Days Supply (1 yr)	e=a*(1+d)			24,171,955
Projected Rolling-12 dispensing rate (Generic and Brand split)	f	**86.6%**	**13.4%**	
Non-Specialty Projected # Days Supply: Generic and Brand	g=e*f	20,942,843	3,229,112	
Utilization Trends: Generic and Brand	h=g/a-1	**5.9%**	**-8.4%**	
Calculated Annual Trend		*5.0%*	*13.1%*	
Contract Change for FY 2015		*0.9771*	*0.9973*	
Adjusted Annual Trend		*2.6%*	*12.8%*	
Cost Trends	i	**5.3%**	**27.3%**	
Projected Allowed Charge per Supply	j=b*(1+i)	$0.85	$8.77	
Projected Total Allowed Charges	k=g*j	$17,856,041	$28,324,147	*$46,180,188*
Total Trends - 2 years	l=k/c-1	**11.6%**	**16.6%**	***14.6%***
Annual Trend		**5.6%**	**8.0%**	**7.1%**
PMPM Calculation				
Member Months for the 12 months ending November 2013	m			729,421
PMPM by category	n=c/m	$21.94	$33.30	$55.24

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

EXHIBIT 3F

PHARMACY TREND DEVELOPMENT
SPECIALTY DRUGS - TOTAL TREND

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Members	Allowed Charge	PMPM	Monthly Trend	Members	Allowed Charge	PMPM	Rolling 12 Trend	Monthly Data	Rolling 12 Data
Nov-10	37,896	$526,408	$13.89							
Dec-10	37,708	$559,830	$14.85							
Jan-11	40,728	$532,878	$13.08							
Feb-11	41,137	$537,616	$13.07						$12.19	$13.66
Mar-11	41,544	$662,601	$15.95						$12.39	$13.79
Apr-11	41,847	$553,873	$13.24						$12.63	$13.94
May-11	42,167	$597,594	$14.17						$12.86	$14.09
Jun-11	42,279	$601,958	$14.24						$13.11	$14.24
Jul-11	42,536	$618,423	$14.54						$13.35	$14.39
Aug-11	42,651	$713,085	$16.72						$13.60	$14.54
Sep-11	42,862	$699,431	$16.32						$13.86	$14.70
Oct-11	42,747	$769,604	$18.00		496,102	$7,373,300	$14.86		$14.11	$14.85
Nov-11	42,728	$740,057	$17.32		500,934	$7,586,949	$15.15		$14.38	$15.01
Dec-11	42,763	$834,801	$19.52	31.5%	505,989	$7,861,920	$15.54		$14.65	$15.17
Jan-12	60,442	$857,027	$14.18	8.4%	525,703	$8,186,069	$15.57		$14.92	$15.33
Feb-12	60,483	$865,078	$14.30	9.4%	545,049	$8,513,531	$15.62		$15.21	$15.49
Mar-12	60,785	$964,067	$15.86	-0.6%	564,290	$8,814,997	$15.62		$15.48	$15.65
Apr-12	60,990	$985,265	$16.15	22.1%	583,433	$9,246,389	$15.85		$15.77	$15.82
May-12	60,929	$1,062,224	$17.43	23.0%	602,195	$9,711,019	$16.13		$16.06	$15.98
Jun-12	60,891	$1,050,184	$17.25	21.1%	620,807	$10,159,245	$16.36		$16.37	$16.15
Jul-12	60,850	$1,038,425	$17.07	17.4%	639,121	$10,579,248	$16.55		$16.67	$16.32
Aug-12	60,836	$1,027,878	$16.90	1.1%	657,306	$10,894,041	$16.57		$16.99	$16.50
Sep-12	61,055	$1,011,023	$16.56	1.5%	675,499	$11,205,633	$16.59		$17.31	$16.67
Oct-12	60,917	$1,147,616	$18.84	4.6%	693,669	$11,583,645	$16.70		$17.63	$16.85
Nov-12	61,059	$1,003,570	$16.44	-5.1%	712,000	$11,847,159	$16.64	9.9%	$17.96	$17.03
Dec-12	61,186	$1,119,152	$18.29	-6.3%	730,423	$12,131,509	$16.61	6.9%	$18.29	$17.21
Jan-13	60,791	$1,114,776	$18.34	29.3%	730,772	$12,389,258	$16.95	8.9%	$18.64	$17.39
Feb-13	60,577	$1,056,432	$17.44	21.9%	730,866	$12,580,612	$17.21	10.2%	$18.99	$17.58
Mar-13	60,635	$1,236,943	$20.40	28.6%	730,716	$12,853,488	$17.59	12.6%	$19.32	$17.75
Apr-13	60,560	$1,196,841	$19.76	22.3%	730,286	$13,065,064	$17.89	12.9%	$19.69	$17.94
May-13	60,431	$1,249,468	$20.68	18.6%	729,788	$13,252,309	$18.16	12.6%	$20.05	$18.12
Jun-13	60,739	$1,177,350	$19.38	12.4%	729,636	$13,379,474	$18.34	12.1%	$20.43	$18.32
Jul-13	61,204	$1,328,247	$21.70	27.2%	729,990	$13,669,296	$18.73	13.1%	$20.81	$18.51
Aug-13	61,332	$1,298,459	$21.17	25.3%	730,486	$13,939,878	$19.08	15.1%	$21.20	$18.71
Sep-13	61,148	$1,325,112	$21.67	30.9%	730,579	$14,253,966	$19.51	17.6%	$21.60	$18.91
Oct-13	60,840	$1,374,682	$22.60	19.9%	730,502	$14,481,032	$19.82	18.7%	$22.00	$19.11
Nov-13	60,849	$1,308,655	$21.51	30.8%	730,292	$14,786,117	$20.25	21.7%	$22.42	$19.31
Dec-13	60,315	$1,407,043	$23.33	27.5%	729,421	$15,074,008	$20.67	24.4%	$22.83	$19.51
								Exponential Trend:	24.8%	13.4%



BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

MEDICAL TREND DEVELOPMENT
ILLUSTRATION OF CONTRACT NORMALIZATION

Month	Contract Increase	Normalization Factor	Experience Claims	Normalized Claims
Jan-10		1.1699	$1,000,000	$1,169,859
Feb-10		1.1699	$1,000,000	$1,169,859
Mar-10		1.1699	$1,000,000	$1,169,859
Apr-10		1.1699	$1,000,000	$1,169,859
May-10		1.1699	$1,000,000	$1,169,859
Jun-10		1.1699	$1,000,000	$1,169,859
Jul-10		1.1699	$1,000,000	$1,169,859
Aug-10		1.1699	$1,000,000	$1,169,859
Sep-10		1.1699	$1,000,000	$1,169,859
Oct-10	1.0400	1.1249	$1,000,000	$1,124,864
Nov-10		1.1249	$1,000,000	$1,124,864
Dec-10		1.1249	$1,000,000	$1,124,864
Jan-11		1.1249	$1,000,000	$1,124,864
Feb-11		1.1249	$1,000,000	$1,124,864
Mar-11		1.1249	$1,000,000	$1,124,864
Apr-11		1.1249	$1,000,000	$1,124,864
May-11		1.1249	$1,000,000	$1,124,864
Jun-11		1.1249	$1,000,000	$1,124,864
Jul-11		1.1249	$1,000,000	$1,124,864
Aug-11		1.1249	$1,000,000	$1,124,864
Sep-11		1.1249	$1,000,000	$1,124,864
Oct-11	1.0400	1.0816	$1,000,000	$1,081,600
Nov-11		1.0816	$1,000,000	$1,081,600
Dec-11		1.0816	$1,000,000	$1,081,600
Jan-12		1.0816	$1,000,000	$1,081,600
Feb-12		1.0816	$1,000,000	$1,081,600
Mar-12		1.0816	$1,000,000	$1,081,600
Apr-12		1.0816	$1,000,000	$1,081,600
May-12		1.0816	$1,000,000	$1,081,600
Jun-12		1.0816	$1,000,000	$1,081,600
Jul-12		1.0816	$1,000,000	$1,081,600
Aug-12		1.0816	$1,000,000	$1,081,600
Sep-12		1.0816	$1,000,000	$1,081,600
Oct-12	1.0400	1.0400	$1,000,000	$1,040,000
Nov-12		1.0400	$1,000,000	$1,040,000
Dec-12		1.0400	$1,000,000	$1,040,000
Jan-13		1.0400	$1,000,000	$1,040,000
Feb-13		1.0400	$1,000,000	$1,040,000
Mar-13		1.0400	$1,000,000	$1,040,000
Apr-13		1.0400	$1,000,000	$1,040,000
May-13		1.0400	$1,000,000	$1,040,000
Jun-13		1.0400	$1,000,000	$1,040,000
Jul-13		1.0400	$1,000,000	$1,040,000
Aug-13		1.0400	$1,000,000	$1,040,000
Sep-13		1.0400	$1,000,000	$1,040,000
Oct-13	1.0400	1.0000	$1,000,000	$1,000,000
Nov-13		1.0000	$1,000,000	$1,000,000
Dec-13		1.0000	$1,000,000	$1,000,000

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

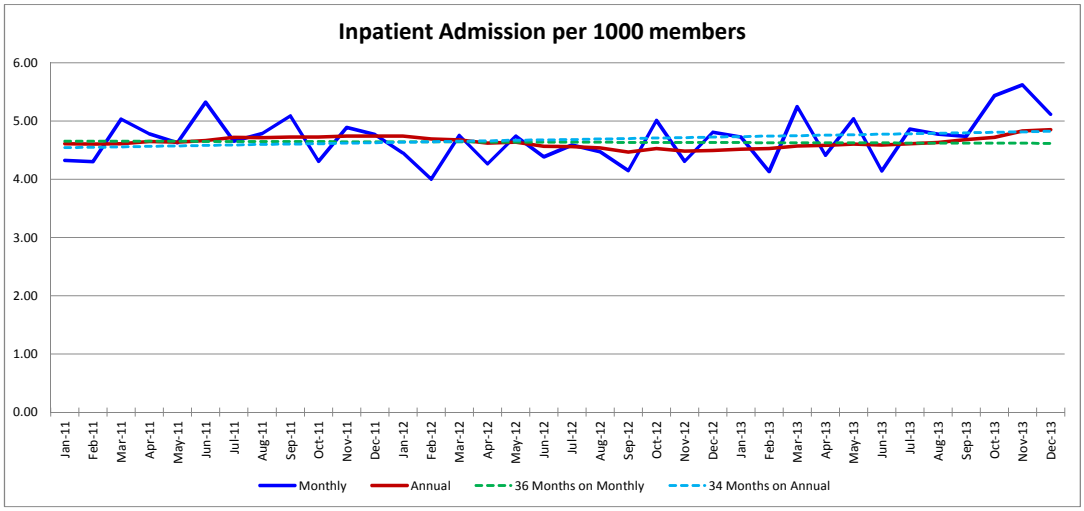
MEDICAL TREND DEVELOPMENT
UTILIZATION TREND CALCULATION

Month	Membership	Original Claims	Original PMPM	Adjusted Claims - Normalized for Contract Changes	Adjusted PMPM	Regression on Adjusted PMPM - 36 Months - Incl. Q4 2013	Regression on Adjusted PMPM - 24 Months - Incl. Q4 2013	Regression on Adjusted PMPM - 36 Months - Excl. Q4 2013	Regression on Adjusted PMPM - 24 Months - Excl. Q4 2013
Jan-10	37,505	$12,606,699	$336.13	$15,402,614	$410.68	$408.94	$376.24	$429.79	$449.39
Feb-10	37,454	$13,149,674	$351.09	$16,041,023	$428.29	$409.18	$377.28	$429.19	$448.18
Mar-10	37,460	$13,889,073	$370.77	$16,905,585	$451.30	$409.41	$378.22	$428.65	$447.10
Apr-10	37,594	$13,217,386	$351.58	$16,033,443	$426.49	$409.66	$379.26	$428.05	$445.90
May-10	37,802	$13,034,972	$344.82	$15,814,532	$418.35	$409.90	$380.27	$427.47	$444.74
Jun-10	37,461	$13,637,212	$364.04	$16,529,612	$441.25	$410.14	$381.31	$426.87	$443.55
Jul-10	37,547	$12,762,000	$339.89	$15,395,708	$410.04	$410.38	$382.33	$426.30	$442.40
Aug-10	37,491	$12,666,344	$337.85	$15,259,237	$407.01	$410.63	$383.38	$425.70	$441.21
Sep-10	37,394	$13,327,917	$356.42	$16,171,708	$432.47	$410.88	$384.43	$425.11	$440.03
Oct-10	37,710	$13,173,106	$349.33	$15,603,888	$413.79	$411.12	$385.45	$424.53	$438.89
Nov-10	37,896	$14,501,166	$382.66	$17,056,102	$450.08	$411.37	$386.51	$423.94	$437.71
Dec-10	37,708	$14,246,280	$377.81	$16,717,490	$443.34	$411.61	$387.54	$423.37	$436.58
Jan-11	40,728	$14,441,620	$354.59	$16,912,793	$415.26	$411.86	$388.61	$422.77	$435.41
Feb-11	41,137	$12,824,858	$311.76	$15,024,179	$365.22	$412.11	$389.68	$422.18	$434.24
Mar-11	41,544	$16,392,613	$394.58	$19,130,428	$460.49	$412.34	$390.65	$421.65	$433.19
Apr-11	41,847	$14,516,545	$346.90	$16,870,367	$403.14	$412.59	$391.72	$421.06	$432.03
May-11	42,167	$14,628,302	$346.91	$16,954,423	$402.08	$412.83	$392.76	$420.49	$430.90
Jun-11	42,279	$15,949,514	$377.24	$18,366,065	$434.40	$413.08	$393.84	$419.91	$429.75
Jul-11	42,536	$14,059,624	$330.53	$16,186,804	$380.54	$413.32	$394.89	$419.34	$428.63
Aug-11	42,651	$15,399,452	$361.06	$17,705,701	$415.13	$413.57	$395.98	$418.75	$427.48
Sep-11	42,862	$16,615,002	$387.64	$19,217,676	$448.36	$413.82	$397.07	$418.17	$426.34
Oct-11	42,747	$16,180,220	$378.51	$18,176,370	$425.21	$414.06	$398.12	$417.61	$425.23
Nov-11	42,728	$17,500,951	$409.59	$19,247,184	$450.46	$414.32	$399.22	$417.02	$424.09
Dec-11	42,763	$17,829,761	$416.94	$19,584,369	$457.97	$414.56	$400.28	$416.46	$422.99
Jan-12	60,442	$22,163,320	$366.69	$24,339,403	$402.69	$414.81	$401.38	$415.88	$421.86
Feb-12	60,483	$22,467,449	$371.47	$24,696,222	$408.32	$415.06	$402.49	$415.30	$420.73
Mar-12	60,785	$24,333,520	$400.32	$26,595,390	$437.53	$415.30	$403.52	$414.75	$419.67
Apr-12	60,990	$22,905,142	$375.56	$25,029,648	$410.39	$415.55	$404.63	$414.18	$418.55
May-12	60,929	$25,347,817	$416.02	$27,698,759	$454.61	$415.79	$405.71	$413.62	$417.46
Jun-12	60,891	$21,695,230	$356.30	$23,594,404	$387.49	$416.04	$406.82	$413.04	$416.34
Jul-12	60,850	$21,706,396	$356.72	$23,529,826	$386.69	$416.29	$407.91	$412.48	$415.26
Aug-12	60,836	$22,856,139	$375.70	$24,664,068	$405.42	$416.54	$409.03	$411.90	$414.15
Sep-12	61,055	$19,577,489	$320.65	$21,087,935	$345.39	$416.79	$410.15	$411.33	$413.04
Oct-12	60,917	$24,927,324	$409.20	$26,630,533	$437.16	$417.04	$411.24	$410.77	$411.96
Nov-12	61,059	$24,463,339	$400.65	$26,075,658	$427.06	$417.29	$412.38	$410.20	$410.86
Dec-12	61,186	$24,770,501	$404.84	$25,427,530	$415.58	$417.53	$413.47	$409.65	$409.79
Jan-13	60,791	$24,880,630	$409.28	$25,462,088	$418.85	$417.79	$414.61	$409.07	$408.69
Feb-13	60,577	$22,053,796	$364.06	$22,560,852	$372.43	$418.04	$415.75	$408.50	$407.60
Mar-13	60,635	$24,381,976	$402.11	$24,890,465	$410.50	$418.27	$416.78	$407.99	$406.61
Apr-13	60,560	$25,323,385	$418.15	$25,805,368	$426.11	$418.52	$417.93	$407.42	$405.52
May-13	60,431	$25,719,131	$425.59	$26,206,650	$433.66	$418.77	$419.04	$406.87	$404.47
Jun-13	60,739	$23,270,802	$383.13	$23,650,129	$389.37	$419.02	$420.19	$406.30	$403.38
Jul-13	61,204	$24,488,474	$400.11	$24,799,878	$405.20	$419.26	$421.31	$405.75	$402.34
Aug-13	61,332	$24,111,049	$393.12	$24,362,488	$397.22	$419.52	$422.47	$405.18	$401.26
Sep-13	61,148	$25,138,420	$411.11	$25,368,247	$414.87	$419.77	$423.63	$404.62	$400.18
Oct-13	60,840	$29,176,396	$479.56	$29,297,871	$481.56	$420.02	$424.76	$404.07	$399.15
Nov-13	60,849	$26,631,687	$437.67	$26,678,535	$438.44	$420.27	$425.93	$403.51	$398.07
Dec-13	60,315	$27,345,508	$453.38	$27,345,508	$453.38	$420.52	$427.06	$402.96	$397.04
				Annual Increase		0.7%	3.3%	-1.6%	-3.1%

MEDICAL TREND DEVELOPMENT

Inpatient Admissions per 1000 members

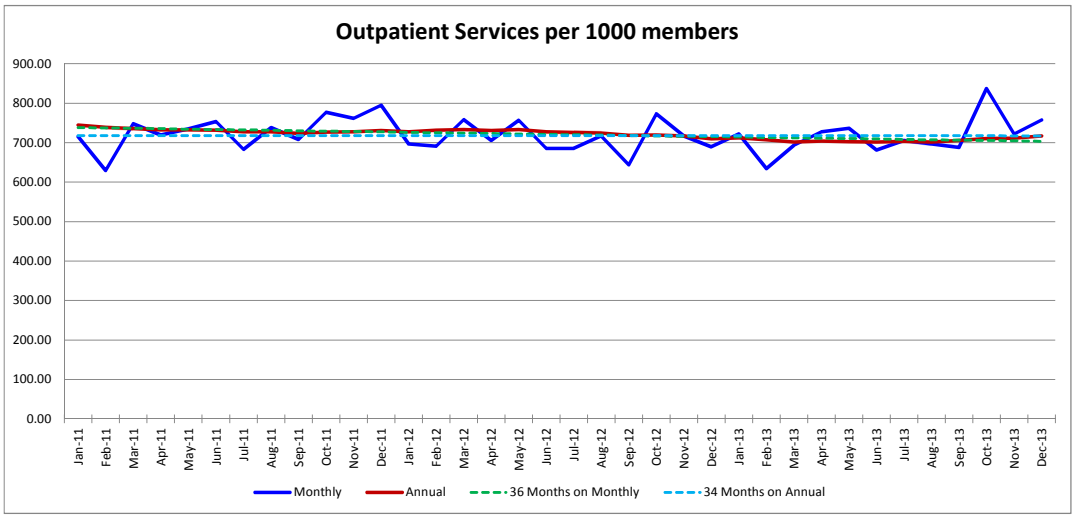
	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Admissions	Members	Admission per 1000 members	Monthly Utilization Trend	Admissions	Members	Admission per 1000 members	Annual Utilization Trend	Monthly Data	Rolling 12 Data
Jan-10	160	37,505	4.27							
Feb-10	165	37,454	4.41							
Mar-10	186	37,460	4.97							
Apr-10	164	37,594	4.36							
May-10	180	37,802	4.76							
Jun-10	188	37,461	5.02							
Jul-10	149	37,547	3.97							
Aug-10	181	37,491	4.83							
Sep-10	187	37,394	5.00							
Oct-10	160	37,710	4.24							
Nov-10	179	37,896	4.72							
Dec-10	180	37,708	4.77		2,079	451,022	4.61		4.53	4.66
Jan-11	176	40,728	4.32		2,095	454,245	4.61		4.54	4.66
Feb-11	177	41,137	4.30		2,107	457,928	4.60		4.55	4.65
Mar-11	209	41,544	5.03		2,130	462,012	4.61		4.56	4.65
Apr-11	200	41,847	4.78		2,166	466,265	4.65		4.56	4.65
May-11	195	42,167	4.62		2,181	470,630	4.63		4.57	4.65
Jun-11	225	42,279	5.32		2,218	475,448	4.67		4.58	4.65
Jul-11	198	42,536	4.65		2,267	480,437	4.72		4.59	4.65
Aug-11	204	42,651	4.78		2,290	485,597	4.72		4.60	4.65
Sep-11	218	42,862	5.09		2,321	491,065	4.73		4.60	4.65
Oct-11	184	42,747	4.30		2,345	496,102	4.73		4.61	4.65
Nov-11	209	42,728	4.89		2,375	500,934	4.74		4.62	4.64
Dec-11	204	42,763	4.77		2,399	505,989	4.74		4.63	4.64
Jan-12	269	60,442	4.45	3.0%	2,492	525,703	4.74		4.64	4.64
Feb-12	242	60,483	4.00	-7.0%	2,557	545,049	4.69		4.64	4.64
Mar-12	289	60,785	4.75	-5.5%	2,637	564,290	4.67		4.65	4.64
Apr-12	260	60,990	4.26	-10.8%	2,697	583,433	4.62		4.66	4.64
May-12	289	60,929	4.74	2.6%	2,791	602,195	4.63		4.67	4.64
Jun-12	267	60,891	4.38	-17.6%	2,833	620,807	4.56		4.68	4.64
Jul-12	279	60,850	4.59	-1.5%	2,914	639,121	4.56		4.68	4.64
Aug-12	272	60,836	4.47	-6.5%	2,982	657,306	4.54		4.69	4.63
Sep-12	253	61,055	4.15	-18.5%	3,017	675,499	4.47		4.70	4.63
Oct-12	305	60,917	5.01	16.4%	3,138	693,669	4.52		4.71	4.63
Nov-12	263	61,059	4.31	-11.9%	3,192	712,000	4.48		4.72	4.63
Dec-12	294	61,186	4.81	0.8%	3,283	730,423	4.49	-5.2%	4.72	4.63
Jan-13	287	60,791	4.72	6.1%	3,301	730,772	4.52	-4.7%	4.73	4.63
Feb-13	250	60,577	4.13	3.2%	3,309	730,866	4.53	-3.5%	4.74	4.63
Mar-13	318	60,635	5.25	10.4%	3,338	730,716	4.57	-2.2%	4.75	4.63
Apr-13	267	60,560	4.41	3.5%	3,345	730,286	4.58	-0.9%	4.76	4.63
May-13	304	60,431	5.04	6.2%	3,361	729,788	4.61	-0.6%	4.76	4.62
Jun-13	252	60,739	4.14	-5.6%	3,345	729,636	4.58	0.5%	4.77	4.62
Jul-13	297	61,204	4.86	6.0%	3,364	729,990	4.61	1.1%	4.78	4.62
Aug-13	293	61,332	4.77	6.7%	3,384	730,486	4.63	2.1%	4.79	4.62
Sep-13	289	61,148	4.73	14.2%	3,421	730,579	4.68	4.8%	4.80	4.62
Oct-13	330	60,840	5.43	8.5%	3,446	730,502	4.72	4.3%	4.81	4.62
Nov-13	342	60,849	5.62	30.4%	3,525	730,292	4.83	7.6%	4.81	4.62
Dec-13	308	60,315	5.11	6.3%	3,539	729,421	4.85	8.0%	4.82	4.62
								Exponential Trend:	2.1%	-0.3%



MEDICAL TREND DEVELOPMENT

Outpatient Services per 1000 members

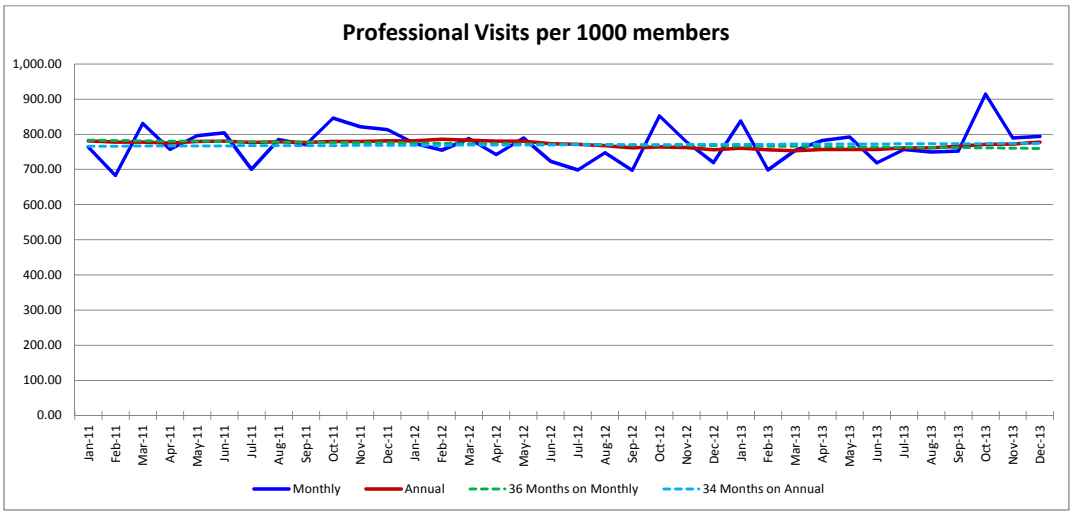
	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Services	Members	Service per 1000 members	Monthly Utilization Trend	Services	Members	Service per 1000 members	Annual Utilization Trend	Monthly Data	Rolling 12 Data
Jan-10	26,064	37,505	694.95							
Feb-10	25,668	37,454	685.32							
Mar-10	29,576	37,460	789.54							
Apr-10	28,560	37,594	759.70							
May-10	27,701	37,802	732.79							
Jun-10	29,024	37,461	774.78							
Jul-10	27,052	37,547	720.48							
Aug-10	27,867	37,491	743.30							
Sep-10	28,187	37,394	753.78							
Oct-10	28,067	37,710	744.29							
Nov-10	28,582	37,896	754.22							
Dec-10	28,852	37,708	765.14		335,200	451,022	743.20		718.06	739.31
Jan-11	29,141	40,728	715.50		338,277	454,245	744.70		718.04	738.27
Feb-11	25,889	41,137	629.34		338,498	457,928	739.19		718.02	737.24
Mar-11	31,073	41,544	747.95		339,995	462,012	735.90		718.00	736.30
Apr-11	30,095	41,847	719.17		341,530	466,265	732.48		717.98	735.27
May-11	30,987	42,167	734.86		344,816	470,630	732.67		717.96	734.27
Jun-11	31,852	42,279	753.38		347,644	475,448	731.19		717.94	733.24
Jul-11	29,051	42,536	682.97		349,643	480,437	727.76		717.92	732.24
Aug-11	31,474	42,651	737.94		353,250	485,597	727.46		717.90	731.21
Sep-11	30,352	42,862	708.13		355,415	491,065	723.76		717.88	730.19
Oct-11	33,211	42,747	776.92		360,559	496,102	726.78		717.86	729.19
Nov-11	32,531	42,728	761.35		364,508	500,934	727.66		717.84	728.17
Dec-11	34,004	42,763	795.18		369,661	505,989	730.57		717.82	727.18
Jan-12	42,095	60,442	696.46	-2.7%	382,615	525,703	727.82		717.80	726.16
Feb-12	41,787	60,483	690.89	9.8%	398,513	545,049	731.15		717.78	725.14
Mar-12	46,105	60,785	758.50	1.4%	413,546	564,290	732.86	-0.4%	717.76	724.19
Apr-12	43,048	60,990	705.83	-1.9%	426,499	583,433	731.02	-0.2%	717.74	723.17
May-12	46,089	60,929	756.44	2.9%	441,601	602,195	733.32	0.1%	717.72	722.19
Jun-12	41,709	60,891	684.99	-9.1%	451,458	620,807	727.21	-0.5%	717.69	721.17
Jul-12	41,712	60,850	685.49	0.4%	464,120	639,121	726.18	-0.2%	717.67	720.19
Aug-12	43,625	60,836	717.10	-2.8%	476,271	657,306	724.58	-0.4%	717.65	719.18
Sep-12	39,342	61,055	644.36	-9.0%	485,261	675,499	718.37	-0.7%	717.63	718.17
Oct-12	47,106	60,917	773.28	-0.5%	499,156	693,669	719.59	-1.0%	717.61	717.20
Nov-12	43,779	61,059	717.00	-5.8%	510,404	712,000	716.86	-1.5%	717.59	716.19
Dec-12	42,156	61,186	688.99	-13.4%	518,556	730,423	709.94	-2.8%	717.57	715.22
Jan-13	43,882	60,791	721.85	3.6%	520,342	730,772	712.04	-2.2%	717.55	714.21
Feb-13	38,406	60,577	634.01	-8.2%	516,961	730,866	707.33	-3.3%	717.53	713.21
Mar-13	42,023	60,635	693.05	-8.6%	512,880	730,716	701.89	-4.2%	717.51	712.31
Apr-13	44,075	60,560	727.79	3.1%	513,906	730,286	703.71	-3.7%	717.49	711.30
May-13	44,523	60,431	736.76	-2.6%	512,340	729,788	702.04	-4.3%	717.47	710.34
Jun-13	41,364	60,739	681.02	-0.6%	511,995	729,636	701.71	-3.5%	717.45	709.34
Jul-13	43,192	61,204	705.71	2.9%	513,475	729,990	703.40	-3.1%	717.43	708.38
Aug-13	42,717	61,332	696.49	-2.9%	512,567	730,486	701.68	-3.2%	717.41	707.38
Sep-13	42,061	61,148	687.86	6.8%	515,287	730,579	705.31	-1.8%	717.39	706.39
Oct-13	50,911	60,840	836.80	8.2%	519,092	730,502	710.60	-1.2%	717.37	705.43
Nov-13	43,901	60,849	721.48	0.6%	519,214	730,292	710.97	-0.8%	717.35	704.44
Dec-13	45,684	60,315	757.42	9.9%	522,742	729,421	716.65	0.9%	717.33	703.48
								Exponential Trend:	0.0%	-1.6%



MEDICAL TREND DEVELOPMENT

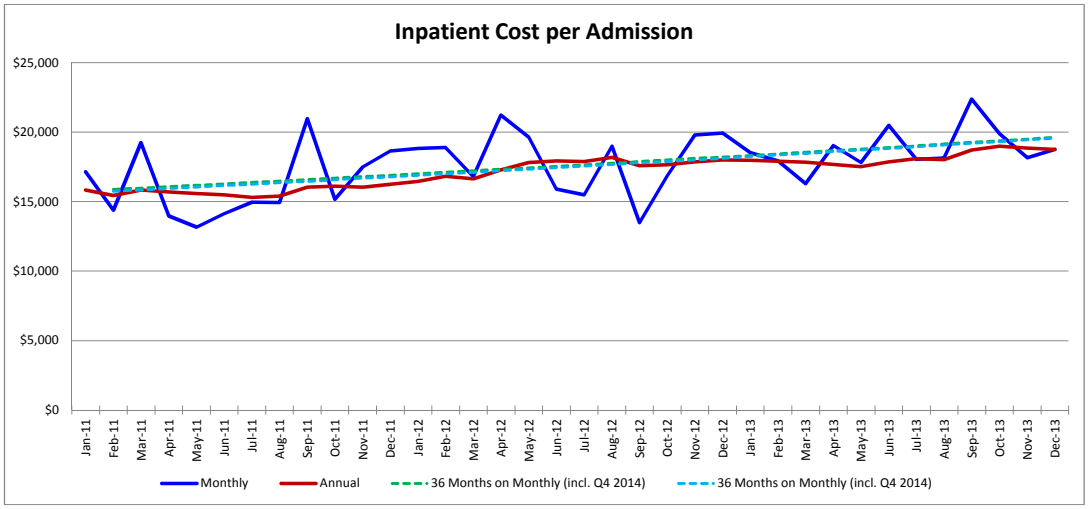
Professional Visits per 1000 members

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Visits	Members	Visits per 1000 members	Monthly Utilization Trend	Visits	Members	Visits per 1000 members	Annual Utilization Trend	Monthly Data	Rolling 12 Data
Jan-10	29,150	37,505	777.23							
Feb-10	26,636	37,454	711.17							
Mar-10	31,685	37,460	845.84							
Apr-10	29,347	37,594	780.63							
May-10	28,072	37,802	742.61							
Jun-10	30,019	37,461	801.34							
Jul-10	27,648	37,547	736.36							
Aug-10	28,606	37,491	763.01							
Sep-10	29,637	37,394	792.56							
Oct-10	30,955	37,710	820.87							
Nov-10	31,022	37,896	818.61							
Dec-10	30,142	37,708	799.35		352,919	451,022	782.49		765.82	783.46
Jan-11	31,133	40,728	764.41		354,902	454,245	781.30		766.05	782.79
Feb-11	28,083	41,137	682.67		356,349	457,928	778.18		766.28	782.11
Mar-11	34,508	41,544	830.64		359,172	462,012	777.41		766.48	781.50
Apr-11	31,660	41,847	756.57		361,485	466,265	775.28		766.71	780.83
May-11	33,573	42,167	796.19		366,986	470,630	779.78		766.93	780.17
Jun-11	33,998	42,279	804.14		370,965	475,448	780.24		767.16	779.50
Jul-11	29,803	42,536	700.65		373,120	480,437	776.63		767.39	778.85
Aug-11	33,489	42,651	785.19		378,003	485,597	778.43		767.61	778.18
Sep-11	33,032	42,862	770.66		381,398	491,065	776.68		767.84	777.50
Oct-11	36,181	42,747	846.40		386,624	496,102	779.32		768.07	776.85
Nov-11	35,091	42,728	821.27		390,693	500,934	779.93		768.30	776.18
Dec-11	34,768	42,763	813.05		395,320	505,989	781.28	-0.2%	768.52	775.53
Jan-12	46,781	60,442	773.99	1.3%	410,968	525,703	781.75	0.1%	768.75	774.86
Feb-12	45,669	60,483	755.08	10.6%	428,554	545,049	786.27	1.0%	768.98	774.20
Mar-12	47,894	60,785	787.93	-5.1%	441,941	564,290	783.18	0.7%	769.19	773.57
Apr-12	45,273	60,990	742.31	-1.9%	455,554	583,433	780.82	0.7%	769.42	772.90
May-12	48,108	60,929	789.58	-0.8%	470,089	602,195	780.63	0.1%	769.65	772.26
Jun-12	44,015	60,891	722.86	-10.1%	480,107	620,807	773.36	-0.9%	769.88	771.59
Jul-12	42,507	60,850	698.55	-0.3%	492,810	639,121	771.07	-0.7%	770.10	770.94
Aug-12	45,474	60,836	747.49	-4.8%	504,795	657,306	767.98	-1.3%	770.33	770.28
Sep-12	42,612	61,055	697.92	-9.4%	514,375	675,499	761.47	-2.0%	770.56	769.61
Oct-12	51,913	60,917	852.20	0.7%	530,107	693,669	764.21	-1.9%	770.78	768.97
Nov-12	47,530	61,059	778.42	-5.2%	542,546	712,000	762.00	-2.3%	771.02	768.31
Dec-12	44,040	61,186	719.77	-11.5%	551,817	730,423	755.48	-3.3%	771.24	767.66
Jan-13	50,908	60,791	837.42	8.2%	555,944	730,772	760.76	-2.7%	771.47	767.00
Feb-13	42,310	60,577	698.45	-7.5%	552,584	730,866	756.07	-3.8%	771.70	766.34
Mar-13	45,740	60,635	754.35	-4.3%	550,430	730,716	753.27	-3.8%	771.91	765.74
Apr-13	47,379	60,560	782.34	5.4%	552,535	730,286	756.60	-3.1%	772.14	765.08
May-13	47,879	60,431	792.29	0.3%	552,306	729,788	756.80	-3.1%	772.36	764.44
Jun-13	43,636	60,739	718.42	-0.6%	551,926	729,636	756.44	-2.2%	772.59	763.78
Jul-13	46,306	61,204	756.58	8.3%	555,725	729,990	761.28	-1.3%	772.82	763.14
Aug-13	45,952	61,332	749.23	0.2%	556,203	730,486	761.41	-0.9%	773.05	762.48
Sep-13	45,972	61,148	751.82	7.7%	559,563	730,579	765.92	0.6%	773.28	761.83
Oct-13	55,602	60,840	913.91	7.2%	563,252	730,502	771.05	0.9%	773.51	761.19
Nov-13	48,039	60,849	789.48	1.4%	563,762	730,292	771.97	1.3%	773.74	760.53
Dec-13	47,896	60,315	794.09	10.3%	567,618	729,421	778.18	3.0%	773.96	759.90
								Exponential Trend:	0.4%	-1.0%



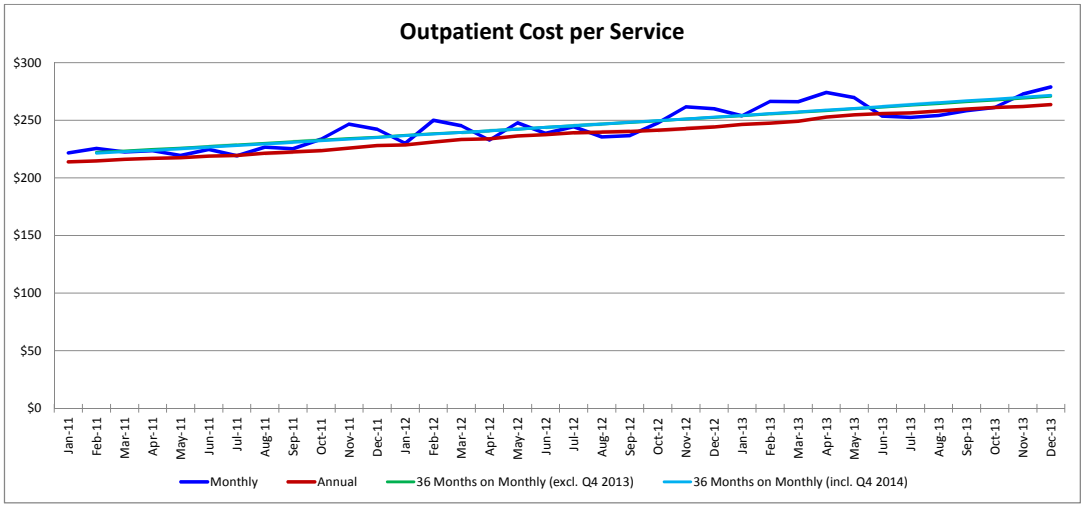
MEDICAL TREND DEVELOPMENT
Inpatient Costs per Admission

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Admission	Allowed Charge	Cost/ Admission	Monthly Cost Trend	Admission	Allowed Charge	Cost/ Admission	Annual Cost Trend	Including Q4 2013	Excluding Q4 2013
Jan-10	160	$2,345,182	$14,657							
Feb-10	165	$3,210,533	$19,458							
Mar-10	186	$2,791,509	$15,008							
Apr-10	164	$2,528,361	$15,417							
May-10	180	$2,583,019	$14,350							
Jun-10	188	$2,816,787	$14,983							
Jul-10	149	$2,612,514	$17,534							
Aug-10	181	$2,478,630	$13,694							
Sep-10	187	$2,629,661	$14,062							
Oct-10	160	$2,238,564	$13,991							
Nov-10	179	$3,312,371	$18,505							
Dec-10	180	$2,967,822	$16,488		2,079	$32,514,952	$15,640			
Jan-11	176	$3,016,500	$17,139		2,095	$33,186,270	$15,841			
Feb-11	177	$2,546,343	$14,386		2,107	$32,522,080	$15,435		$15,752	$15,885
Mar-11	209	$4,022,363	$19,246		2,130	$33,752,935	$15,846		$15,845	$15,976
Apr-11	200	$2,794,145	$13,971		2,166	$34,018,719	$15,706		$15,948	$16,078
May-11	195	$2,564,978	$13,154		2,181	$34,000,678	$15,589		$16,049	$16,177
Jun-11	225	$3,180,328	$14,135		2,218	$34,364,219	$15,493		$16,153	$16,280
Jul-11	198	$2,964,318	$14,971		2,267	$34,716,023	$15,314		$16,255	$16,380
Aug-11	204	$3,045,395	$14,928		2,290	$35,282,788	$15,407		$16,361	$16,484
Sep-11	218	$4,572,894	$20,977		2,321	$37,226,021	$16,039		$16,468	$16,589
Oct-11	184	$2,790,369	$15,165		2,345	$37,777,827	$16,110		$16,572	$16,691
Nov-11	209	$3,656,863	$17,497		2,375	$38,122,318	$16,051		$16,680	$16,797
Dec-11	204	$3,802,892	$18,641		2,399	$38,957,388	$16,239		$16,785	$16,901
Jan-12	269	$5,062,241	$18,819	9.8%	2,492	$41,003,129	$16,454		$16,895	$17,008
Feb-12	242	$4,573,422	$18,898	31.4%	2,557	$43,030,208	$16,828		$17,005	$17,116
Mar-12	289	$4,858,178	$16,810	-12.7%	2,637	$43,866,022	$16,635		$17,108	$17,218
Apr-12	260	$5,519,735	$21,230	52.0%	2,697	$46,591,612	$17,275		$17,220	$17,328
May-12	289	$5,677,447	$19,645	49.3%	2,791	$49,704,081	$17,809		$17,329	$17,434
Jun-12	267	$4,244,786	$15,898	12.5%	2,833	$50,768,539	$17,920		$17,442	$17,545
Jul-12	279	$4,325,718	$15,498	3.5%	2,914	$52,129,940	$17,889		$17,552	$17,653
Aug-12	272	$5,162,521	$18,980	27.1%	2,982	$54,247,066	$18,191		$17,666	$17,766
Sep-12	253	$3,410,802	$13,477	-35.8%	3,017	$53,084,975	$17,594		$17,781	$17,879
Oct-12	305	$5,144,891	$16,864	11.2%	3,138	$55,439,496	$17,666		$17,893	$17,989
Nov-12	263	$5,205,961	$19,787	13.1%	3,192	$56,988,594	$17,851		$18,010	$18,103
Dec-12	294	$5,867,786	$19,945	7.0%	3,283	$59,053,488	$17,990	10.8%	$18,124	$18,214
Jan-13	287	$5,318,164	$18,518	-1.6%	3,301	$59,309,411	$17,968	9.2%	$18,242	$18,330
Feb-13	250	$4,484,063	$17,925	-5.1%	3,309	$59,220,053	$17,897	6.4%	$18,361	$18,447
Mar-13	318	$5,187,161	$16,300	-3.0%	3,338	$59,549,036	$17,839	7.2%	$18,469	$18,553
Apr-13	267	$5,087,649	$19,043	-10.3%	3,345	$59,116,949	$17,672	2.3%	$18,589	$18,671
May-13	304	$5,425,685	$17,822	-9.3%	3,361	$58,865,187	$17,515	-1.6%	$18,706	$18,786
Jun-13	252	$5,154,370	$20,494	28.9%	3,345	$59,774,770	$17,868	-0.3%	$18,828	$18,905
Jul-13	297	$5,366,699	$18,040	16.4%	3,364	$60,815,751	$18,080	1.1%	$18,947	$19,022
Aug-13	293	$5,308,097	$18,135	-4.5%	3,384	$60,961,327	$18,013	-1.0%	$19,071	$19,143
Sep-13	289	$6,476,670	$22,379	66.0%	3,421	$64,027,195	$18,718	6.4%	$19,195	$19,264
Oct-13	330	$6,573,677	$19,893	18.0%	3,446	$65,455,982	$18,995	7.5%	$19,316	$19,383
Nov-13	342	$6,205,846	$18,154	-8.3%	3,525	$66,455,867	$18,854	5.6%	$19,442	$19,506
Dec-13	308	$5,784,032	$18,759	-5.9%	3,539	$66,372,113	$18,755	4.3%	$19,565	$19,626
								Exponential Trend:	8.0%	7.8%



MEDICAL TREND DEVELOPMENT
Outpatient Costs per Service

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Services	Allowed Charge	Cost/Service	Monthly Cost Trend	Services	Allowed Charge	Cost/Service	Annual Cost Trend	Including Q4 2013	Excluding Q4 2013
Jan-10	26,064	$5,852,777	$225							
Feb-10	25,668	$5,525,042	$215							
Mar-10	29,576	$6,117,621	$207							
Apr-10	28,560	$6,100,659	$214							
May-10	27,701	$5,949,521	$215							
Jun-10	29,024	$6,046,628	$208							
Jul-10	27,052	$5,748,785	$213							
Aug-10	27,867	$5,683,894	$204							
Sep-10	28,187	$5,970,504	$212							
Oct-10	28,067	$6,184,774	$220							
Nov-10	28,582	$6,272,030	$219							
Dec-10	28,852	$6,330,499	$219							
Jan-11	29,141	$6,460,617	$222		338,277	$72,390,573	$214			
Feb-11	25,889	$5,840,856	$226		338,498	$72,706,387	$215		$221	$222
Mar-11	31,073	$6,911,282	$222		339,995	$73,500,049	$216		$223	$223
Apr-11	30,095	$6,732,338	$224		341,530	$74,131,728	$217		$224	$225
May-11	30,987	$6,804,307	$220		344,816	$74,986,514	$217		$225	$226
Jun-11	31,852	$7,160,986	$225		347,644	$76,100,873	$219		$227	$227
Jul-11	29,051	$6,371,416	$219		349,643	$76,723,503	$219		$228	$229
Aug-11	31,474	$7,134,479	$227		353,250	$78,174,088	$221		$230	$230
Sep-11	30,352	$6,836,112	$225		355,415	$79,039,695	$222		$231	$231
Oct-11	33,211	$7,755,909	$234		360,559	$80,610,831	$224		$232	$233
Nov-11	32,531	$8,025,654	$247		364,508	$82,364,456	$226		$234	$234
Dec-11	34,004	$8,236,268	$242		369,661	$84,270,226	$228		$235	$235
Jan-12	42,095	$9,684,272	$230	3.8%	382,615	$87,493,880	$229		$237	$237
Feb-12	41,787	$10,443,727	$250	10.8%	398,513	$92,096,751	$231		$238	$238
Mar-12	46,105	$11,310,340	$245	10.3%	413,546	$96,495,809	$233		$239	$240
Apr-12	43,048	$10,023,140	$233	4.1%	426,499	$99,786,610	$234		$241	$241
May-12	46,089	$11,415,435	$248	12.8%	441,601	$104,397,738	$236		$242	$242
Jun-12	41,709	$9,953,370	$239	6.1%	451,458	$107,190,121	$237		$244	$244
Jul-12	41,712	$10,195,352	$244	11.4%	464,120	$111,014,058	$239		$245	$245
Aug-12	43,625	$10,281,629	$236	4.0%	476,271	$114,161,208	$240		$247	$247
Sep-12	39,342	$9,305,952	$237	5.0%	485,261	$116,631,049	$240		$248	$248
Oct-12	47,106	$11,660,044	$248	6.0%	499,156	$120,535,184	$241		$250	$250
Nov-12	43,779	$11,456,020	$262	6.1%	510,404	$123,965,550	$243		$251	$251
Dec-12	42,156	$10,957,317	$260	7.3%	518,556	$126,686,598	$244	7.2%	$253	$252
Jan-13	43,882	$11,138,222	$254	10.3%	520,342	$128,140,548	$246	7.7%	$254	$254
Feb-13	38,406	$10,228,944	$266	6.6%	516,961	$127,925,765	$247	7.1%	$256	$255
Mar-13	42,023	$11,184,257	$266	8.5%	512,880	$127,799,682	$249	6.8%	$257	$257
Apr-13	44,075	$12,081,871	$274	17.7%	513,906	$129,858,413	$253	8.0%	$259	$258
May-13	44,523	$12,003,483	$270	8.8%	512,340	$130,446,461	$255	7.7%	$260	$260
Jun-13	41,364	$10,487,629	$254	6.2%	511,995	$130,980,721	$256	7.7%	$262	$261
Jul-13	43,192	$10,903,430	$252	3.3%	513,475	$131,688,799	$256	7.2%	$264	$263
Aug-13	42,717	$10,858,183	$254	7.9%	512,567	$132,265,353	$258	7.7%	$265	$264
Sep-13	42,061	$10,869,372	$258	9.2%	515,287	$133,828,773	$260	8.1%	$267	$266
Oct-13	50,911	$13,298,035	$261	5.5%	519,092	$135,466,764	$261	8.1%	$268	$268
Nov-13	43,901	$11,974,622	$273	4.2%	519,214	$135,985,365	$262	7.8%	$270	$269
Dec-13	45,684	$12,739,799	$279	7.3%	522,742	$137,767,847	$264	7.9%	$272	$271
								Exponential Trend:	7.5%	7.2%



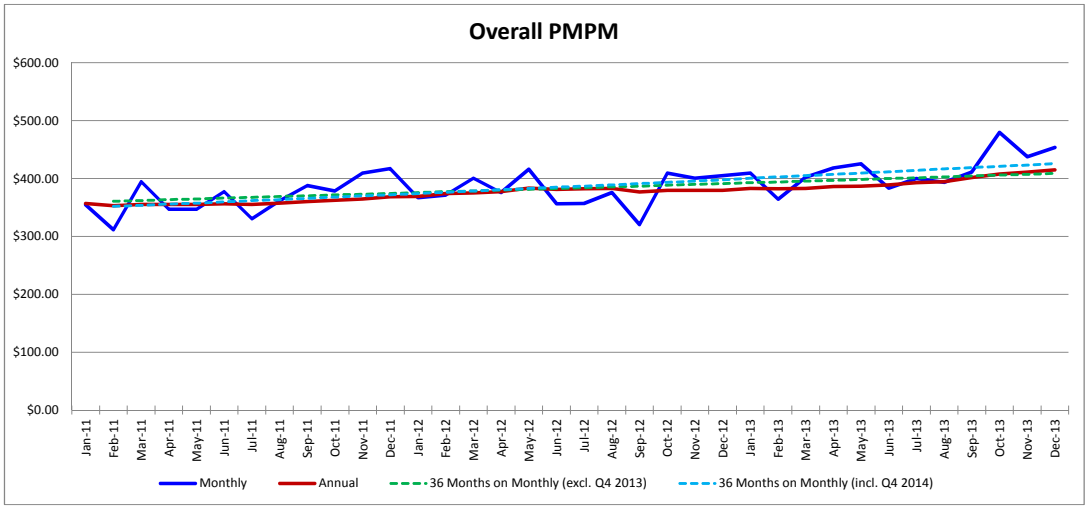
MEDICAL TREND DEVELOPMENT
Professional and Other Costs per Visit

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Visit	Allowed Charge	Cost/ Visit	Monthly Cost Trend	Visit	Adjusted Allowed Charge	Cost/ Visit	Annual Cost Trend	Including Q4 2013	Excluding Q4 2013
Jan-10	29,150	$4,408,739	$151							
Feb-10	26,636	$4,414,099	$166							
Mar-10	31,685	$4,979,943	$157							
Apr-10	29,347	$4,588,366	$156							
May-10	28,072	$4,502,431	$160							
Jun-10	30,019	$4,773,797	$159							
Jul-10	27,648	$4,400,701	$159							
Aug-10	28,606	$4,503,819	$157							
Sep-10	29,637	$4,727,752	$160							
Oct-10	30,955	$4,749,768	$153							
Nov-10	31,022	$4,916,765	$158							
Dec-10	30,142	$4,947,960	$164							
Jan-11	31,133	$4,964,502	$159							
Feb-11	28,083	$4,437,659	$158		356,349	$56,493,465	$159		$157	$158
Mar-11	34,508	$5,458,967	$158		359,172	$56,972,489	$159		$158	$158
Apr-11	31,660	$4,990,062	$158		361,485	$57,374,185	$159		$158	$159
May-11	33,573	$5,259,017	$157		366,986	$58,130,771	$158		$159	$159
Jun-11	33,998	$5,608,200	$165		370,965	$58,965,174	$159		$159	$160
Jul-11	29,803	$4,723,891	$159		373,120	$59,288,364	$159		$160	$160
Aug-11	33,489	$5,219,579	$156		378,003	$60,004,123	$159		$160	$161
Sep-11	33,032	$5,205,996	$158		381,398	$60,482,367	$159		$161	$161
Oct-11	36,181	$5,633,941	$156		386,624	$61,366,540	$159		$161	$162
Nov-11	35,091	$5,818,434	$166		390,693	$62,268,209	$159		$162	$162
Dec-11	34,768	$5,790,601	$167		395,320	$63,110,850	$160		$163	$163
Jan-12	46,781	$7,416,807	$159	-0.6%	410,968	$65,563,155	$160		$163	$163
Feb-12	45,669	$7,450,300	$163	3.2%	428,554	$68,575,795	$160		$164	$164
Mar-12	47,894	$8,165,003	$170	7.8%	441,941	$71,281,831	$161		$164	$164
Apr-12	45,273	$7,362,267	$163	3.2%	455,554	$73,654,035	$162		$165	$165
May-12	48,108	$8,254,934	$172	9.5%	470,089	$76,649,952	$163		$165	$165
Jun-12	44,015	$7,497,074	$170	3.3%	480,107	$78,538,827	$164		$166	$166
Jul-12	42,507	$7,185,326	$169	6.6%	492,810	$81,000,262	$164		$166	$167
Aug-12	45,474	$7,411,988	$163	4.6%	504,795	$83,192,671	$165		$167	$167
Sep-12	42,612	$6,860,735	$161	2.2%	514,375	$84,847,410	$165		$168	$168
Oct-12	51,913	$8,122,389	$156	0.5%	530,107	$87,335,858	$165		$168	$168
Nov-12	47,530	$7,801,358	$164	-1.0%	542,546	$89,318,782	$165		$169	$169
Dec-12	44,040	$7,945,398	$180	8.3%	551,817	$91,473,580	$166	3.8%	$169	$169
Jan-13	50,908	$8,424,244	$165	4.4%	555,944	$92,481,016	$166	4.3%	$170	$170
Feb-13	42,310	$7,340,790	$174	6.4%	552,584	$92,371,506	$167	4.5%	$170	$170
Mar-13	45,740	$8,010,559	$175	2.7%	550,430	$92,217,063	$168	3.9%	$171	$171
Apr-13	47,379	$8,153,866	$172	5.8%	552,535	$93,008,661	$168	4.1%	$172	$171
May-13	47,879	$8,289,963	$173	0.9%	552,306	$93,043,690	$168	3.3%	$172	$172
Jun-13	43,636	$7,628,802	$175	2.6%	551,926	$93,175,418	$169	3.2%	$173	$172
Jul-13	46,306	$8,218,344	$177	5.0%	555,725	$94,208,437	$170	3.1%	$173	$173
Aug-13	45,952	$7,944,769	$173	6.1%	556,203	$94,741,217	$170	3.4%	$174	$173
Sep-13	45,972	$7,792,378	$170	5.3%	559,563	$95,672,861	$171	3.7%	$175	$174
Oct-13	55,602	$9,304,684	$167	7.0%	563,252	$96,855,155	$172	4.4%	$175	$175
Nov-13	48,039	$8,451,220	$176	7.2%	563,762	$97,505,017	$173	5.1%	$176	$175
Dec-13	47,896	$8,821,677	$184	2.1%	567,618	$98,381,296	$173	4.6%	$176	$176
								Exponential Trend:	4.1%	3.8%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

MEDICAL TREND DEVELOPMENT
Overall PMPM

	MONTHLY DATA				ROLLING 12				EXPONENTIAL FIT	
Incurred Date	Membership	Allowed Charge	PMPM	Monthly Cost Trend	Admission	Allowed Charge	Cost/ Admission	Annual Cost Trend	Including Q4 2013	Excluding Q4 2013
Jan-10	37,505	$12,606,699	$336.13							
Feb-10	37,454	$13,149,674	$351.09							
Mar-10	37,460	$13,889,073	$370.77							
Apr-10	37,594	$13,217,386	$351.58							
May-10	37,802	$13,034,972	$344.82							
Jun-10	37,461	$13,637,212	$364.04							
Jul-10	37,547	$12,762,000	$339.89							
Aug-10	37,491	$12,666,344	$337.85							
Sep-10	37,394	$13,327,917	$356.42							
Oct-10	37,710	$13,173,106	$349.33							
Nov-10	37,896	$14,501,166	$382.66							
Dec-10	37,708	$14,246,280	$377.81		451,022	$160,211,828	$355.22			
Jan-11	40,728	$14,441,620	$354.59		454,245	$162,046,749	$356.74			
Feb-11	41,137	$12,824,858	$311.76		457,928	$161,721,933	$353.16		$351.71	$360.81
Mar-11	41,544	$16,392,613	$394.58		462,012	$164,225,473	$355.46		$353.54	$362.03
Apr-11	41,847	$14,516,545	$346.90		466,265	$165,524,633	$355.00		$355.57	$363.39
May-11	42,167	$14,628,302	$346.91		470,630	$167,117,963	$355.09		$357.54	$364.70
Jun-11	42,279	$15,949,514	$377.24		475,448	$169,430,266	$356.36		$359.60	$366.07
Jul-11	42,536	$14,059,624	$330.53		480,437	$170,727,890	$355.36		$361.59	$367.40
Aug-11	42,651	$15,399,452	$361.06		485,597	$173,460,998	$357.21		$363.67	$368.78
Sep-11	42,862	$16,615,002	$387.64		491,065	$176,748,083	$359.93		$365.76	$370.16
Oct-11	42,747	$16,180,220	$378.51		496,102	$179,755,197	$362.34		$367.79	$371.50
Nov-11	42,728	$17,500,951	$409.59		500,934	$182,754,983	$364.83		$369.91	$372.89
Dec-11	42,763	$17,829,761	$416.94		505,989	$186,338,464	$368.27		$371.96	$374.24
Jan-12	60,442	$22,163,320	$366.69	3.4%	525,703	$194,060,164	$369.14		$374.10	$375.65
Feb-12	60,483	$22,467,449	$371.47	19.2%	545,049	$203,702,754	$373.73		$376.25	$377.06
Mar-12	60,785	$24,333,520	$400.32	1.5%	564,290	$211,643,661	$375.06		$378.27	$378.38
Apr-12	60,990	$22,905,142	$375.56	8.3%	583,433	$220,032,257	$377.13		$380.44	$379.80
May-12	60,929	$25,347,817	$416.02	19.9%	602,195	$230,751,772	$383.18		$382.56	$381.17
Jun-12	60,891	$21,695,230	$356.30	-5.6%	620,807	$236,497,487	$380.95		$384.75	$382.60
Jul-12	60,850	$21,706,396	$356.72	7.9%	639,121	$244,144,259	$382.00		$386.89	$383.99
Aug-12	60,836	$22,856,139	$375.70	4.1%	657,306	$251,600,946	$382.78		$389.11	$385.43
Sep-12	61,055	$19,577,489	$320.65	-17.3%	675,499	$254,563,433	$376.85		$391.35	$386.87
Oct-12	60,917	$24,927,324	$409.20	8.1%	693,669	$263,310,538	$379.59		$393.52	$388.28
Nov-12	61,059	$24,463,339	$400.65	-2.2%	712,000	$270,272,925	$379.60		$395.78	$389.73
Dec-12	61,186	$24,770,501	$404.84	-2.9%	730,423	$277,213,665	$379.52	3.1%	$397.98	$391.14
Jan-13	60,791	$24,880,630	$409.28	11.6%	730,772	$279,930,976	$383.06	3.8%	$400.27	$392.61
Feb-13	60,577	$22,053,796	$364.06	-2.0%	730,866	$279,517,324	$382.45	2.3%	$402.57	$394.08
Mar-13	60,635	$24,381,976	$402.11	0.4%	730,716	$279,565,780	$382.59	2.0%	$404.66	$395.42
Apr-13	60,560	$25,323,385	$418.15	11.3%	730,286	$281,984,023	$386.13	2.4%	$406.98	$396.90
May-13	60,431	$25,719,131	$425.59	2.3%	729,788	$282,355,338	$386.90	1.0%	$409.24	$398.34
Jun-13	60,739	$23,270,802	$383.13	7.5%	729,636	$283,930,909	$389.14	2.1%	$411.59	$399.83
Jul-13	61,204	$24,488,474	$400.11	12.2%	729,990	$286,712,987	$392.76	2.8%	$413.88	$401.28
Aug-13	61,332	$24,111,049	$393.12	4.6%	730,486	$287,967,898	$394.21	3.0%	$416.26	$402.78
Sep-13	61,148	$25,138,420	$411.11	28.2%	730,579	$293,528,828	$401.78	6.6%	$418.65	$404.29
Oct-13	60,840	$29,176,396	$479.56	17.2%	730,502	$297,777,901	$407.63	7.4%	$420.98	$405.76
Nov-13	60,849	$26,631,687	$437.67	9.2%	730,292	$299,946,249	$410.72	8.2%	$423.39	$407.28
Dec-13	60,315	$27,345,508	$453.38	12.0%	729,421	$302,521,256	$414.74	9.3%	$425.75	$408.76
								Exponential Trend:	7.0%	4.5%



BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

MEDICAL TREND DEVELOPMENT
PROJECTION FACTOR FOR INDEX RATE CALCULATION

TREND FACTORS

Annual	Cost	Utilization	Total
Medical	4.4%	0.0%	4.4%
Pharmacy	6.4%	1.9%	8.4%

MEDICAL

Coverage Category in the Experience	Membership	CY 2013 Allowed PMPM Adjuted for Network	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2015 EPO Allowed
Catamount	196,948	$523.92	1.0903	$571.21	1.0000	$571.21
Indemnity/PPO	261,297	$368.37	1.0903	$401.62	1.0000	$401.62
Point-of-Service	3,893	$383.50	1.0903	$418.11	1.0000	$418.11
HMO	267,283	$380.08	1.0903	$414.39	1.0000	$414.39

PHARMACY

Coverage Category in the Experience	Membership	CY 2013 Allowed PMPM Adjuted for Network	Cost Trend (24mths)	Adding Cost	Utilization Trend (24mths)	CY 2015 EPO Allowed
Catamount	196,948	$107.71	1.1318	$121.91	1.0377	$126.50
Indemnity/PPO	261,297	$61.32	1.1318	$69.40	1.0377	$72.02
Point-of-Service	3,893	$75.65	1.1318	$85.62	1.0377	$88.85
HMO	267,283	$69.21	1.1318	$78.33	1.0377	$81.29

		Cost Trend (24mths)		Utilization Trend (24mths)	
Medical	$414.74	1.0903	$452.18	1.0000	$452.18
Rx	$76.81	1.1318	$86.94	1.0377	$90.21
Total	$491.56	1.0968	$539.11	1.0061	$542.39

Cost Trend	$1+d_1$	1.0968
Utilization Trend	$1+d_2$	1.0061

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

EXPECTED TRANSITIONAL REINSURANCE RECOVERIES

Product	Expected Transitional Reinsurance Recoveries (PMPM)	Projected Individual Members
Catastrophic	-$12.88	88
Non-Standard Gold	-$34.66	797
Non-Standard Gold - CSR 100%	-$36.73	-
Non-Standard Silver	-$33.58	847
Non-Standard Silver - CSR 100%	-$36.73	-
Non-Standard Silver - CSR 73%	-$34.04	350
Non-Standard Silver - CSR 77%	-$34.08	593
Non-Standard Silver - CSR 87%	-$35.47	828
Non-Standard Silver - CSR 94%	-$36.18	187
Non-Standard Bronze CDHP - CSR 100%	-$36.73	1
Non-Standard Bronze CDHP	-$33.41	1,346
Standard Platinum	-$35.71	3,773
Standard Platinum - CSR 100%	-$36.73	-
Standard Gold	-$34.16	2,657
Standard Gold - CSR 100%	-$36.73	-
Standard Silver	-$33.64	2,115
Standard Silver - CSR 100%	-$36.73	2
Standard Silver - CSR 73%	-$34.17	767
Standard Silver - CSR 77%	-$34.72	1,264
Standard Silver - CSR 87%	-$35.83	1,708
Standard Silver - CSR 94%	-$36.35	524
Standard Silver CDHP	-$34.02	1,698
Standard Silver CDHP - CSR 100%	-$36.73	1
Standard Silver CDHP - CSR 73%	-$34.85	393
Standard Silver CDHP - CSR 77%	-$35.32	555
Standard Silver CDHP - CSR 87%	-$36.15	722
Standard Silver CDHP - CSR 94%	-$36.46	211
Standard Bronze	-$33.34	1,006
Standard Bronze - CSR 100%	-$36.73	-
Standard Bronze CDHP	-$33.42	1,092
Standard Bronze CDHP - CSR 100%	-$36.73	-
Weighted Average on Individual Members Only	-$34.54	23,525
Projected Small Group Members		34,665
Projected Total Members		58,190
Total Recoveried spread across all 58,190 members	**-$13.96**	
Uniform Reinsurance Contribution Rate of $44 per Member per Year	**$3.67**	
Market Wide Adjustment for the Transitional Reinsurance Program	**-$10.29**	

INDEX RATE CALCULATION

Index Rate : Experience Period Allowed Claims for EHB	A	$445.21
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of Guarantee Issue	$1+b_1$	1.0000
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	0.9918
Impact of insured formerly on Employer coverage	$1+b_4$	1.0000
Impact of new enrollment from prior high risk pool	$1+b_5$	1.0000
Impact of mandated coverage on morbidity	$1+b_6$	1.0000
Impact of Pent-up demand	$1+b_7$	1.0000
Impact of Premium Subsidy	$1+b_8$	1.0000
Changes in pool morbidity	$1+b_9$	0.9426
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	1.0096
Changes in provider networks	$1+c_2$	1.1041
Changes in demographics (age, gender, region, etc.)	$1+c_3$	0.9978
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in network delivery system	$1+c_5$	1.0000
Changes in Family Tiering	$1+c_6$	0.9644
Adjusted Experience Period Allowed Claims for EHB		$446.47
Trend Factors		
Cost Trend	$1+d_1$	1.0968
Utilization Trend	$1+d_2$	1.0061
Projected Period Allowed Claims for Experience EHB		$492.65
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$4.01
Projected Blue Print Payments	e_2	$2.09
Projected ITS Fees	e_3	$1.79
Projected Vaccine Payments	e_4	$1.24
Projected Net cost of Reinsurance	e_5	$1.08
Additional Adjustments for Additional Mandated Benefits		
Projected Allowed Claims for Pediatric Vision	e_6	$0.58
Projected Allowed Claims for Pediatric Dental	e_7	$7.99
Projected Index Rate : Projected Period Expected Allowed Claims	$F = A\prod_{n=1}^{9}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$503.40
Market Wide Adjustments		
Risk Adjustment Payments and Fees	g_1	$0.08
Transitional Reinsurance Payments and Recoveries	g_2	-$10.29
Vermont Exchange Fees	g_3	$0.00
Market Adjusted Index Rate	$H = F + \sum_{n=1}^{3} g_n$	**$493.19**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 6A

PLAN LEVEL ADJUSTMENT SUMMARY

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	Weighted
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Average
Market Adjusted Index Rate	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	
Paid to Allowed Ratio	82.04%	74.65%	65.36%	92.48%	84.39%	75.84%	76.01%	66.89%	68.87%	66.59%	
Benefit Richness Adjustment	1.0125	0.9545	0.9035	1.1115	1.0335	0.9677	0.9672	0.9136	0.9213	0.9091	
Changes in Family Tiers	0.9752	0.9598	0.9462	1.0328	1.0308	1.0262	0.9528	1.0178	0.9487	0.9459	
For Catastrophic Only - Impact of Eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.5920	
Expected Claims Cost	**$399.52**	**$337.31**	**$275.57**	**$523.59**	**$443.36**	**$371.43**	**$345.49**	**$306.73**	**$296.87**	**$167.18**	**$395.56**
Administrative Charges Plan Level Adjustment	1.0688	1.0806	1.0987	1.0521	1.0613	1.0731	1.0788	1.0887	1.0919	1.1623	
Taxes and Fees Plan Level Adjustment	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0395	
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	
Plan Level Adjusted Index Rate	**$448.40**	**$382.77**	**$317.91**	**$578.46**	**$494.10**	**$418.56**	**$391.37**	**$350.65**	**$340.37**	**$204.02**	**$443.96**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 6B

PLAN LEVEL ADJUSTMENT
PAID TO ALLOWED RATIOS

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total
Projected Period Allowed Claims for Experience EHB	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65	$492.65
Paid to Allowed Ratio for EHB Portion	82.43%	75.15%	66.70%	92.61%	84.71%	76.34%	76.97%	67.49%	69.94%	67.99%	
Projected Period Paid Claims for Experience EHB	$406.09	$370.24	$328.62	$456.26	$417.30	$376.09	$379.21	$332.49	$344.54	$334.94	$393.77
Additional EHB Allowed Claims	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57	$8.57
Additional EHB Paid Claims	$6.57	$5.95	$1.76	$7.87	$6.90	$5.99	$3.69	$5.42	$3.16	$1.51	$5.73
Non-System Claims	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18
Market Wide Adjustments	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21
Market Adjusted Index Rate	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19
Total Paid Claims	$404.62	$368.16	$322.35	$456.10	$416.18	$374.05	$374.87	$329.87	$339.67	$328.42	$391.47
Paid to Allowed Ratio	82.04%	74.65%	65.36%	92.48%	84.39%	75.84%	76.01%	66.89%	68.87%	66.59%	79.38%
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 6C

PLAN LEVEL ADJUSTMENT
BENEFIT RICHNESS ADJUSTMENT FACTOR

	NON-STANDARD PLANS			STANDARD PLANS								
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic		
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL	*% of Total*
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190	
Modeled Benefit Richness Adjustment - For Medical	0.9982	0.9327	0.8739	1.0881	0.9991	0.9303	0.9419	0.8768	0.8909	0.8837	0.9707	*83.37%*
Modeled Benefit Richness Adjustment - For Pharmacy	0.9158	0.9074	0.9135	1.0445	1.0347	0.9967	0.9363	0.9518	0.9280	0.8965	0.9815	*16.63%*
Projected Period Paid Claims for Experience EHB	$406.09	$370.24	$328.62	$456.26	$417.30	$376.09	$379.21	$332.49	$344.54	$334.94		
Normalized Benefit Richness Adjustment for EHB	1.0125	0.9548	0.9053	1.1115	1.0334	0.9679	0.9676	0.9143	0.9224	0.9109	1.0000	
Additional EHB Paid Claims	$6.57	$5.95	$1.76	$7.87	$6.90	$5.99	$3.69	$5.42	$3.16	$1.51		
Non-System Claims	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18		
Market Wide Adjustments	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21		
Total Paid Claims with Benefit Richness Adjustment	$409.68	$351.42	$291.23	$506.96	$430.10	$361.96	$362.58	$301.38	$312.92	$298.56		
Overall Benefit Richness Adjustment	1.0125	0.9545	0.9035	1.1115	1.0335	0.9677	0.9672	0.9136	0.9213	0.9091		

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

PLAN LEVEL ADJUSTMENT
CHANGE IN FAMILY TIER FACTOR

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	TOTAL
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190
Family Multiplier PMPM Adjustment	0.9405	0.9259	0.9135	0.9960	0.9940	0.9895	0.9194	0.9814	0.9156	0.9132	0.9644
Projected Period Paid Claims for Experience EHB	$406.09	$370.24	$328.62	$456.26	$417.30	$376.09	$379.21	$332.49	$344.54	$334.94	
Normalized Family Multiplier for EHB	0.9753	0.9601	0.9472	1.0328	1.0307	1.0260	0.9534	1.0176	0.9494	0.9469	1.0000
Additional EHB Paid Claims	$6.57	$5.95	$1.76	$7.87	$6.90	$5.99	$3.69	$5.42	$3.16	$1.51	
Non-System Claims	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	$2.18	
Market Wide Adjustments	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	-$10.21	
Total Paid Claims with Family Multiplier Adjustment	$394.59	$353.38	$305.01	$471.07	$429.00	$383.84	$357.20	$335.73	$322.24	$310.64	
Overall Family Multiplier Adjustment	0.9752	0.9598	0.9462	1.0328	1.0308	1.0262	0.9528	1.0178	0.9487	0.9459	

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 6E

PLAN LEVEL ADJUSTMENTS
IMPACT OF SPECIFIC ELIGIBILITY CAREGORIES FOR THE CATASTROPHIC PLAN

	Eligible Members	Projected Allowed Charges for Experience EHB	Paid to Allowed Ratio for EHB Claims	Projected Paid Claims for EHB Claims
Average Population	7,861	$542.39	68.0%	$368.76
Individual Ages 30 or Less	6,125	$269.87	56.6%	$152.71
Individual Ages over 30	1,736	$664.07	70.1%	$465.22
Weighted Average		$356.92	62.1%	$221.72
Allowed Charges Adjustment		0.6581		
Paid to Allowed Ratio Adjustment			0.9137	
Additional Normalization Adjustment *			0.9846	
Total Adjustment for Catastrophic Plan			**0.5920**	

Expected Claims Cost Calculation for Catastrophic	
Projected Period Paid Claims for Experience EHB	$334.94
Normalized Benefit Richness Adjustment for EHB	0.9109
Normalized Family Multiplier for EHB	0.9469
Catastrophic Adjustment	0.6013
Other Paid Claims	-$6.52
Expected Plan Level Adjusted Index Rate	$167.18
Calculated Plan Level Adjusted Index Rate without Normalization Adjustment	$169.79
Needed Normalization Adjustment	0.9846

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 7A

DETAILS OF ADMINISTRATIVE CHARGES

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
BCBSVT Base Administrative Charges	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78	$25.78
Administrative Charges for Outside Vendors	$1.70	$1.42	$1.40	$1.48	$1.38	$1.38	$1.43	$1.41	$1.49	$1.34	$1.44
Blue For You Reward Program	$0.00	$0.00	$0.00							$0.00	$0.00
Total Administrative Charges PMPM	**$27.49**	**$27.20**	**$27.19**	**$27.27**	**$27.16**	**$27.16**	**$27.21**	**$27.19**	**$27.28**	**$27.12**	**$27.22**
Administrative Charges Plan Level Adjustment	1.0688	1.0806	1.0987	1.0521	1.0613	1.0731	1.0788	1.0887	1.0919	1.1623	1.0688
Administrative Charges as a percent of Premium	6.13%	7.11%	8.55%	4.71%	5.50%	6.49%	6.95%	7.76%	8.01%	13.29%	**6.13%**

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

DETAILS OF CONTRIBUTION TO RESERVE

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
BCBSVT Contribution to Reserve	$4.48	$3.83	$3.18	$5.78	$4.94	$4.19	$3.91	$3.51	$3.40	$2.04	$4.44
Total Contribution to Reserve PMPM	**$4.48**	**$3.83**	**$3.18**	**$5.78**	**$4.94**	**$4.19**	**$3.91**	**$3.51**	**$3.40**	**$2.04**	$4.44
Contribution to Reserve Plan Level Adjustment	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101	1.0101
Contribution to Reserve as a percent of Premium	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

DETAILS OF TAXES AND FEES

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**Total**
State Assessment - HCCA	$3.25	$2.75	$2.26	$4.25	$3.60	$3.03	$2.82	$2.51	$2.43	$1.39	$3.22
State Tax - VITL	$0.81	$0.69	$0.56	$1.06	$0.90	$0.76	$0.70	$0.63	$0.61	$0.35	$0.80
Federal Assessment - PCORI	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18
Federal Insurer Fee	$12.67	$10.81	$8.98	$16.34	$13.96	$11.82	$11.06	$9.91	$9.62	$5.76	$12.54
Total Taxes and Fees PMPM	**$16.91**	**$14.43**	**$11.98**	**$21.82**	**$18.64**	**$15.78**	**$14.76**	**$13.22**	**$12.83**	**$7.68**	**$16.74**
Taxes and Fees Plan Level Adjustment	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0396	1.0395	1.0396
Taxes and Fees as a percent of Premium	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%	3.77%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

AV PRICING VALUE

	NON-STANDARD PLANS			STANDARD PLANS						
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards
Market Wide Adjusted Index Rate	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19	$493.19
Plan Level Adjusted Index Rate	$448.40	$382.77	$317.91	$578.46	$494.10	$418.56	$391.37	$350.65	$340.37	$204.02
AV Pricing Value	90.92%	77.61%	64.46%	117.29%	100.18%	84.87%	79.35%	71.10%	69.02%	41.37%

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 8

FEDERAL MINIMUM LOSS RATIO for COMBINED MARKET
(PROJECTION)

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	**TOTAL**
Expected Direct Claims PMPM	$409.73	$347.52	$285.75	$533.80	$453.57	$381.65	$355.69	$316.95	$307.06	$177.39	$405.77
Transitional Reinsurance Recoveries PMPM	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96	-$13.96
Adjustments for Health Care Quality PMPM*	$7.19	$7.17	$7.17	$7.17	$7.16	$7.16	$7.17	$7.17	$7.17	$7.16	$7.17
MLR Claims	**$402.96**	**$340.72**	**$278.95**	**$527.01**	**$446.77**	**$374.85**	**$348.90**	**$310.15**	**$300.27**	**$170.59**	**$398.98**
Premium PMPM	$448.40	$382.77	$317.91	$578.46	$494.10	$418.56	$391.37	$350.65	$340.37	$204.02	$443.96
Licensing and regulatory fees	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75	-$3.75
Taxes & Fees PMPM	-$16.91	-$14.43	-$11.98	-$21.82	-$18.64	-$15.78	-$14.76	-$13.22	-$12.83	-$7.68	-$16.74
MLR Premium	**$427.74**	**$364.59**	**$302.18**	**$552.89**	**$471.71**	**$399.03**	**$372.86**	**$333.68**	**$323.80**	**$192.59**	**$423.47**
Expected Loss Ratio	94.2%	93.5%	92.3%	95.3%	94.7%	93.9%	93.6%	92.9%	92.7%	88.6%	94.2%
Projected Membership	2,765	3,677	2,792	12,857	7,088	12,638	9,439	2,711	4,135	88	58,190

*Approximately 8.59% of current BCBSVT Administrative Charges are for health care quality plus the Blue For You PMPM

BLUE CROSS AND BLUE SHIELD OF VERMONT
2015 VERMONT EXCHANGE PRODUCTS RATE FILING

Exhibit 9

CONSUMER ADJUSTED PREMIUM RATES

	NON-STANDARD PLANS			STANDARD PLANS							
	GOLD	SILVER	BRONZE	PLATINUM	GOLD	SILVER		BRONZE		Catastrophic	
	Blue Rewards	Blue Rewards	Blue Rewards CDHP	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Blue Rewards	Total Annual Premium
Plan Level Adjusted Index Rate	$448.40	$382.77	$317.91	$578.46	$494.10	$418.56	$391.37	$350.65	$340.37	$204.02	
PMPM to Single Contract Conversion Factor	1.1246	1.1246	1.1246	1.1246	1.1246	1.1246	1.1246	1.1246	1.1246	1.1246	
2015 Proposed Rates											
Single Rate	$504.25	$430.45	$357.52	$650.52	$555.65	$470.70	$440.12	$394.33	$382.78	$229.44	
Couple Rate	$1,008.51	$860.91	$715.03	$1,301.04	$1,111.30	$941.40	$880.24	$788.67	$765.55	$458.88	
Adult and Child(ren) Rate	$973.21	$830.78	$690.00	$1,255.50	$1,072.40	$908.46	$849.44	$761.06	$738.76	$442.82	
Family Rate	$1,416.95	$1,209.58	$1,004.62	$1,827.96	$1,561.37	$1,322.67	$1,236.74	$1,108.08	$1,075.60	$644.72	$310,011,258.04
2014 Approved Rates											
Single Rate	$460.37	$395.26	$341.15	$582.79	$497.06	$425.19	$412.83	$359.47	$362.34	$213.68	
Couple Rate	$920.74	$790.52	$682.30	$1,165.58	$994.12	$850.38	$825.66	$718.94	$724.68	$427.36	
Adult and Child(ren) Rate	$888.51	$762.85	$658.42	$1,124.78	$959.33	$820.62	$796.76	$693.78	$699.32	$412.40	
Family Rate	$1,293.64	$1,110.68	$958.63	$1,637.64	$1,396.74	$1,194.78	$1,160.05	$1,010.11	$1,018.18	$600.44	$282,312,944.26
2015 Proposed Rate Increases											
Single Rate	9.5%	8.9%	4.8%	11.6%	11.8%	10.7%	6.6%	9.7%	5.6%	7.4%	
Couple Rate	9.5%	8.9%	4.8%	11.6%	11.8%	10.7%	6.6%	9.7%	5.6%	7.4%	
Adult and Child(ren) Rate	9.5%	8.9%	4.8%	11.6%	11.8%	10.7%	6.6%	9.7%	5.6%	7.4%	
Family Rate	9.5%	8.9%	4.8%	11.6%	11.8%	10.7%	6.6%	9.7%	5.6%	7.4%	**9.8%**
Projected 2015 Contracts											
Single Rate	1,013	1,348	1,023	4,713	2,598	4,632	3,460	994	1,516	32	
Couple Rate	321	427	324	1,491	822	1,466	1,095	314	480	10	
Adult and Child(ren) Rate	56	75	57	263	145	258	193	55	84	2	
Family Rate	247	329	250	1,150	634	1,130	844	242	370	8	

WAKELY CONSULTING GROUP
CONSULTING ACTUARIES & HEALTHCARE SPECIALISTS
Clearwater, FL • Louisville, KY • Denver, CO

March 21, 2014

Ms. Lindsey Tucker
Deputy Commissioner, Health Benefit Exchange
Department of Vermont Health Access
Via Email Only

RE: State of Vermont Actuarial Value Certification for 2015 Standard Plan Designs - Revised

Dear Lindsey:

The Affordable Care Act requires that health care coverage provided by issuers to non-grandfathered individual and small groups must cover all Essential Health Benefits (EHBs) and have Actuarial Values (AVs) that fall under the Platinum (90% AV), Gold (80% AV), Silver (70% AV) or Bronze (60% AV) tiers. The ACA allows for a 2% de minimis range around these target AVs. For example, any plan design that has an AV from 68-72%, would be considered a Silver plan. The Center for Consumer Information and Insurance Oversight (CCIIO) recently released the final 2015 Actuarial Value Calculator (AVC)[1] that issuers must use to determine the AV of a plan. While CCIIO anticipates that most plans will be able to use the AVC without modification, some plan designs will have features which are not supported by the AVC. In these instances, an actuary can either modify the inputs to most closely represent the plan design or an actuary can modify the results of the AVC to account for the features not supported by the AVC. An actuarial certification documenting the development of the AV for these plan designs is required.

The State of Vermont (State) is standardizing several plan designs that all issuers offering plans in the exchange, Vermont Health Connect, must offer. Issuers must offer the standard plan designs in the individual and small group merged market. One Platinum, one Gold, two Silver and two Bronze standard plan designs were developed for Vermont Health Connect. There is a traditional deductible plan at each of the four metal levels and a High Deductible Health Plan (HDHP) at each of the Silver and Bronze levels. For each of the Silver standard plan designs, the cost sharing reduction plan designs are also standard. Cost sharing reduction plan (CSR) designs were developed at each of the 73% (federal), 77% (Vermont specific), 87% (federal) and 94% (federal) AV levels.

The State contracted with Wakely Consulting Group, Inc. (Wakely) to assist in the development of the standard plan designs. The standard plan designs for 2015 include the following changes from the 2014 standard plan designs.

- If pediatric dental benefits are covered, there is no cost sharing for Class I (basic) pediatric oral health essential health benefits and the deductible must be waived
- The primary care and specialist office visits were increased by $5 on both the Standard Silver Deductible plan and the Standard Silver Deductible 73% AV CSR plan. This increased the copays from $20 to $25 for primary care visits and from $40 to $45 for specialist visits
- The medical deductible on the Standard Silver Deductible 87% AV CSR plan decreased from $750 to $600
- The drug deductible on the Standard Bronze Deductible plan increased from $200 to $300

[1] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

The IRS has yet to release the minimum deductible amount for HDHPs for 2015. The drug deductibles and MOOPs for HDHPs may need to change if the IRS changes the minimum deductible. The likely amounts for 2015 are $1250 or $1300 compared to the 2014 amount of $1250. The current plan designs use the 2014 amounts, although Wakely did verify that if the minimum deductible is increased to $1300, all plan designs are still within the required ranges.

Three of the standard plan designs (and the HDHP cost sharing reduction plan designs) have features not supported by the AVC and thus an actuarial certification is required. The remaining standard plan designs and their corresponding CSR plans have features that may warrant an AV adjustment but no explicit adjustment or actuarial certification has been done for these plans. In developing these standard plan designs and the resulting actuarial certification, Wakely also followed applicable Actuarial Standards of Practice (ASOP) as detailed in Appendix C and including:

- ASOP No. 23 *Data Quality*;
- ASOP No. 25 *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage; and*
- ASOP No. 41 *Actuarial Communications*.

EXECUTIVE SUMMARY

A summary of Vermont's standard plan designs is in Appendix B. The Silver HDHP and both Bronze plans have design features that are both significant and not supported by the AVC. The Silver HDHP cost sharing reduction plan designs have similar features. The issuers that opt to offer pediatric dental would also have design features that could be significant and not supported by the AVC. While most plans have some subtleties in their design that are not supported by the AVC, CCIIO has stated and regulations dictate that modifications should be made only for substantial differences. The four potential substantial differences that Wakely considered include:

1. Family deductible and Maximum Out of Pockets (MOOPs). There are two common types of applications for deductibles and MOOPs, commonly referred to in Vermont as stacked and aggregate[2]. The data supporting the AVC is only at the member level, and thus most closely resembles the stacked application of deductibles and MOOPs. Most HDHP plans use the aggregate application of deductible and MOOPs which can significantly lower the AV since a family of two would need to accumulate to a deductible that is twice that of a single contract. The impact is greater at higher deductible and MOOP amounts. Wakely had previously developed a model to account for aggregate family deductibles and thus, a specific adjustment has been made to the appropriate AVs for HDHPs.

[2] Stacked deductibles and MOOPs are typical in traditional deductible plans where the individual deductible and MOOP apply to each member of a contract and the family deductible and MOOP is used as a protection for contracts where multiple members have claims. For example, if the family MOOP is two times the individual MOOP but three members of a contract all would have reached their individual MOOP, it limits the family's liability to two times the individual MOOP.

Aggregate deductible and MOOPs are typical in HDHPs where all claims for all members of a non-single contract accumulate to the family deductible and MOOP. For two person or family contracts where only one member has significant claims, the member still must reach the higher deductible and MOOP amounts which makes the average member liability higher under an aggregate deductible.

2. Vermont implemented a regulation (H.559 Sec. 32. 8 V.S.A. § 4089) for prescription drug deductibles and MOOPs. The requirement mandates, in part, that the MOOP for prescription drug costs in any plan design shall not exceed the minimum deductible amount for HDHPs per Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 ($1250 and $2500 for individual and family coverage in 2014; 2015 amounts are not known so remain at 2014 levels). The requirement also states that for HDHPs the cost sharing benefit for prescription drugs must start after the minimum deductible amount for HDHPs (same $1250 and $2500 for individuals and family coverage) is met, but the amount may be met with either medical or prescription drug claims. This means that for all HDHPs, for purposes of prescription drug coverage, the deductible is considered met when accumulated medical and drug claims reach $1250 for individual or $2500 for family, regardless of what the medical deductible amount is. Similarly, the MOOP for only drug claims (including amounts used to accumulate to the deductible) is $1250 or $2500, regardless of the amount of the overall MOOP which will include both drug and medical claims.

   Since for an integrated deductible and MOOP, only one amount is able to be input in the AVC, the value of the lower drug deductible and MOOP cannot be modeled in the AVC. This regulation has a significant impact on AV, particularly at the lower AV tiers where the difference between the medical and prescription drug deductible and MOOP is greater. Wakely had previously developed a model to account for Vermont's prescription drug regulation and thus, where appropriate, a specific adjustment has been made to the AVs using this model.

3. In the current market, most Vermont HDHPs waive the deductible for preventive prescription drugs. This is another plan feature not currently supported by the AVC. While Wakely has a list of the drugs for which the deductible is waived, Wakely has not analyzed the exact portion of drugs this represents. The impact to AV would only apply to drug costs that would normally be incurred prior to the member reaching the deductible. Any costs after the deductible is met and after the MOOP is met would be similar to the AVC. It is possible that this design feature could have a significant impact on the AV. However the impact of this benefit is likely not enough to warrant an additional analysis. Based on some high level estimates, Wakely believes the maximum impact to AV for this design feature is approximately 0.5% with the likely expected impact to be half of that. Since Wakely did not quantify the exact adjustment of the preventive drug difference for HDHPs, Wakely did not make a specific adjustment but did make sure that any AVs developed for HDHPs were at least 0.5% below the high end of the de minimis range in order to account for this increased benefit. It is expected that the impact for these drugs would be highest for the bronze plan where the deductible is highest and the impact would decrease as deductibles decrease (and AVs increase).

4. If a plan covers pediatric dental, starting in 2015 there can be no cost sharing for Class I (basic) pediatric oral health essential health benefits. Pediatric dental is not explicitly reflected in the federal AVC. It is included as part of the "other" benefits which are assumed to have average cost sharing for the plan. The reduction in cost sharing for the Class I benefits will result in a higher AV than what is modeled in the AVC, particularly for the higher deductible plans. It is possible that this design feature could have a significant impact on the AV. Based on some high level estimates, Wakely believes the maximum impact to AV for this design feature is approximately 0.5%. Since this adjustment may apply to some issuers and not to others, Wakely did not make a specific adjustment but did make sure that any AVs developed were at least 0.5% below the high end of the de minimis range in order to account for this benefit. It is expected that the impact for these drugs would be highest for the bronze plan where the deductible is highest and the impact would decrease as deductibles decrease (and AVs increase).

In addition to the four features listed above, the federal AVC can produce results that are counter intuitive. For example, when the Standard Bronze drug deductible is increased from $200 to $300 the federal AVC produces an AV that increases by almost 2% when the AV should decrease. As a result, Wakely believes the AVC is not accurately capturing the AV of this plan design change and has made an additional adjustment to account for the change in the drug deductible. This adjustment is discussed further in the methodology section.

There are other potential design features for which adjustments could be made. However, given the expectation that adjustments be made for only the most substantive deviations, Wakely does not believe additional adjustments are warranted. It is also important to note that the bucketing of claims and the methodology used to calculate the AVC are not always clearly defined. Thus, at times it is difficult to ascertain whether an adjustment is warranted and how that adjustment would be estimated.

As stated, Wakely made explicit adjustments to account for the aggregate family deductible/MOOP and Vermont's prescription drug regulation. These adjustments are described in detail in the Methodology section. For the preventive prescription drug and pediatric dental benefits, Wakely did not make an explicit adjustment but did allow room in the AV such that an increase of up to 0.5% would not result in the AV falling outside of the required range.

The following table shows all plan designs for which adjustments were made, the adjustments considered, the original AV from the AVC, and the final adjusted AV. The pediatric dental consideration may also apply to the Platinum, Gold and Silver Deductible and CSR plans when issuers include the benefit but no explicit adjustment was made since coverage of the pediatric dental benefit is optional.

Table 1: Summary of Adjustments Considered and Final Adjusted AVs

Adjustments Considered	Silver HDHP	Bronze HDHP	Bronze Deductible *	Silver HDHP - CSR 73%	Silver HDHP - CSR 77%	Silver HDHP - CSR 87%	Silver HDHP - CSR 94%
Aggregate Ded/MOOP	Yes	Yes	No	Yes	Yes	Yes	Yes
Drug Regulation	Yes	Yes	Yes	Yes	Yes	No	No
Preventive Drugs	Yes	Yes	No	Yes	Yes	Yes	Yes
Pediatric Dental	Yes	Yes	Yes	Yes	Yes	Yes	Yes
AV from AVC	70.3%	63.6%	59.9%	74.4%	78.6%	87.7%	93.9%
Final Adjusted AV	68.7%	60.9%	61.5%	72.8%	76.8%	87.2%	93.8%

*The bronze deductible plan was also adjusted for counter intuitive AVC changes

METHODOLOGY

Since several of the standard plan designs have features not supported by the AVC, Wakely developed an HDHP model to capture the impact of these features on the AV. It was anticipated that the AVC would not accommodate all of the Vermont plan design features and this model was developed several months prior to the draft 2014 AVC being released. While there are similarities in the data used (for example, only group data is included in both models), there are also differences (for example, the HDHP model includes all members regardless of duration while the AVC includes only members who are enrolled the full 12 months).

If a plan does have substantive differences from what the AVC allows, there are two allowed approaches defined in the federal regulations. The first allows the actuary to adjust the inputs of the plan design to "fit" it into the AVC. The second allows the actuary to put in as many of the design features as possible into the AVC and then adjust the resulting AV to account for the unique design features. Wakely determined the second approach was most appropriate for the Vermont plan design differences. Thus for the seven plan designs where adjustments were made, Wakely first input as much of the plan design as possible into the AVC and then modified the resulting AV to account for the unique features.

The following discusses the HDHP model that Wakely developed and the process used to adjust the actuarial values from the AVC.

HDHP Model

Anticipating the need to quantify some of Vermont's unique plan design features, in mid-2012 Wakely developed an HDHP model that would account for both aggregate deductibles and MOOPs as well as quantify the impact of Vermont's prescription drug regulation.

In developing the model Wakely was provided with membership and medical and pharmacy claims data extracts from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Filters were then applied to the data to target a specific population for the model and reduce the amount of records to work with. The data used included:

- Allowed commercial medical and prescription drug data that was incurred in 2010
- Products types HMO (non-Medicare risk), PPO, POS and EPO
- Used claims with a Useflag='0'
- All market categories except individual
- Limited to members in select payer ids

After all filters were applied, the remaining data included allowed claims and membership for approximately 2.5 million member months.

The methodology developed for the HDHP model does not use the traditional approach of continuance tables. When determining the paid claims and resulting actuarial value of the plan designs where the prescription drug regulation is a factor, the order in which the claims occur is important. Continuance tables fail to recognize the impact of the order of the claims on actuarial values. Thus, the HDHP model re-prices the claims based on the inputs provided in the model rather than rely on continuance tables.

The HDHP model allows a user to enter the following:

- Medical and Prescription drug deductible amounts for both individual and family contracts. These amounts can differ but the model assumes the amounts are always integrated, or that both medical and drug claims will accumulate to both deductibles, even if different amounts.

- Medical and prescription drug maximum out of pocket amounts for both individual and family contracts. These amounts can differ and the model allows for different treatment of the MOOPs as noted below.

- Medical and prescription drug coinsurance amounts. If the plan design includes copays, an effective coinsurance needs to be input.

- The structure of the deductibles and MOOPs. As can be seen in the table below, the model can distinguish between aggregate and stacked deductibles and MOOPs. It also allows for different accumulations of claims to the medical and prescription drug MOOPs. There are five structural selections available in the model, described in the table below. Option 5 is most closely aligned to the federal AVC. Option 1 represents the design of the Vermont HDHPs.

Options	Costs that Accumulate			Deductible / MOOP Type
	Deductible	Maximum Out-of-Pocket (MOOP)		
		Medical	Rx	
1	Medical & Rx	Medical & Rx	Rx Only	Aggregate
2	Medical & Rx	Medical & Rx	Rx Only	Stacked
3	Medical & Rx	Medical Only	Rx Only	Aggregate
4	Medical & Rx	Medical Only	Rx Only	Stacked
5	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Adjusted AV Calculations

Using the federal AV calculator and the HDHP model as outlined above, the following methodology was used to develop the adjusted AV calculations for the HDHPs:

1. The plan designs were entered into the AVC ignoring the separate prescription drug deductible and MOOP thresholds. The resulting AV is the unadjusted value, which does not account for the prescription drug regulations or the aggregate family deductible and MOOP levels.

2. The HDHP model was used to determine the revised AV.
    a. The same plan design input into the AVC was input into the HDHP model. The HDHP model only allows for coinsurance. Since the HDHP designs include copays, an effective coinsurance was developed for each plan design. The effective coinsurance amounts were developed separately for medical and prescription drug services using the allowed weights and average cost per service from the federal AVC continuance tables for the relevant metal tier.
    b. The HDHP model was normalized to the AVC for each plan design. This means the same plan design, ignoring the prescription drug thresholds and assuming a stacked family deductible and MOOP, was input into the HDHP model and the underlying data was adjusted to arrive at the same AV as the AVC. This was done to ensure the same starting AV in both models and to try to mirror the induced utilization in the AVC. The normalization factors were reviewed for reasonability and deemed reasonable given they are accounting for trend, regional differences in cost and utilization and induced utilization.
    c. The plan design in the HDHP model was adjusted to lower the prescription drug deductible and MOOP inputs (if applicable) to the appropriate plan design amounts. The application of deductible and MOOP was also changed to use an aggregate family deductible and MOOP and also to adjust the prescription drug MOOP to only consider prescription drug claims (the medical MOOP amount continues to use both medical and prescription drug claims).

3. The resulting AV from the HDHP model is used as the final AV for tier placement.

The HDHP model was intended only for HDHPs where medical and drug claims both accumulate to the deductible. The Bronze deductible plan needs to be adjusted to account for the lower prescription drug MOOP, but the deductible plan has separate medical and drug deductibles. Thus, the HDHP model was used but with a slight variation in methodology. The following highlight the differences in methodology used only for the Bronze Deductible plan.

1. Same as for HDHPs, as much of the plan design as possible was entered into the AVC. This is the unadjusted AV. Since the increase from a $200 drug deductible to a $300 drug deductible produced counter intuitive results, the 2014 plan design with the $200 drug deductible was entered into the 2015 AVC. The Bronze Deductible plan then needs to be adjusted for the increased deductible and to account for the lower and separate prescription drug MOOP.

2. The $200 plan design results in a reasonable AV in the final 2015 AVC so this AV was used as the starting point. The change in plan design was then accounted for using the Truven Wakely Benefit Modeler[3]. The ratio of the 2015 plan design ($300 deductible) AV over the 2014 plan design ($200 deductible) AV was applied to the federal AV for the 2014 plan design. This produced an adjusted AV that more accurately accounts for the change in the drug deductible. The AV was then further adjusted for the lower prescription drug MOOP.

3. The HDHP model was used to develop the AV adjustments in a slightly different process than for the HDHPs.
    a. The HDHP model cannot accommodate plan designs where both medical and drug claims do not accumulate to the deductible. Thus, the same plan design was entered into the HDHP model as in the AVC but the model selection indicated that both medical and drug claims accumulated to the deductible amounts.
    b. The HDHP model was then re-run with the lower drug MOOP and to adjust the prescription drug MOOP to only consider prescription drug claims (the medical MOOP amount continues to use both medical and prescription drug claims). The model continued to use a stacked application for deductible and MOOP since it is a traditional deductible plan.

4. The final AV is the ratio of the AV from 3c and 3b applied to the adjusted AV from 2.

Appendix D includes screen shots from the AVC and the HDHP model for each plan design with an adjusted actuarial value. Also included is a summary of the AVs and in the instance of the Bronze Deductible plan, a calculation of the adjustment.

Wakely followed the same methodology to verify that the AVs for HDHP plans remained in the acceptable range using a $1300 deductible and MOOP for drug benefits. Appendix E includes screen shots of the HDHP results with the $1300 deductible.

[3] The Truven Wakely Benefit Modeler uses Truven's MarketScan data as the underlying data and uses continuance tables and other actuarial adjustments to estimate the paid, allowed and AVs for various plan designs.

RELIANCES

We have relied on others for information used in the actuarial value adjustments. For the original AV, the final 2015 federal AVC model was relied on. While reasonability tests have shown some errors in the calculations and there are some assumptions and methodologies that are not consistent with expectations, the AVC was developed for plan classification and not pricing. Thus, the model is being used as such and we make no warranties for the accuracy of the AVs that result from the AVC.

VHCURES data supplied by the state was used in the development of the HDHP model. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information.

DISCLOSURES AND LIMITATIONS

Wakely is financially and organizationally independent from the State of Vermont and any issuer in the state.

Wakely does not warrant or guarantee that actual experience will tie to the AV estimated for the placement of plan designs into tiers. The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

The distribution of this report to other users is limited to the State of Vermont and issuers within that state that will be submitting standard plan designs. Distribution to such parties should be made in its entirety. Distribution to other parties should only be made with Wakely's consent.

Exhibit A contains the formal actuarial certification. If you have any questions regarding this letter or the certification, please contact me.

Sincerely,

Julie A. Peper, FSA, MAAA
Director and Senior Consulting Actuary

WAKELY CONSULTING GROUP
CONSULTING ACTUARIES & HEALTHCARE SPECIALISTS
Clearwater, FL • Louisville, KY • Denver, CO

APPENDIX A

Actuarial Certification
State of Vermont
Actuarial Value of Standard Plan Designs
Effective January 1, 2015

I, Julie A. Peper, am associated with the firm of Wakely Consulting Group, Inc. (Wakely), am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. Wakely was retained by the State of Vermont to provide a certification of the actuarial value of the state's standard plan designs that are effective January 1, 2015 on Vermont Health Connect. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the actuarial values provided with this certification are considered actuarially sound for purposes of § 156.135(b), according to the following criteria:

- The final 2015 federal Actuarial Value Calculator was used to determine the AV for the plan provisions that fit within the calculator parameters;
- Appropriate adjustments were calculated, to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV calculator;
- The actuarial values have been developed in accordance with generally accepted actuarial principles and practices; and
- The actuarial values meet the requirements of § 156.135(b).

The assumptions and methodology used to development the actuarial values have been documented in my correspondence with the State of Vermont. The actuarial values associated with this certification are for standard plan designs (Silver HDHP, Bronze HDHP, Bronze Deductible, Silver HDHP CSR 73%, Silver HDHP CSR 77%, Silver HDHP CSR 87% and Silver HDHP CSR 94%) that will be effective as of January 1, 2015 on Vermont Health Connect.

The developed actuarial values are for the purposes of classifying plan designs of similar value and do not represent the expected actuarial value of a plan. Actual AVs will vary based on a plan's specific population, utilization, unit cost and other variables.

In developing the actuarial values, I have relied upon the federal Actuarial Value calculator and data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). I did not audit the data provided; however, I did review the data for reasonableness and consistency.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Julie A. Peper, FSA, MAAA
March 21, 2014

APPENDIX B

Standard Plan Designs

	Deductible Plans				HDHPs	
Deductible/OOP Max	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
Type of Plan	Deductible	Deductible	Deductible	Deductible	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$150	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	$1,250	$1,250
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,250	$1,250
Integrated OOPM	No	No	No	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb	Preventive	Preventive	Preventive
Drug Deductible waived for:	N/A	Generic scripts	Generic scripts	Applies to all scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	10%	20%	40%	50%	20%	50%
Outpatient [2]	10%	20%	40%	50%	20%	50%
ER [3]	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$25	$35	10%	50%
MH/SA Office Visit	$10	$15	$25	$35	10%	50%
Specialist Office Visit [4]	$20	$25	$45	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%
Actuarial Value						
Federal AVC, Adjusted if Necessary	88.1%	80.2%	71.5%	61.5%	68.7%	60.9%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Plan Designs – Cost Sharing Reduction Plans (Deductibles)

	Cost Sharing Reduction Plan Designs - Deductible Plans				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	Deductible	Deductible	Deductible	Deductible	Deductible
Medical Ded	$1,900	$1,900	$1,500	$600	$100
Rx Ded	$100	$100	$100	$100	$0
Integrated Ded	No	No	No	No	No
Medical OOPM	$5,100	$4,000	$3,000	$1,250	$500
Rx OOPM	$1,250	$1,200	$1,000	$400	$200
Integrated OOPM	No	No	No	No	No
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb
Drug Deductible waived for:	Generic scripts	Generic scripts	Generic scripts	Generic scripts	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	40%	40%	40%	40%	10%
Outpatient [2]	40%	40%	40%	40%	10%
ER [3]	$250	$250	$250	$250	$75
Radiology (MRI, CT, PET)	40%	40%	40%	40%	10%
Preventive	$0	$0	$0	$0	$0
PCP Office Visit	$25	$25	$20	$10	$5
MH/SA Office Visit	$25	$25	$20	$10	$5
Specialist Office Visit [4]	$45	$45	$40	$30	$15
Urgent Care	$60	$60	$60	$50	$35
Ambulance	$100	$100	$100	$100	$50
Rx Generic	$12	$12	$12	$10	$5
Rx Preferred Brand	$50	$50	$50	$50	$20
Rx Non-Preferred Brand	50%	50%	50%	50%	30%
Actuarial Value					
Federal AVC, Adjusted if Necessary	71.5%	73.6%	76.9%	87.0%	94.0%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

Standard Plan Designs – Cost Sharing Reduction Plans (HDHPs)

	Cost Sharing Reduction Plan Designs - HDHPs				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,550	$1,400	$1,250	$1,000	$450
Rx Ded	$1,250	$1,250	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$5,750	$3,400	$2,500	$1,000	$450
Rx OOPM	$1,250	$1,250	$1,250	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**				
Inpatient [1]	20%	20%	20%	0%	0%
Outpatient [2]	20%	20%	20%	0%	0%
ER [3]	20%	20%	20%	0%	0%
Radiology (MRI, CT, PET)	20%	20%	20%	0%	0%
Preventive	0%	0%	0%	0%	0%
PCP Office Visit	10%	10%	10%	0%	0%
MH/SA Office Visit	10%	10%	10%	0%	0%
Specialist Office Visit [4]	20%	20%	20%	0%	0%
Urgent Care	20%	20%	20%	0%	0%
Ambulance	20%	20%	20%	0%	0%
Rx Generic	$10	$10	$5	$0	$0
Rx Preferred Brand	$40	$40	$30	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	0%	0%
Actuarial Value					
Federal AVC, Adjusted if Necessary	68.7%	72.8%	76.8%	87.2%	93.8%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

APPENDIX C

Comments Relative to Applicable ASOPs

This appendix includes comments relative to the following applicable Actuarial Standards of Practice (ASOP).

• ASOP No. 23, *Data Quality*;

• ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*; and

• ASOP No. 41, *Actuarial Communications*.

ASOP 23: Data Quality

3.1 Overview – VHCURES data was used as the basis for the HDHP model and this data source was deemed reasonable for the analysis discussed in the management report.

3.2 Selection of Data - The data was considered reasonable for our analysis subject to the following considerations -

a. The data sources contained all material data elements.

b. The following considerations were reviewed as part of our analysis:

1. Data was appropriate and sufficiently current. The data was for similar/same populations and the most applicable data set available.
2. Data was reasonable and comprehensive of the necessary data elements.
3. There were no known, material limitations of the data.
4. No alternative data sets were reasonably available. The reliability of the data underlying our analysis did not require support from alternative data sets.
5. Alternative data sets were not deemed necessary to complete the analysis.
6. Sampling methods were not required.

3.3 Reliance on Data Supplied by Others - Reliance is discussed in the management report to which this appendix is attached.

3.4 Reliance on Other Information Relevant to the Use of Data - We relied on information contained in the report. We did not detect any material errors in the data provided and relied upon the data as part of our analysis.

3.5 Review of Data - We reviewed the data. Data definitions were included as part of the VHCURES data. Ultimately the data was reasonable with the adjustments discussed in our management report.

3.6 Limitation of the Actuary's Responsibility - We did not audit the data.

3.7 Use of Data– Use and adjustments to the data are discussed in this management report. In addition:

a. We deem that the data are of sufficient quality to perform the analysis;

b. The data did not require enhancement before the analysis could be performed

c. The data was reasonable for the analysis and did not require adjustment beyond that discussed in the management report;

d. We did not detect any material defects in any data source;

e. The data were adequate to perform our analysis.

ASOP 25: Credibility Procedures

The HDHP model uses data as its starting point. The experience used is fully credible and therefore no credibility blending or adjustments were necessary.

ASOP41: Actuarial Communications

This report and the actuarial memorandum submitted are consistent with the guidance in ASOP 41.

3.1 General Requirements for Actuarial Communications

3.1.1 Principal and Scope of Engagement – These results were developed to comply with § 156.135(b) and should not be used for any other purpose. The distribution of this report to other users is limited to the State of Vermont.
3.1.2 Form and Content – The State of Vermont was the principal for this engagement and the scope of the engagement included developing and certifying the actuarial values for the standard plan designs as discussed in the management report.
3.1.3 Timing of Communication – This report is provided in conjunction with the actuarial certification of the submitted actuarial values.
3.1.4 Identification of Responsible Actuary – The responsible actuary is identified in the attestation and this management report.

3.2 Actuarial Report – This management report is an Actuarial Report as defined in this ASOP. Correspondence between Wakely and the State of Vermont as part of this engagement should also be considered part of the Actuarial Report.

3.3 Specific Circumstances – No constraints apply beyond any discussed in the attachment management report.

3.4 Disclosures Within an Actuarial Report - all relevant disclosures have been made in the management report. Consistent with this ASOP, we make specific mention to the following items here:

3.4.1 Uncertainty or Risk – Uncertainty is discussed in the management report.
3.4.2 Conflict of Interest – Wakely is financially, organizationally, and otherwise independent from the State of Vermont and any reliant parties.
3.4.3 Reliance on Other Sources for Data and Other Information - Reliance regarding data and assumptions are discussed in this management report.
3.4.4 Responsibility for Assumptions and Methods - Assumptions and methods are discussed in the management report and the parties associated with the assumptions and methods have been delineated. Therefore, pursuant to this ASOP, no additional disclosure is necessary.
3.4.5 Information Date of Report -The management report list the applicable dates for the analysis and correspondence.
3.4.6 Subsequent Events - There are no subsequent events, as of the date of this report that would materially affect the results presented herein.

3.5 Explanation of Material Differences - Wakely has issued no other report regarding the development of these actuarial values. No comparison to prior results is necessary.

3.6 Oral Communications - No oral communication is considered part of this actuarial report. Any material assumptions or methods discussed in oral communications have been documented in written form as well.

3.7 Responsibility to Other Users - Intended users of this report have been specifically noted in the document.

Appendix D

Screen shots and AV Development

1. Silver HDHP
2. Bronze HDHP
3. Bronze Deductible Plan
4. Silver HDHP CSR – 73%
5. Silver HDHP CSR – 77%
6. Silver HDHP CSR – 87%
7. Silver HDHP CSR – 94%

1. Silver HDHP

AV from AVC = 70.3%
Adjusted AV = 68.7%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,750.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.3%
Metal Tier:	Silver

1. Silver HDHP, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	5,750	5,750
Family Out-of-Pocket	11,500	11,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$201.61	$50.40	$252.01
Plan PMPM	$148.76	$28.45	$177.21
Actuarial Value	73.8%	56.4%	70.3%

1. **Silver HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,250
Family Deductible	3,100	2,500
Individual Out-of-Pocket	5,750	1,250
Family Out-of-Pocket	11,500	2,500
Coinsurance (50% or Less)	18%	33%

Costs that Accumulate

	Deductible	OOP Medical	OOP Rx	Deductible / OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$201.61	$50.40	$252.01
Plan PMPM	$140.46	$32.61	$173.08
Actuarial Value	69.7%	64.7%	68.7%

2. Bronze HDHP

AV from AVC = 63.6%
Adjusted AV = 60.9%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$12.00	☑	☑		
Preferred Brand Drugs	☑	☑	60%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	40%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	63.6%
Metal Tier:	

2. Bronze HDHP, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	2,000
Family Deductible	4,000	4,000
Individual Out-of-Pocket	6,250	6,250
Family Out-of-Pocket	12,500	12,500
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$236.89	$59.22	$296.11
Plan PMPM	$156.43	$31.76	$188.19
Actuarial Value	66.0%	53.6%	63.6%

2. **Bronze HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	1,250
Family Deductible	4,000	2,500
Individual Out-of-Pocket	6,250	1,250
Family Out-of-Pocket	12,500	2,500
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$236.89	$59.22	$296.11
Plan PMPM	$141.48	$38.92	$180.41
Actuarial Value	59.7%	65.7%	60.9%

3. Bronze Deductible

AV from AVC = 59.9%
Adjustments

- Wakely pricing model at $300 Deductible / Wakely pricing model at $200 Deductible = 59.5%/60.0% = .992 x .59.9% = 59.4%
- HDHP Model with drug adjustments / HDHP Model without drug adjustments = 61.5%/59.4% = 1.035 x .594 = 61.5%

Adjusted AV = 61.5%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)	$3,500.00	$200.00				
Coinsurance (%, Insurer's Cost Share)	50.00%	40.00%				
OOP Maximum ($)	$6,350.00					
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$35.00	☑	☑		
Specialist Visit	☑	☐		$80.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$35.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☐		$80.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$80.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$20.00	☑	☑		
Preferred Brand Drugs	☑	☐		$80.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.9%
Metal Tier:	Bronze

3. Bronze Deductible, Continued

HDHP Model – Without Prescription Drug Adjustments:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	3,500	300
Family Deductible	7,000	600
Individual Out-of-Pocket	6,350	6,350
Family Out-of-Pocket	12,700	12,700
Coinsurance (50% or Less)	48%	57%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$223.21	$55.80	$279.01
Plan PMPM	$134.44	$31.27	$165.72
Actuarial Value	60.2%	56.0%	59.4%

3. **Bronze Deductible, Continued**

HDHP Model – With Prescription Drug Adjustments:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	3,500	300
Family Deductible	7,000	600
Individual Out-of-Pocket	6,350	1,250
Family Out-of-Pocket	12,700	2,500
Coinsurance (50% or Less)	48%	57%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$223.21	$55.80	$279.01
Plan PMPM	$132.11	$39.39	$171.50
Actuarial Value	59.2%	70.6%	61.5%

4. Silver HDHP CSR – 73%

AV from AVC = 74.4%
Adjusted AV = 72.8%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,400.00			
Coinsurance (% Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$3,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$10.00	☑	☑		
Preferred Brand Drugs	☑	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	74.4%
Metal Tier:	

4. Silver HDHP CSR – 73%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,400
Family Deductible	2,800	2,800
Individual Out-of-Pocket	3,400	3,400
Family Out-of-Pocket	6,800	6,800
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$218.41	$54.60	$273.01
Plan PMPM	$169.34	$33.82	$203.16
Actuarial Value	77.5%	61.9%	74.4%

4. **Silver HDHP CSR – 73%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,250
Family Deductible	2,800	2,500
Individual Out-of-Pocket	3,400	1,250
Family Out-of-Pocket	6,800	2,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$218.41	$54.60	$273.01
Plan PMPM	$162.25	$36.51	$198.75
Actuarial Value	74.3%	66.9%	72.8%

5. Silver HDHP CSR – 77%

AV from AVC = 78.6%
Adjusted AV = 76.8%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.6%
Metal Tier:	Gold

5. Silver HDHP CSR – 77%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	2,500	2,500
Family Out-of-Pocket	5,000	5,000
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$237.61	$59.40	$297.01
Plan PMPM	$192.32	$41.15	$233.47
Actuarial Value	80.9%	69.3%	78.6%

5. **Silver HDHP CSR – 77%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,250	1,250
Family Deductible	2,500	2,500
Individual Out-of-Pocket	2,500	1,250
Family Out-of-Pocket	5,000	2,500
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$237.61	$59.40	$297.01
Plan PMPM	$186.32	$41.75	$228.08
Actuarial Value	78.4%	70.3%	76.8%

6. Silver HDHP CSR – 87%

AV from AVC = 87.7%
Adjusted AV = 87.2%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. M-ISA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Calculate

Status/Error Messages:	Calculation resolved without matching metal tiers.
Actuarial Value:	87.7%
Metal Tier:	Platinum

6. Silver HDHP CSR – 87%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,000	1,000
Family Deductible	2,000	2,000
Individual Out-of-Pocket	1,000	1,000
Family Out-of-Pocket	2,000	2,000
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$256.81	$64.20	$321.01
Plan PMPM	$228.28	$53.31	$281.58
Actuarial Value	88.9%	83.0%	87.7%

6. **Silver HDHP CSR – 87%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,000	1,000
Family Deductible	2,000	2,000
Individual Out-of-Pocket	1,000	1,000
Family Out-of-Pocket	2,000	2,000
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$256.81	$64.20	$321.01
Plan PMPM	$226.90	$53.08	$279.99
Actuarial Value	88.4%	82.7%	87.2%

7. Silver HDHP CSR – 94%

AV from AVC = 93.9%
Adjusted AV = 93.8%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$450.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.9%
Metal Tier:	Platinum

7. Silver HDHP CSR – 94%, Continued

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	450	450
Family Deductible	900	900
Individual Out-of-Pocket	450	450
Family Out-of-Pocket	900	900
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$264.01	$66.00	$330.01
Plan PMPM	$249.44	$60.28	$309.73
Actuarial Value	94.5%	91.3%	93.9%

7. **Silver HDHP CSR – 94%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	450	450
Family Deductible	900	900
Individual Out-of-Pocket	450	450
Family Out-of-Pocket	900	900
Coinsurance (50% or Less)	0%	0%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$264.01	$66.00	$330.01
Plan PMPM	$249.35	$60.26	$309.61
Actuarial Value	94.4%	91.3%	93.8%

Appendix E

Screen shots and AV Development – using $1300 drug deductible and MOOP

1. Silver HDHP
2. Bronze HDHP
3. Silver HDHP CSR – 73%
4. Silver HDHP CSR – 77%

1. **Silver HDHP**

AV from AVC = 70.3%
Adjusted AV = 68.5%

No change in AVC calculation

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,550
Family Deductible	3,100	3,100
Individual Out-of-Pocket	5,750	5,750
Family Out-of-Pocket	11,500	11,500
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$202.21	$50.55	$252.76
Plan PMPM	$149.01	$28.62	$177.63
Actuarial Value	73.7%	56.6%	70.3%

1, **Silver HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,550	1,300
Family Deductible	3,100	2,600
Individual Out-of-Pocket	5,750	1,300
Family Out-of-Pocket	11,500	2,600
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$202.21	$50.55	$252.76
Plan PMPM	$140.71	$32.44	$173.16
Actuarial Value	69.6%	64.2%	68.5%

2. **Bronze HDHP**

AV from AVC = 63.6%
Adjusted AV = 60.9%

No change in AVC calculation

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	2,000
Family Deductible	4,000	4,000
Individual Out-of-Pocket	6,250	6,250
Family Out-of-Pocket	12,500	12,500
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$237.61	$59.40	$297.01
Plan PMPM	$157.02	$31.94	$188.96
Actuarial Value	66.1%	53.8%	63.6%

2. **Bronze HDHP, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	2,000	1,300
Family Deductible	4,000	2,600
Individual Out-of-Pocket	6,250	1,300
Family Out-of-Pocket	12,500	2,600
Coinsurance (50% or Less)	50%	45%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$237.61	$59.40	$297.01
Plan PMPM	$142.15	$38.68	$180.83
Actuarial Value	59.8%	65.1%	60.9%

3. **Silver HDHP CSR – 73%**

AV from AVC = 74.4%
Adjusted AV = 72.7%

No change in AVC calculation

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,400
Family Deductible	2,800	2,800
Individual Out-of-Pocket	3,400	3,400
Family Out-of-Pocket	6,800	6,800
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$219.01	$54.75	$273.76
Plan PMPM	$169.69	$34.00	$203.70
Actuarial Value	77.5%	62.1%	74.4%

3. **Silver HDHP CSR – 73%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,400	1,300
Family Deductible	2,800	2,600
Individual Out-of-Pocket	3,400	1,300
Family Out-of-Pocket	6,800	2,600
Coinsurance (50% or Less)	18%	33%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$219.01	$54.75	$273.76
Plan PMPM	$162.63	$36.32	$198.95
Actuarial Value	74.3%	66.3%	72.7%

4. **Silver HDHP CSR – 77%**

AV from AVC = 78.4%
Adjusted AV = 76.4%

AVC Screen Shot:

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,300.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	90%		☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	90%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.4%
Metal Tier:	Gold

4. **Silver HDHP CSR – 77%, Continued**

HDHP Model – Normalization:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,500	2,500
Family Out-of-Pocket	5,000	5,000
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Medical & Rx	Stacked

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$238.81	$59.70	$298.51
Plan PMPM	$192.65	$41.25	$233.90
Actuarial Value	80.7%	69.1%	78.4%

4. **Silver HDHP CSR – 77%, Continued**

HDHP Model – Adjusted Actuarial Value:

Inputs

Enter values in the blue cells below, choose a setting option from the drop down box, and press 'Calculate'.
Press 'Calculate' anytime an input or dropdown selection is changed.
Note that the model run-time will vary based on the computers processing speed.
A message box will appear to indicate that the calculations are done.

	Medical	Rx
Individual Deductible	1,300	1,300
Family Deductible	2,600	2,600
Individual Out-of-Pocket	2,500	1,300
Family Out-of-Pocket	5,000	2,600
Coinsurance (50% or Less)	18%	25%

	Costs that Accumulate			
		OOP		Deductible /
	Deductible	Medical	Rx	OOP Type
Settings	Medical & Rx	Medical & Rx	Rx Only	Aggregate

Calculate

Results

	Medical	Rx	Total
Allowed PMPM	$238.81	$59.70	$298.51
Plan PMPM	$186.61	$41.58	$228.19
Actuarial Value	78.1%	69.7%	76.4%

ATTACHMENT A

State of Vermont
Standard Plan Designs
Revised May 5, 2014

	Deductible Plans				HDHPs	
Deductible/OOP Max	**Platinum**	**Gold**	**Silver**	**Bronze**	**Silver**	**Bronze**
Type of Plan	Deductible	Deductible	Deductible	Deductible	HSA Q/HDHP	HSA Q/HDHP
Medical Ded	$150	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	$1,300	$1,300
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	No	No	No	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb, ER	Prev, OV, UC, Amb	Preventive	Preventive	Preventive
Drug Deductible waived for:	N/A	Generic scripts	Generic scripts	Applies to all scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	10%	20%	40%	50%	20%	50%
Outpatient [2]	10%	20%	40%	50%	20%	50%
ER [3]	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$25	$35	10%	50%
MH/SA Office Visit	$10	$15	$25	$35	10%	50%
Specialist Office Visit [4]	$20	$25	$45	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%
Actuarial Value						
Federal AVC, Adjusted if Necessary	88.1%	80.2%	71.5%	61.5%	68.5%	60.9%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

State of Vermont
Standard Plan Designs - CSRs
Revised May 5, 2014

	Cost Sharing Reduction Plan Designs - Deductible Plans				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	Deductible	Deductible	Deductible	Deductible	Deductible
Medical Ded	$1,900	$1,900	$1,500	$600	$100
Rx Ded	$100	$100	$100	$100	$0
Integrated Ded	No	No	No	No	No
Medical OOPM	$5,100	$4,000	$3,000	$1,250	$500
Rx OOPM	$1,250	$1,200	$1,000	$400	$200
Integrated OOPM	No	No	No	No	No
Family Deductible / OOP	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual	Stacked, 2x Individual
Medical Deductible waived for:	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb	Prev, OV, UC, Amb
Drug Deductible waived for:	Generic scripts	Generic scripts	Generic scripts	Generic scripts	N/A
Service Category	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**	**Copay / Coinsurance**
Inpatient [1]	40%	40%	40%	40%	10%
Outpatient [2]	40%	40%	40%	40%	10%
ER [3]	$250	$250	$250	$250	$75
Radiology (MRI, CT, PET)	40%	40%	40%	40%	10%
Preventive	$0	$0	$0	$0	$0
PCP Office Visit	$25	$25	$20	$10	$5
MH/SA Office Visit	$25	$25	$20	$10	$5
Specialist Office Visit [4]	$45	$45	$40	$30	$15
Urgent Care	$60	$60	$60	$50	$35
Ambulance	$100	$100	$100	$100	$50
Rx Generic	$12	$12	$12	$10	$5
Rx Preferred Brand	$50	$50	$50	$50	$20
Rx Non-Preferred Brand	50%	50%	50%	50%	30%
Actuarial Value					
Federal AVC, Adjusted if Necessary	71.5%	73.6%	76.9%	87.0%	94.0%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF and MH/SA. This cost sharing will also include physician and anesthesia costs, as appropriate.
2 Outpatient includes ASCs. This cost sharing will also include physician and anesthesia costs, as appropriate.
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, and any alternative medicine benefits, as appropriate.

State of Vermont
Standard Plan Designs - CSRs
Revised May 5, 2014

	Cost Sharing Reduction Plan Designs - HDHPs				
Deductible/OOP Max	**300% FPL + (70% AV)**	**250-300% FPL (73% AV)**	**200-250% FPL (77% AV)**	**150-200% FPL (87% AV)**	**133-150% FPL (94% AV)**
Type of Plan	HSA Q/HDHP	HSA Q/HDHP	HSA Q/HDHP	Deductible (NOT HSAQ)	Deductible (NOT HSAQ)
Medical Ded	$1,550	$1,400	$1,300	$1,000	$450
Rx Ded	$1,300	$1,300	N/A	N/A	N/A
Integrated Ded	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$5,750	$3,400	$2,500	$1,000	$450
Rx OOPM	$1,300	$1,300	$1,300	N/A	N/A
Integrated OOPM	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Rx -No, Medical - Yes	Yes	Yes
Family Deductible / OOP	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual	Aggregate, 2x Individual
Medical Deductible waived for:	Preventive	Preventive	Preventive	Preventive	Preventive
Drug Deductible waived for:	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts	Wellness scripts
Service Category	**Copay / Coinsurance**				
Inpatient [1]	20%	20%	20%	0%	0%
Outpatient [2]	20%	20%	20%	0%	0%
ER [3]	20%	20%	20%	0%	0%
Radiology (MRI, CT, PET)	20%	20%	20%	0%	0%
Preventive	0%	0%	0%	0%	0%
PCP Office Visit	10%	10%	10%	0%	0%
MH/SA Office Visit	10%	10%	10%	0%	0%
Specialist Office Visit [4]	20%	20%	20%	0%	0%
Urgent Care	20%	20%	20%	0%	0%
Ambulance	20%	20%	20%	0%	0%
Rx Generic	$10	$10	$5	$0	$0
Rx Preferred Brand	$40	$40	$30	$0	$0
Rx Non-Preferred Brand	50%	50%	50%	0%	0%
Actuarial Value					
Federal AVC, Adjusted if Necessary	68.5%	72.7%	76.4%	87.2%	93.8%

1 Inpatient includes surgery, ICU/NICU, maternity, SNF
2 Outpatient includes ASCs. This cost sharing will also
3 ER copay is waived if admitted.
4 Specialist copay also applies to PT/ST/OT, vision, ar

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Introduction

On March 5, 2014, CMS released the final Rules on the Actuarial Value and the final Actuarial Value Calculator (AVC) for 2015. The final 2015 AVC is the final 2014 AVC with updated cost sharing limits. Since the AVC did not change, BCBSVT started its analysis with the 2014 results and updated the plans for known benefit changes.

Limitations of the Federal Actuarial Calculator

The AVC is known to have some limitations with respect to certain benefit designs. The most important limitations in the Final Actuarial Value Calculator for the Non-Standard plans are:

- The AVC does not support the Rx OOPM Limit as dictated by Act 171.
- The AVC does not support copayments after the deductible.
- The AVC does not support Wellness (Safe Harbor) pharmacy drugs outside the deductible on HSA compliant plans.
- The AVC does not support certain MH/SA visits at no cost share before the deductible.
- The AVC does not support a copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services nor Home Health Care.
- The AVC does not support Class I Pediatric Dental covered at no cost share.

Method Used to Calculate Adjustments

The objective of the adjustment process is to produce an estimate of the result the AVC would have produced with respect to the specific plan in question had it been able to produce a value for that plan. We modified our pricing model to calculate the ratio of expected benefits to allowed charges. See the description of the BCBSVT AV Model (BAVM) below. We then compared the results of the BAVM with the results of the AVC for various benefit plans for which results could be obtained from both. This was done separately for blocks of plans within each of the AVC's metallic range categories. We observed that the results of the two were highly correlated. This allowed us to normalize the results of the BAVM to those of the AVC.

We begin with the result of the AVC model value for the plan incorporating all the features of the plan in question that the AVC is able to value. We then adjust this value to estimate the result of the AVC on the plan in question by applying the difference between the normalized value of the BAVM applied to the plan incorporating all the features of the plan in question, and the normalized value of the BAVM applied to the plan incorporating all the features of the plan in question that could be valued by the AVC. See the more detailed description of the adjustment method below.

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BCBSVT AV Model Methodology[1]

BCBSVT uses a re-adjudication model to assess the impact of various deductible types, Rx limits, and out-of-pocket maximums to calculate the paid-to-allowed ratio for different benefit designs. The re-adjudication is performed using the same set of claims for all benefit plans. Claims data was taken from BCBSVT's data warehouse. The starting point of the analysis is allowed charges as determined by the BCBSVT claims adjudication system. The claims data includes benefit codes that enable us to identify the services and benefit structures (copays, deductibles, and coinsurance). Although the model is similar to that used for our Benefit Relativity factors, it did not include the benefit level adjustments.

The in-network claims from Insured Group and Self Funded business are included in the analysis; Individual lines of business claims have been excluded. Only plans with both medical and pharmacy benefits are included since both medical and pharmacy data is included.

The claims were categorized according to how benefits are paid, and one record was generated for each member/ service date.

For all products, claims for preventive mandated benefits were kept separate and the model assumes they are paid in a manner consistent with the mandates.

A total of 368,039 member months were used for this analysis. Because of the normalization adjustment described below, it is appropriate to use this large, credible data set as a proxy for the HHS data underlying the AV model. Non-permitted factors such as projected demographic changes were not considered in the analysis.

The model has the flexibility to apply either coinsurance or copayments after the deductible is met.

Adjustment of the Federal Actuarial Value Calculator Result using the BCBSVT Actuarial Value Model

For each Metal tier and CSR tier, we observed a correlation between the outputs of the AVC for various integrated deductible plans and BCBSVT model's paid-to-allowed ratio for those plans. From these we calculated the appropriate linear regression function to normalize the results of the BAVM to approximate those of the AVC.

The tables following the Actuarial Opinion show the relationship between the BAVM and the AVC. All the benefits used to fit the regression lines have integrated medical and drug for both the deductible and the OOPM. These benefits designs are only for In-Network claims. For each Metal tier and CSR tier, we show the regression line used to calculate the adjustment needed for items not supported by the AVC.

[1] This methodology is consistent with that described in the approved Q2 2012 Benefit Relativity Factor Filing (SERFF Tracking # BCVT-127786182, VFN 57179).

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The adjustment is calculated as:

{the difference between the actuarial value estimate from the BCBSVT model for the non-standard plan and the actuarial value estimate from the BCBSVT model for the corresponding plan having only the features supported by the AV calculator} times {the linear parameter 'm' from the regression function}[2].

A complete description of plan provisions is attached at the end of this document. The tables following the Actuarial Opinion contain information regarding the specific benefits that were calculated as adjustments to the AVC model.

Actuarial Opinion

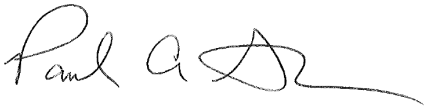
The purpose of this calculation is to comply with the requirements of 45 CFR 156.135(b)(3). The Actuarial Values were determined based on the plans' benefits and coverage data, the standard population, utilization and continuance tables published by HHS for purposes of valuation of Actuarial Value. These calculations are not intended to be used for other purposes.

I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, meet the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United Stated promulgated by the American Academy of Actuaries, and have the education and experience necessary to perform the work.

In my opinion, each of the plans described herein meets the AV requirements in the metal tiers for calendar year 2015.

The adjustments for plan design features unable to be determined directly through application of the AV calculator were developed in accordance with generally accepted actuarial principals and methodologies, Actuarial Standards of Practice established by the Actuarial Standards Board, and applicable laws and regulations, and are appropriate for the purpose intended.

Data used for the analysis were taken from the BCBSVT claims adjudication system, and normalized to the data underlying the AV calculator. This data was reviewed for reasonableness and consistency, but an audit was not performed.



Paul Schultz, F.S.A., M.A.A.A.
Actuarial Director
Blue Cross and Blue Shield of Vermont

[2] m*BAVM(x)-b is the normalized value of the BAVM result for plan x {normalized to approximate the AVC(x)}.

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Bronze Design

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$5,000	50%	$6,500	60.89%	58.15%
$4,500	50%	$6,500	61.25%	58.61%
$4,000	50%	$6,500	61.72%	59.16%
$3,500	50%	$6,500	62.32%	59.80%
$3,000	50%	$6,500	63.06%	60.57%
$2,500	50%	$6,500	63.98%	61.68%
$2,250	50%	$6,500	64.52%	62.31%
$5,000	50%	$6,250	61.52%	58.78%
$4,500	50%	$6,250	61.84%	59.24%
$4,000	50%	$6,250	62.28%	59.78%

Linear Regression Output		
m	b	r^2
1.13966	-0.11236	99.89%

Plan : Non-Standard CDHP Plan - Bronze			
Items supported by the AV Calculator	Deductible	$5,000	
	Coinsurance	50%	
	OOPM	$6,250	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	58.78%
BCBSVT Model Output for items supported by the AVC		(b)	61.52%
BCBSVT Model Output for complete benefit design		(c)	63.70%
Adjustment to the AVC	Difference	(d)=(c)-(b)	2.18%
	m	(e)	1.13966
	adjustment	(f)=(d)*(e)	2.48%
	Estimated AVC value	(g)=(a)+(f)	**61.26%**

Items not supported by the AVC:

- Rx OOPM limit of $1,300
- Wellness (Safe Harbor) pharmacy drugs outside of the deductible
- Copays applied after the deductible

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			50.00%			
OOP Maximum ($)			$6,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductible	Tier 2 Subject to Coinsurance	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑	60%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.78%
Metal Tier:	Bronze

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Silver Design

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$2,000	80%	$6,350	72.30%	70.42%
$2,000	80%	$6,250	72.38%	70.50%
$2,000	80%	$6,150	72.45%	70.59%
$2,000	80%	$5,500	73.00%	71.16%
$2,000	80%	$5,000	73.51%	71.75%
$1,750	80%	$6,250	73.56%	71.81%
$2,000	80%	$4,500	74.12%	72.40%
$1,750	80%	$5,000	74.63%	72.98%
$1,750	80%	$4,500	75.20%	73.57%
$1,500	80%	$5,850	75.14%	73.54%

Linear Regression Output		
m	b	r^2
1.09541	-0.08784	99.99%

Plan : Non-Standard Plan - Silver			
Items supported by the AV Calculator	Deductible	$2,000	
	Coinsurance	80%	
	OOPM	$6,250	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	70.50%
BCBSVT Model Output for items supported by the AVC		(b)	72.38%
BCBSVT Model Output for complete benefit design		(c)	72.88%
Adjustment to the AVC	Difference	(d)=(c)-(b)	0.50%
	m	(e)	1.09541
	adjustment	(f)=(d)*(e)	0.55%
	Estimated AVC value	(g)=(a)+(f)	**71.05%**

* Since the Federal AV Calculator does not support copays applied after the deductible, we used 80% (Insurer's cost share) as a place holder to represent that the plan has some cost sharing between the deductible and Out-of-Pocket maximum.

Items not supported by the AVC:

- Rx OOPM limit of $1,250
- Three Mental Health office visit at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment applied after the deductible
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care.

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.50%
Metal Tier:	Silver

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Gold Designs

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$1,250	80%	$5,250	77.00%	75.53%
$1,250	80%	$5,000	77.22%	75.74%
$1,250	80%	$4,750	77.46%	76.04%
$1,250	80%	$4,500	77.72%	76.34%
$1,250	80%	$4,250	78.00%	76.64%
$1,225	80%	$4,250	78.14%	76.79%
$1,200	80%	$4,250	78.28%	76.94%
$1,150	80%	$4,250	78.56%	77.24%
$1,100	80%	$4,250	78.86%	77.54%
$1,000	80%	$4,250	79.47%	78.17%

Linear Regression Output		
m	b	r^2
1.08031	-0.07643	99.92%

Plan : Non-Standard Plan - Gold			
Items supported by the AV Calculator	Deductible	$1,250	
	Coinsurance	80%	
	OOPM	$4,250	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	76.64%
BCBSVT Model Output for items supported by the AVC		(b)	78.00%
BCBSVT Model Output for complete benefit design		(c)	80.97%
Adjustment to the AVC	Difference	(d)=(c)-(b)	2.97%
	m	(e)	1.08031
	adjustment	(f)=(d)*(e)	3.21%
	Estimated AVC value	(g)=(a)+(f)	**79.85%**

* Since the Federal AV Calculator does not support copays applied after the deductible, we used 80% (Insurer's cost share) as a place holder to represent that the plan has some cost sharing between the deductible and Out-of-Pocket maximum.

Items not supported by the AV Calculator:

- Rx OOPM limit of $1,250
- Three Mental Health office visit at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment applied after the deductible
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care.

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ AI	☑ AI			☑ AI	☑ AI		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ AI	☑ AI			☑ AI	☑ AI		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value:	76.64%
Metal Tier:	

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Cost Sharing Reduction (73%) Design

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$1,750	80%	$5,200	74.43%	72.75%
$1,700	80%	$5,200	74.67%	73.01%
$1,650	80%	$5,200	74.91%	73.27%
$1,600	80%	$5,200	75.16%	73.53%
$1,550	80%	$5,200	75.41%	73.81%
$1,500	80%	$5,200	75.67%	74.08%
$1,450	80%	$5,200	75.93%	74.37%
$1,350	80%	$5,200	76.48%	74.97%
$1,300	80%	$5,200	76.76%	75.27%
$1,250	80%	$5,200	77.05%	75.57%

Linear Regression Output		
m	b	r^2
1.08191	-0.07781	100.00%

Plan : Non-Standard Plan - CSR 73%			
Items supported by the AV Calculator	Deductible	$1,550	
	Coinsurance	80%	
	OOPM	$5,200	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	73.81%
BCBSVT Model Output for items supported by the AVC		(b)	75.41%
BCBSVT Model Output for complete benefit design		(c)	75.38%
Adjustment to the AVC	Difference	(d)=(c)-(b)	-0.03%
	m	(e)	1.08191
	adjustment	(f)=(d)*(e)	-0.03%
	Estimated AVC value	(g)=(a)+(f)	**73.78%**

* Since the Federal AV Calculator does not support copays applied after the deductible, we used 80% (Insurer's cost share) as a place holder to represent that the plan has some cost sharing between the deductible and Out-of-Pocket maximum.

Items not supported by the AV Calculator:

- Rx OOPM limit of $1,250
- Three Mental Health office visit at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment applied after the deductible
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care.

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,550.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☑ AI	☑ AI			☑ AI	☑ AI		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ AI	☑ AI			☑ AI	☑ AI		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.81%
Metal Tier:	Silver

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Cost Sharing Reduction (77%) Design

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$1,000	80%	$5,200	78.57%	77.16%
$950	80%	$5,200	78.90%	77.50%
$900	80%	$5,200	79.24%	77.83%
$850	80%	$5,200	79.58%	78.18%
$800	80%	$5,200	79.93%	78.52%
$750	80%	$5,200	80.29%	78.87%
$700	80%	$5,200	80.66%	79.22%
$650	80%	$5,200	81.04%	79.59%
$600	80%	$5,200	81.43%	79.95%
$550	80%	$5,200	81.84%	80.33%

Linear Regression Output		
m	b	r^2
0.96980	0.00985	99.98%

Plan : Non-Standard Plan – CSR 77%			
Items supported by the AV Calculator	Deductible	$1,000	
	Coinsurance	80%	
	OOPM	$5,200	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	77.16%
BCBSVT Model Output for items supported by the AVC		(b)	78.57%
BCBSVT Model Output for complete benefit design		(c)	78.07%
Adjustment to the AVC	Difference	(d)=(c)-(b)	-0.50%
	m	(e)	0.96980
	adjustment	(f)=(d)*(e)	-0.48%
	Estimated AVC value	(g)=(a)+(f)	**76.68%**

* Since the Federal AV Calculator does not support copays applied after the deductible, we used 80% (Insurer's cost share) as a place holder to represent that the plan has some cost sharing between the deductible and Out-of-Pocket maximum.

Items not supported by the AV Calculator:

- Rx OOPM limit of $1,250
- Three Mental Health office visit at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment applied after the deductible
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care.

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$5,200.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☑ AI	☑ AI			☑ AI	☑ AI		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ AI	☑ AI			☑ AI	☑ AI		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	Error: Result is outside of +/- 1 percent de minimis variation for CSRs.
Actuarial Value:	77.16%
Metal Tier:	

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Cost Sharing Reduction (87%) Design

Deductible	Coinsurance	OOPM	BCBSVT Model AV	AV Calculator
$400	20%	$2,250	86.60%	85.45%
$350	20%	$2,250	87.00%	85.78%
$300	20%	$2,250	87.41%	86.13%
$250	20%	$2,250	87.84%	86.52%
$200	20%	$2,250	88.29%	86.91%
$150	20%	$2,250	88.76%	87.34%
$100	20%	$2,250	89.26%	87.76%
$50	20%	$2,250	89.78%	88.30%
$0	20%	$2,100	90.60%	89.10%
$0	20%	$2,000	90.79%	89.29%

Linear Regression Output		
m	b	r^2
0.91729	0.05955	99.90%

Plan : Non-Standard Plan – CSR 87%			
Items supported by the AV Calculator	Deductible	$200	
	Coinsurance	80%	
	OOPM	$2,250	
AVC Output for items supported by the AVC (Screen Print Below)		(a)	86.91%
BCBSVT Model Output for items supported by the AVC		(b)	88.29%
BCBSVT Model Output for complete benefit design		(c)	87.35%
Adjustment to the AVC	Difference	(d)=(c)-(b)	-0.94%
	m	(e)	0.91729
	adjustment	(f)=(d)*(e)	-0.86%
	Estimated AVC value	(g)=(a)+(f)	**86.05%**

* Since the Federal AV Calculator does not support copays applied after the deductible, we used 80% (Insurer's cost share) as a place holder to represent that the plan has some cost sharing between the deductible and Out-of-Pocket maximum.

Items not supported by the AV Calculator:

- Rx OOPM limit of $1,250
- Three Mental Health office visit at no cost share before the deductible
- Class I Pediatric Dental at no cost share
- Copayment applied after the deductible
- Copayment on Outpatient Surgery, Urgent Care, Emergency Medical Transportation, DME services and Home Health Care.

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User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☑	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsurance, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsurance, if	Tier 2 Copay, if separate
Medical	☑ AI	☑ AI			☑ AI	☑ AI		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ AI	☑ AI			☑ AI	☑ AI		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.91%
Metal Tier:	Gold

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Cost Sharing Reduction (94%) Design

The inclusion of Mental Health office visits in the three PCP or Mental Health Office visits at no cost share before the deductible benefit and copays on Urgent Care, Emergency Medical Transportation, DME services and Home Health Care are not supported by the AVC for this plan. The difference between the AVC benefit of three PCP visits at no cost share before the deductible and the BCBSVT benefit of three PCP or MHSA visits at no cost share is immaterial[3] and the addition of copays on Urgent Care, Emergency Medical Transportation, DME services and Home Health Care is also immaterial; therefore we are using the AVC directly for this plan.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$0.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$850.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsuranc	Tier 1 Coinsuranc e, if	Tier 1 Copay, if separate	Tier 2 Subject to Deductibl	Tier 2 Subject to Coinsuran	Tier 2 Coinsuran ce, if	Tier 2 Copay, if separate
Medical	☑ AI	☐ AI			☑ AI	☑ AI		
Emergency Room Services	☑	☐		$250.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑		
Specialist Visit	☑	☐		$35.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$15.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$35.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$35.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$35.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ AI	☑ AI			☑ AI	☑ AI		
Generics	☑	☐		$5.00	☑	☑		
Preferred Brand Drugs	☑	☑	60%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	40%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
# Visits (1-10):	3
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Calculate

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.14%
Metal Tier:	Platinum

[3] The AV calculator produces an AV of 93.18% for a plan with identical inputs other than MHSA cost sharing which is set to no cost sharing, Therefore the waiving of cost sharing on up to three MHSA visits for those not having 3 or more PCP visits is not expected to have any material impact.

BCBSVT Exchange Non-Standard Plans
2015

	GOLD	SILVER	BRONZE	CSR 73%	CSR 77%	CSR 87%	CSR 94%
	Blue For You	Blue For You	Blue For You	Blue For You	Blue For You	Blue For You	Blue For You
Deductible/OOP Max	Deductible	Deductible	CDHP	Deductible	Deductible	Deductible	Deductible
Medical Ded	$1,250	$2,000	$5,000	$1,550	$1,000	$200	$0
Rx Ded	Combined	Combined	Combined	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$6,250	$6,250	$5,200	$5,200	$2,250	$850
Rx OOPM	$1,250	$1,250	$1,300	$1,250	$1,250	$1,250	$850
Integrated OOPM	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family Deductible / OOP	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate
Medical Deductible waived for:	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Dental Class I	Preventive Care, 3 PCP/MH Office Visits, Dental Class I
Drug Deductible waived for:	N/A	N/A	Wellness Scripts	N/A	N/A	N/A	N/A
Service Category							
Preventive	$0	$0	$0	$0	$0	$0	$0
PCP Office Visit	3 visits per member combined PCP/MH at no cost share before deductible then $20 copay	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	50%	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	3 visits per member combined PCP/MH at no cost share before deductible then $30 copay	3 visits per member combined PCP/MH at no cost share before deductible then $15 copay
MH/SA Office Visit			50%				
Specialist Office Visit	$30	$50	50%	$50	$50	$50	$35
Urgent Care	$30	$50	50%	$50	$50	$50	$35
Ambulance	$30	$50	50%	$50	$50	$50	$35
DME	$30	$50	50%	$50	$50	$50	$35
ER	$250	$250	50%	$250	$250	$250	$250
Radiology (MRI, CT, PET)	$500	$1,750	50%	$1,750	$1,750	$1,750	$0
Outpatient	$500	$1,750	50%	$1,750	$1,750	$1,750	$0
Inpatient	$500	$1,750	50%	$1,750	$1,750	$1,750	$0
Rx Generic	$5	$5	$25	$5	$5	$5	$5
Rx Preferred Brand	40%	40%	40%	40%	40%	40%	40%
Rx Non-Preferred Brand	60%	60%	60%	60%	60%	60%	60%
Pediatric Vision (Exam and Materials)	$30	$50	50%	$50	$50	$50	$35
Pediatric Dental Class I	0%	0%	0%	0%	0%	0%	0%
Pediatric Dental Class II	30%	30%	30%	30%	30%	30%	30%
Pediatric Dental Class III	50%	50%	50%	50%	50%	50%	50%

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May 26, 2014

Ms. Ruth Greene
Vice President, Treasurer & CFO
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

Re: Projected CY 2015 Net Claims Costs for Pediatric Dental

Dear Ruth:

As you requested, we have developed projected CY 2015 net claims costs for pediatric dental services. The estimates assume the pediatric dental coverage is integrated with the medical coverage, as opposed to being offered as a standalone plan. We assumed the integrated deductible applies to all dental services except Class 1 services, except for the CDHP plans and the Catastrophic plan where it also applies to Class 1 services. This is a significant change from the 2014 benefits where the integrated deductible applies to Class 1 services for all plans. We modeled results for each of the six standard medical plans specified by the State, as well as the four non-standard plans designed by Blue Cross and Blue Shield of Vermont (BCBSVT). The projection is appropriate for CY 2015; adjustments should be made for rates that apply to subsequent periods.

The projected CY 2015 net claims cost per child per month amounts are shown below for each plan:

Medical Plan	Projected Dental Cost
Standard Platinum	$38.77
Standard Gold	$33.62
Standard Silver	$28.78
Standard Bronze	$25.71
Standard Silver CDHP	$16.56
Standard Bronze CDHP	$13.70
Non-Standard Gold	$31.83
Non-Standard Silver	$28.54
Non-Standard Bronze CDHP	$6.28
Non-Standard Catastrophic	$4.94

It should be noted there is a considerable amount of uncertainty in these projections. BCBSVT does not have credible dental claims experience, and as a result, the estimates are based on manual rates using the Milliman Dental Cost Guidelines (DCGs). Beyond the normal level of uncertainty associated with manual rates, there are a number of elements in this pricing that create significant additional uncertainty, such as the integration of medical and dental benefits, potential pent-up demand for dental services, no annual maximum benefit limit, and uncertainty in identifying medically necessary orthodontia services.

It is our understanding that these estimates will be added without any adjustment to BCBSVT's estimates of medical costs to develop premium rates, and that normalization for the expected impact of various rating factors does not apply.

These estimates are intended to assist BCBSVT with its development of proposed CY 2015 rates for individual and small group business that will be sold on the Vermont Exchange for a 1/1/2015 effective date. The estimates may not be appropriate for any other use.

Development of Projected Claims for Non-Orthodontia Services

The projected claims costs for non-orthodontia are based on the Milliman Dental Cost Guidelines (DCGs). The DCG starting costs reflect national average billed charges. The methodology consists of the following steps:

- *Starting Costs* – The DCGs contain starting data by age/gender category. We used the average claims costs for ages 0-21 based on the BCBSVT age mix within the 0-21 age band.

- *Area* – We adjusted the national average starting data to statewide Vermont based on area factors contained in the DCGs.

- *Trend* – We trended the CY 2013 starting data to CY 2015 using a 5% annual trend.

- *Discounts* – We used the 2013 fee level data provided by BCBSVT to develop discount percentages, which were then applied to the projected 2015 billed charges.

- *Benefit Richness* – We made adjustments to reflect the expected impact of member cost sharing on projected utilization levels. These adjustments are based on the Milliman Dental Cost Guidelines and actuarial judgment.

- *Pent-Up Demand* – We assumed most members would not have prior dental coverage based on information provided by BCBSVT. The DCGs suggest a factor of 1.30 for new business; however that factor applies to a standard population. We reduced the DCG factor to 1.15 to reflect the expected lower impact for the mix of services expected for children. BCBSVT expects this level to moderate to 1.10 for members in their second year of coverage. Based on the expected mix of first and second year members in 2015, BCBSVT estimates an average factor of 1.11.

- *Projected Allowed Costs* – Applying the adjustments described above results in the projected allowed costs for non-orthodontia costs.

- *Projected Net Costs* – As mentioned above, the projections assume the dental benefits are integrated with medical, as specified by BCBSVT. The projections reflect the medical benefits for the six medical plans specified by the State and the four non-standard plans designed by BCBSVT. The medical benefits are shown in the attached tables. The dental coinsurance is 100/70/50% on Classes 1-3 services, respectively, except that Space Maintainers are covered at 100% and Bridges and Simple Repairs are covered at 70%. We developed the net costs in two steps.

  In the first step, we modeled the medical benefits and determined the portion of the deductible and out-of-pocket maximum that would be filled by medical claims, and the portion that would remain to be applied to dental services. We modeled the medical benefits using a child claims probability distribution from the Milliman Health Cost Guidelines (HCGs), scaled to match the projected CY 2015 child allowed PMPM of $266 provided by BCBSVT. We performed a simulation of 10,000 members and tabulated the remaining deductible and out-of-pocket maximum amounts.

  In the second step, we used the remaining deductible and out-of-pocket maximum amounts and the dental coinsurance percentages to develop dental net claims costs for the each of the modeled 10,000 members. The dental development is based on a child non-orthodontia dental claims probability distribution from the DCGs that is scaled to the projected dental allowed claims PMPM described above. The overall projected dental net claims cost is the average of the dental net claims cost for each of the 10,000 modeled members.

  By assuming the medical benefits apply to the deductible and out-of-pocket maximum prior to any dental claims, the projected net claims cost for dental services is overstated. However, our understanding is that BCBSVT is not reflecting the impact of dental costs on the deductible and out-of-pocket maximum in its development of the medical costs, and these projected dental amounts are intended to represent the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT.

Development of Projected Costs for Orthodontia Services

The orthodontia coverage includes medically necessary orthodontia only. While the State's benefit description does include the criteria that define medical necessity, it was not possible to precisely identify medically necessary orthodontia in the orthodontia data available to us.

We started with a child orthodontia claims probability distribution from the DCGs, area adjusted to statewide Vermont and trended to CY 2015. We assumed that medically necessary orthodontia would have a higher average annual claims amount than non-medically necessary orthodontia. We assumed that 30% of children with orthodontia costs greater than $3000 would have medically necessary orthodontia. This results in just under 30% of the overall orthodontia costs being allocated to medically necessary orthodontia.

We modeled orthodontia claims separately from non-orthodontia claims. We assumed the integrated deductible and out-of-pocket maximum apply to orthodontia, and we applied 50% coinsurance. In the orthodontia development we assumed children with medically necessary orthodontia claims have

twice the level of medical claims on average due to the nature of their conditions, and average levels of non-orthodontia costs.

Limitations

The following limitations apply to our analysis.

- *Data Reliance* – In performing our analysis, we relied on data and other information provided by BCBSVT. We have not audited or verified this data and other information. Such a review is beyond the scope of our assignment. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

- *Variability* – It is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in the projections, the actual amounts will also deviate from the projected amounts. We recommend that BCBSVT monitor the emerging experience and make adjustments as warranted.

- *Distribution and Use* – This letter has been prepared for the use of and is only to be relied upon by the management of BCBSVT. No portion of this letter may be provided to any other party without Milliman's prior written consent, which consent shall not be unreasonably withheld but may be conditioned upon the execution by a third party of Milliman's standard release form; provided however, BCBSVT may provide the letter to any applicable governmental or regulatory agency as required by law. In the event such consent is provided, the letter must be provided in its entirety. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

Qualifications

This report may be considered a statement of actuarial opinion under guidelines promulgated by the American Academy of Actuaries. I am a member of the American Academy of Actuaries and meet its Qualification standards to render the opinion contained herein.

Please call me if you have any questions or if there is any additional assistance that we can provide.

Sincerely,

George N. Berry, FSA.
Principal and Consulting Actuary

GNB/pg/jpj
Enclosures

Table 1
Blue Cross Blue Shield of Vermont
Summary of Standard Plan Designs, Revised

Deductible/OOP Max	Platinum	Gold	Silver	Bronze	Silver CDHP	Bronze CDHP
Medical Ded	$150	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	Combined	Combined
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	No	No	No	Yes	Yes	Yes
Family Ded / OOP	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, Dental Class 1, Vision	Preventive, Dental Class 1	Preventive	Preventive
Drug Ded waived for:	N/A	Generic scripts	Generic scripts	N/A	Wellness scripts	Wellness scripts
Service Category	Copay / Coinsurance					
Inpatient	10%	20%	40%	50%	20%	50%
Outpatient	10%	20%	40%	50%	20%	50%
ER	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$25	$35	10%	50%
MH/SA Office Visit	$10	$15	$25	$35	10%	50%
Specialist Office Visit	$20	$25	$45	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
DME	10%	20%	40%	50%	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%

Table 2
Blue Cross Blue Shield of Vermont
Non-Standard Plans

Deductible/OOP Max	Gold	Silver	Bronze CDHP	Catastrophic
Medical Ded	$1,250	$2,000	$5,000	$6,600
Rx Ded	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$6,250	$6,250	$6,600
Rx OOPM	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes
Family Ded / OOP	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, 3 PCP/MH OV, Dental Class 1	Prev, 3 PCP/MH OV, Dental Class 1	Preventive Care	Preventive Care, 3 PCP/MH OV
Drug Ded waived for:	N/A	N/A	Wellness Drugs	N/A
Service Category	Copay / Coinsurance			
Inpatient	$500	$1,750	50%	0%
Outpatient	$500	$1,750	50%	0%
ER	$250	$250	50%	0%
Radiology (MRI, CT, PET)	$500	$1,750	50%	0%
Preventive	$0	$0	0%	0%
PCP Office Visit	3 visits/member combined PCP/MH at no cost share before deductible then $20 copay	3 visits/member combined PCP/MH at no cost share before deductible then $30 copay	50%	3 visits/member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit			50%	
Specialist Office Visit	$30	$50	50%	0%
Urgent Care	$30	$50	50%	0%
Ambulance	$30	$50	50%	0%
DME	$30	$50	50%	0%
Rx Generic	$5	$5	$25	0%
Rx Preferred Brand	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	0%

2015 Rates Table Template v4.0

To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.

If you are a community rating state, select Family Option under Age and fill in all columns.

If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.

If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.

To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.

HIOS Issuer ID*	13627
Federal TIN*	03-0277307
Rate Effective Date*	1/1/2015
Rate Expiration Date*	12/31/2015

					Family Tier						
Plan ID* **Required:** Enter the 14-character Plan ID	**Rating Area ID*** **Required:** Select the Rating Area ID	**Tobacco*** **Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Age*** **Required:** Select the age of a subscriber eligible for the rate	**Individual Rate*** **Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Couple *** **Required:** Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	**Primary Subscriber and One Dependent*** **Required:** Enter the rate of a family based on a single parent with one dependent	**Primary Subscriber and Two Dependents*** **Required:** Enter the rate of a family based on a single parent with two dependents	**Primary Subscriber and Three or More Dependents*** **Required:** Enter the rate of a family based on a single parent with three or more dependents	**Couple and One Dependent*** **Required:** Enter the rate of a family based on a couple with one dependent	**Couple and Two Dependents*** **Required:** Enter the rate of a family based on a couple with two dependents	**Couple and Three or More Dependents*** **Required:** Enter the rate of a family based on a couple with three or more dependents
13627VT0380001	Rating Area 1	No Preference	Family Option	504.25	1008.51	973.21	973.21	973.21	1416.95	1416.95	1416.95
13627VT0380002	Rating Area 1	No Preference	Family Option	430.45	860.91	830.78	830.78	830.78	1209.58	1209.58	1209.58
13627VT0390003	Rating Area 1	No Preference	Family Option	357.52	715.03	690.00	690.00	690.00	1004.62	1004.62	1004.62
13627VT0340002	Rating Area 1	No Preference	Family Option	650.52	1301.04	1255.50	1255.50	1255.50	1827.96	1827.96	1827.96
13627VT0340003	Rating Area 1	No Preference	Family Option	555.65	1111.30	1072.40	1072.40	1072.40	1561.37	1561.37	1561.37
13627VT0340004	Rating Area 1	No Preference	Family Option	470.70	941.40	908.46	908.46	908.46	1322.67	1322.67	1322.67
13627VT0350001	Rating Area 1	No Preference	Family Option	440.12	880.24	849.44	849.44	849.44	1236.74	1236.74	1236.74
13627VT0340005	Rating Area 1	No Preference	Family Option	394.33	788.67	761.06	761.06	761.06	1108.08	1108.08	1108.08
13627VT0350002	Rating Area 1	No Preference	Family Option	382.78	765.55	738.76	738.76	738.76	1075.60	1075.60	1075.60
13627VT0340001	Rating Area 1	No Preference	Family Option	229.44	458.88	442.82	442.82	442.82	644.72	644.72	644.72
13627VT0360001	Rating Area 1	No Preference	Family Option	504.25	1008.51	973.21	973.21	973.21	1416.95	1416.95	1416.95
13627VT0360002	Rating Area 1	No Preference	Family Option	430.45	860.91	830.78	830.78	830.78	1209.58	1209.58	1209.58
13627VT0370003	Rating Area 1	No Preference	Family Option	357.52	715.03	690.00	690.00	690.00	1004.62	1004.62	1004.62
13627VT0320001	Rating Area 1	No Preference	Family Option	650.52	1301.04	1255.50	1255.50	1255.50	1827.96	1827.96	1827.96
13627VT0320002	Rating Area 1	No Preference	Family Option	555.65	1111.30	1072.40	1072.40	1072.40	1561.37	1561.37	1561.37
13627VT0320003	Rating Area 1	No Preference	Family Option	470.70	941.40	908.46	908.46	908.46	1322.67	1322.67	1322.67
13627VT0330001	Rating Area 1	No Preference	Family Option	440.12	880.24	849.44	849.44	849.44	1236.74	1236.74	1236.74
13627VT0320004	Rating Area 1	No Preference	Family Option	394.33	788.67	761.06	761.06	761.06	1108.08	1108.08	1108.08
13627VT0330002	Rating Area 1	No Preference	Family Option	382.78	765.55	738.76	738.76	738.76	1075.60	1075.60	1075.60

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

July 17, 2013

Phil Keller
Director of Insurance Rates and Forms
Vermont Department of Financial Regulation
89 Main Street
Montpelier, VT 05620

RE: Blue Cross and Blue Shield of Vermont – NAIC # 53295
2014 Exchange Rate Filing – Amended Per GMCB Order
SERFF Tracking # BCVT-128957017, VFN 65563

Dear Phil:

Pursuant to your request during our conference call of Tuesday, July 16, we are providing documentation of our methodology and calculations for incorporating the Corrected Decision and Order from the Green Mountain Care Board into our Exchange filing. We step through each Conclusion of Law sequentially below.

I. *The Board Accepts the Commissioner's Recommendations that BCBSVT be Required to*

a. *Decrease its Pediatric Dental Cost by $0.10*

The Projected Allowed Claims for Pediatric Dental (Item e_6 of the Index Rate calculation, See Exhibit XIV) was decreased from $7.65 to $7.55.

b. *Recalculate its Anticipated Recovery from the Transitional Reinsurance Program*

We recalculated the Transitional Reinsurance recoveries for the Individual population (including groups of one) and for the Small Group population (excluding groups of one). The two distinct expected recoveries PMPM are included in Exhibit XV. Using the projected individual membership distribution and our expected distribution of members previously in Individual or Small Group, we calculated an overall expected recovery PMPM of $54.62 PMPM. This expected recovery reduces the index rate by $31.03 when adjusted to reflect the expected ratio of individuals to total Exchange members.

	Individual Population (Including Groups of 1)	Small Group Population (Excluding Groups of 1)	Total Population
Average PMPM Recoveries	$60.48	$40.09	= $60.48*0.713 + $40.09*0.287 = $54.62
Portion of the total Projected Individual Pool previously in:	71.3%	28.7%	100%

Item I.c. and Item II. specified use of utilization factors.

c. *Use Standard HHS Induced Utilization Factors in Determining its Plan-Specific Rate Adjustments*

II. *The Board Rejects the Commissioner's Recommendation to Modify the Filing by Ordering that the Carrier Adjust for the Impact of Increased Utilization on its CSR Silver Plans and Reduces BCBSVT's Overall Utilization Assumption by 1%.*
To address both of these items, we derived the underlying formula for the HHS Factors to be Utilization = $(\text{Model AV})^2 - (\text{Model AV}) + 1.24$. For each benefit in the experience period, we calculated a utilization factor. We then weighted the factors with the experience membership. The overall experience utilization factor is 1.0741. Using the same method on the projected membership distribution, the projected overall utilization factor is 1.0450. The ratio of these two factors (1.0450/1.0741=**0.9729**) is the Impact of different benefit plans (Item $1+c_1$ of the Index Rate calculation, See Exhibit XIV).

We have also used the HHS factors to calculate the plan specific rate adjustment, which results in some rebalancing among the products. Specifically, CDHP plans are now priced less favorably relative to copayment plans. The factors used for each product can be seen on Exhibit V.

III. *BCBSVT Must Reduce its Pharmacy Trend From 6.5% to 4.5%.*
We changed Exhibit II to reflect a 4.5% pharmacy trend. This is also reflected in Item $1+d_1$ of the Index Rate Calculation.

Model COVERAGE CATEGORY	**Experience Period Membership**	**2012 Pharmacy Allowed PMPM**	**2014 Pharmacy Allowed PMPM (Using Original 6.5% Trend)**	**2014 Pharmacy Allowed PMPM (Using Revised 4.5% Trend)**
Catamount Direct Pay	38,011	$122.21	$138.61	$133.46
Catamount Subsidized	133,909	$88.03	$99.85	$96.13
Nongroup/Safety Net	25,288	$98.76	$112.02	$107.85
BCBS SG-CDHP	119,377	$46.29	$52.50	$50.55
BCBS SG-NonCDHP	123,786	$59.54	$67.53	$65.02
BCBS SG-POS	3,901	$76.33	$86.58	$83.35
TVHP SG-CDHP-PHO	129,680	$56.95	$64.59	$62.19
TVHP SG-NonCDHP-PHO	27,639	$81.85	$92.84	$89.38
TVHP SG-CDHP-NonPHO	100,266	$69.28	$78.58	$75.66
TVHP SG-NonCDHP-NonPHO	28,762	$82.82	$93.94	$90.44
Weighted Average PMPM		**$69.94**	**$79.33**	**$76.38**
Overall Annual Trend			**6.5%**	**4.5%**

IV. *BCBSVT's Strong Financial Health Supports a Reduction in Proposed Contribution to Surplus from 1.0% to 0.5%.*
We reduced the Contribution to Reserve from 1.0% to 0.5%. See Exhibit VIII for detail.

V. *The Carrier Must Adjust its Assumption Regarding Morbidity of the Newly Insured.*
We started with the projected 2014 EPO Allowed PMPM for each coverage category. We then adjusted the subsidized coverage category (including members previously from Catamount, VHAP and Uninsured) to reflect the 2% reduction in morbidity. Using the projected membership and comparing the weighted averages, we calculate the aggregate utilization adjustment as $488.66/$491.29=**0.9946**. This factor is reflected in Item $1+b_3$ of the Index Rate Calculation (See Exhibit XIV).

Model COVERAGE CATEGORY	**Projected Membership**	**2014 EPO Allowed**	**Adjustment for Projected Newly Insured Population**	**Adjusted EPO Allowed**	
Catamount Direct Pay	3,082	$861.52	1.00	$861.52	
Catamount Subsidized	14,023	$593.28	0.98	$581.41	
Nongroup/Safety Net	2,093	$524.04	1.00	$524.04	
BCBS SG-CDHP	9,853	$396.28	1.00	$396.28	
BCBS SG-NonCDHP	10,217	$429.98	1.00	$429.98	
BCBS SG-POS	322	$510.04	1.00	$510.04	
TVHP SG-CDHP-PHO	10,703	$397.69	1.00	$397.69	
TVHP SG-NonCDHP-PHO	2,281	$445.05	1.00	$445.05	
TVHP SG-CDHP-NonPHO	8,275	$469.85	1.00	$469.85	
TVHP SG-NonCDHP-NonPHO	2,374	$576.24	1.00	$576.24	
Weighted Average		$491.29		$488.66	0.9946

VI. *The Board modifies BCBSVT's 2014 Vermont Health Connect Rate Filing by reducing the proposed rate for its non-standard silver copayment plan by 4.3% as described in the above conclusions of law.*
To comply with this portion of the order, we modified the plan level adjustment *the plan's provider network, delivery system characteristics, and utilization management practices* to reflect the Board's desire to reduce the Non-Standard Silver copayment plan by precisely

4.3% from the filed rate. A factor of 1.00006 was then applied to all other plans to create an overall annual premium decrease equal to that calculated by applying each of the specific Conclusions of Law explicitly, as described above. See Exhibit V for details.

Sincerely,

Ruth K. Greene
Vice President, Treasurer & CFO

cc: Tammy Tomczyk
Sean Londergan
Kevin Goddard
Vince Mace
Jackie Hughes

BLUE CROSS BLUE SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FILING
ADJUSTMENTS TO ALLOWED CLAIMS DURING THE EXPERIENCE PERIOD

EXHIBIT II
Amended

BCBSVT CATEGORY UTILIZATION TREND

Source : BCBS Q3 2013 Trend Filing
Claims incurred through 10/12, paid through 12/12

	PMPM Allowed	12 Month Regression Util Trend	R^2
Hospital Inpatient	$65.22	0.988	0.32
Hospital Outpatient	$164.96	1.036	0.96
Professional	$109.21	1.006	0.23
Other	$17.13	1.001	0.01
	$356.51	1.016	

CATAMOUNT CATEGORY UTILIZATION TREND

Catamount Only Data
Claims incurred through 10/12, paid through 12/12

	PMPM Allowed	12 Month Regression Util Trend	R^2
Hospital Inpatient	$68.16	1.009	0.04
Hospital Outpatient	$159.20	1.066	0.95
Professional	$82.98	1.053	0.96
Other	$20.41	1.002	0.02
	$330.76	1.047	

TVHP CATEGORY UTILIZATION TREND

Source : TVHP Q3 2013 Trend Filing
Claims incurred through 10/12, paid through 12/12

	PMPM Allowed	12 Month Regression Util Trend	R^2
Hospital Inpatient	$53.46	0.986	0.21
Hospital Outpatient	$145.97	1.006	0.28
Professional	$90.09	1.017	0.70
Other	$14.42	1.025	0.49
	$303.94	1.007	

MEDICAL

COVERAGE CATEGORY	2012 Medical Allowed	EPO Network Adjustment to 12/31/2012	Bring Cost to 12/31/2012	Bring Utilization to 12/31/2012	Trended Allowed 12/31/2012	Experience Period Membership
Catamount Direct Pay	$477.00	1.4115	1.0000	1.0233	$688.95	38,011
Catamount Subsidized	$325.66	1.4117	1.0000	1.0233	$470.44	133,909
Nongroup/Safety Net	$399.47	0.9779	1.0000	1.0082	$393.83	28,436
BCBS SG-CDHP	$331.56	0.9787	1.0000	1.0082	$327.15	119,377
BCBS SG-NonCDHP	$350.23	0.9781	1.0000	1.0082	$345.36	123,786
BCBS SG-POS	$387.20	1.0343	1.0000	1.0082	$403.77	3,901
TVHP SG-CDHP-PHO	$283.05	1.1179	1.0000	1.0033	$317.47	129,680
TVHP SG-NonCDHP-PHO	$300.33	1.1169	1.0000	1.0033	$336.56	27,639
TVHP SG-CDHP-NonPHO	$358.79	1.0362	1.0000	1.0033	$373.02	100,266
TVHP SG-NonCDHP-NonPHO	$441.08	1.0388	1.0000	1.0033	$459.70	28,762
Weighted Average PMPM	**$342.36**	**$383.95**	**$383.95**	**$388.21**	**$388.21**	

PHARMACY

COVERAGE CATEGORY	2012 Pharmacy Allowed	EPO Network Adjustment to 12/31/2012	Bring Cost to 12/31/2012	Bring Utilization to 12/31/2012	Trended Allowed 12/31/2012	Experience Period Membership
Catamount Direct Pay	$122.21	1.0000	1.0223	1.0000	$124.93	38,011
Catamount Subsidized	$88.03	1.0000	1.0223	1.0000	$89.99	133,909
Nongroup/Safety Net	$98.76	1.0000	1.0223	1.0000	$100.96	25,288
BCBS SG-CDHP	$46.29	1.0000	1.0223	1.0000	$47.32	119,377
BCBS SG-NonCDHP	$59.54	1.0000	1.0223	1.0000	$60.86	123,786
BCBS SG-POS	$76.33	1.0000	1.0223	1.0000	$78.03	3,901
TVHP SG-CDHP-PHO	$56.95	1.0000	1.0223	1.0000	$58.22	129,680
TVHP SG-NonCDHP-PHO	$81.85	1.0000	1.0223	1.0000	$83.67	27,639
TVHP SG-CDHP-NonPHO	$69.28	1.0000	1.0223	1.0000	$70.82	100,266
TVHP SG-NonCDHP-NonPHO	$82.82	1.0000	1.0223	1.0000	$84.66	28,762
Weighted Average PMPM	**$69.94**	**$69.94**	**$71.50**	**$71.50**	**$71.50**	

TOTAL

COVERAGE CATEGORY	2012 Total Allowed	EPO Network Adjustment to 12/31/2012	Bring Cost to 12/31/2012	Bring Utilization to 12/31/2012	Trended Allowed 12/31/2012
Catamount Direct Pay	$599.21	1.3276	1.0034	1.0196	$813.88
Catamount Subsidized	$413.69	1.3241	1.0036	1.0194	$560.43
Nongroup/Safety Net	$498.23	0.9823	1.0045	1.0065	$494.79
BCBS SG-CDHP	$377.85	0.9813	1.0028	1.0071	$374.47
BCBS SG-NonCDHP	$409.77	0.9813	1.0033	1.0069	$406.22
BCBS SG-POS	$463.53	1.0287	1.0036	1.0068	$481.79
TVHP SG-CDHP-PHO	$340.00	1.0982	1.0034	1.0028	$375.69
TVHP SG-NonCDHP-PHO	$382.18	1.0919	1.0044	1.0027	$420.23
TVHP SG-CDHP-NonPHO	$428.07	1.0304	1.0035	1.0028	$443.84
TVHP SG-NonCDHP-NonPHO	$523.90	1.0326	1.0034	1.0028	$544.36
Weighted Average PMPM	**$412.30**	**$453.89**	**$455.45**	**$459.71**	**$459.71**
Weighted Average Factors		**1.1009**	**1.0034**	**1.0094**	

BLUE CROSS BLUE SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FILING
PLAN LEVEL EXPECTED CLAIMS PMPM

EXHIBIT V
Amended

	INDIVIDUAL AND SMALL GROUP MARKET: NON-STANDARD PLANS					INDIVIDUAL AND SMALL GROUP MARKET: STANDARD PLANS						
	GOLD		SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		
	Blue For You	CDHP Blue For You	Blue For You	CDHP Blue For You	CDHP Blue For You	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Catastrophic
Projected Index Rate : Projected Period Expected Allowed Claims for EHB	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59
Pricing Actuarial Value	79.7%	78.1%	71.2%	69.5%	61.9%	91.4%	81.8%	72.5%	73.2%	62.6%	65.5%	55.5%
Benefit Richness Adjustment	1.0418	1.0321	0.9979	0.9907	0.9646	1.1195	1.0539	1.0041	1.0071	0.9665	0.9753	0.9499
Changes in Utilization management practices specific to the Plan	1.0000	1.0000	0.9907	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Specific Benchmark Adjustment	1.00006	1.00006	1.00000	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006
For Catastrophic Plan only - Impact of the specific eligibility	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.6603
Expected Claims Cost PMPM	**$383.43**	**$372.01**	**$324.71**	**$317.88**	**$275.83**	**$472.40**	**$398.18**	**$336.03**	**$340.40**	**$279.26**	**$294.91**	**$160.56**

BLUE CROSS BLUE SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FILING
RATES BY TIER

EXHIBIT XI
Amended

	INDIVIDUAL AND SMALL GROUP MARKET: NON-STANDARD PLANS					INDIVIDUAL AND SMALL GROUP MARKET: STANDARD PLANS							
	GOLD		SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE			
	Blue For You	CDHP Blue For You	Blue For You	CDHP Blue For You	CDHP Blue For You	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Catastrophic	
Required PMPM	**$428.73**	**$417.11**	**$368.09**	**$361.18**	**$317.70**	**$520.53**	**$443.96**	**$379.77**	**$384.46**	**$321.07**	**$337.43**	**$198.99**	
Family Cost Sharing Adjustment	1.074	1.074	1.074	1.074	1.074	1.120	1.120	1.120	1.074	1.120	1.074	1.074	
Projected Contracts													
Tier 1	153	153	1,306	1,306	769	162	1,918	8,161	11,677	2,404	3,440	1,739	
Tier 2	0	0	0	0	0	35	415	1,763	0	519	0	0	
Tier 3	2	2	20	20	12	3	41	175	175	51	51	26	
Tier 4	24	24	202	202	119	36	424	1,801	1,801	531	531	268	
AMENDED RATES Per GMCB ORDER													
Tier 1	$460.37	$447.89	$395.26	$387.84	$341.15	$582.79	$497.06	$425.19	$412.83	$359.47	$362.34	$213.68	
Tier 2	$920.74	$895.78	$790.52	$775.68	$682.30	$1,165.58	$994.12	$850.38	$825.66	$718.94	$724.68	$427.36	
Tier 3	$888.51	$864.43	$762.85	$748.53	$658.42	$1,124.78	$959.33	$820.62	$796.76	$693.78	$699.32	$412.40	
Tier 4	$1,293.64	$1,258.57	$1,110.68	$1,089.83	$958.63	$1,637.64	$1,396.74	$1,194.78	$1,160.05	$1,010.11	$1,018.18	$600.44	
Total Annual Premium	*$1,239,132*	*$1,205,541*	*$9,069,887*	*$8,899,624*	*$4,611,868*	*$2,370,440*	*$23,969,654*	*$87,175,234*	*$84,591,588*	*$21,708,563*	*$21,873,222*	*$6,518,758*	*$273,233,510*
RATES FILED IN HIOS ON 4/26/2013													
Tier 1	$474.30	$462.45	$413.03	$400.39	$350.27	$603.39	$523.81	$453.30	$426.94	$368.78	$371.33	$221.68	
Tier 2	$948.60	$924.90	$826.06	$800.78	$700.54	$1,206.78	$1,047.62	$906.60	$853.88	$737.56	$742.66	$443.36	
Tier 3	$915.40	$892.53	$797.15	$772.75	$676.02	$1,164.54	$1,010.95	$874.87	$823.99	$711.75	$716.67	$427.84	
Tier 4	$1,332.78	$1,299.48	$1,160.61	$1,125.10	$984.26	$1,695.53	$1,471.91	$1,273.77	$1,199.70	$1,036.27	$1,043.44	$622.92	
Total Annual Premium	*$1,276,625*	*$1,244,729*	*$9,477,641*	*$9,187,614*	*$4,735,162*	*$2,454,230*	*$25,259,624*	*$92,938,549*	*$87,482,836*	*$22,270,793*	*$22,415,904*	*$6,762,815*	*$285,506,523*

Total Annual Premium Decrease per GMCB Order **-4.299%**

BLUE CROSS AND SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FIILING
INDEX RATE CALCULATION

EXHIBIT XIV

Index Rate : Experience Period Allowed Claims for EHB	A	$412.30
Adjustments from Experience Period to Projection Period		
Population Risk Morbidity		
Impact of Guarantee Issue	$1+b_1$	1.0000
Impact of the take-up rate of the Uninsured	$1+b_2$	1.0000
Impact of the Health Status of the newly insured	$1+b_3$	0.9946
Impact of insured formerly on Employer coverage	$1+b_4$	1.0000
Impact of new enrollment from prior high risk pool	$1+b_5$	1.0000
Impact of mandated coverage on morbidity	$1+b_6$	1.0000
Impact of Pent-up demand	$1+b_7$	1.0000
Impact of Premium Subsidy	$1+b_8$	1.0000
Impact of Additional Market Movement	$1+b_9$	1.0099
Other		
Impact of different benefit plans (in experience vs projection)	$1+c_1$	0.9729
Changes in provider networks	$1+c_2$	1.1009
Changes in demographics (age, gender, region, etc.)	$1+c_3$	0.9996
Changes in pharmacy rebates	$1+c_4$	1.0000
Changes in network delivery system	$1+c_5$	1.0000
Changes in Utilization management practices	$1+c_6$	1.0000
Adjusted Experience Period Allowed Claims for EHB		$443.40
Trend Factors		
Cost Trend	$1+d_1$	1.0329
Utilization Trend	$1+d_2$	1.0380
Projected Period Allowed Claims for Experience EHB		$475.39
Additional Adjustments for Non System Claims		
Projected Pharmacy Rebates	e_1	-$2.62
Projected Blue Print Payments	e_2	$1.54
Projected ITS Fees	e_3	$1.69
Projected Net cost of Reinsurance	e_4	$0.51
Additional Adjustments for Additional Mandated Benefits		
Projected Allowed Claims for Pediatric Vision	e_5	$0.59
Projected Allowed Claims for Pediatric Dental	e_6	$7.55
Projected Allowed Claims for Autism Mandate	e_7	$2.72
Projected Index Rate : Projected Period Expected Allowed Claims for EHB	$F = A\prod_{n=1}^{8}(1+b_n)\prod_{n=1}^{6}(1+c_n)\prod_{n=1}^{2}(1+d_n)+\sum_{n=1}^{7}e_n$	$487.37
Market Wide Adjustments		
Risk Adjustment Payments	g_1	$0.00
Transitional Reinsurance Payments and Recoveries	g_2	-$25.78
Exchange Fees	g_3	$0.00
Projected Index Rate *AFTER* Market wide adjustment	$H = F + \sum_{n=1}^{3} g_n$	$461.59

BLUE CROSS BLUE SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FILING
REQUIRED PREMIUM PMPM

EXHIBIT VIII
Amended

	INDIVIDUAL AND SMALL GROUP MARKET: NON-STANDARD PLANS					INDIVIDUAL AND SMALL GROUP MARKET: STANDARD PLANS						
	GOLD		SILVER		BRONZE	PLATINUM	GOLD	SILVER		BRONZE		
	Blue For You	CDHP Blue For You	Blue For You	CDHP Blue For You	CDHP Blue For You	Deductible	Deductible	Deductible	CDHP	Deductible	CDHP	Catastrophic
Projected Index Rate : Projected Period Expected Allowed Claims for EHB	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59
Pricing Actuarial Value	79.7%	78.1%	71.2%	69.5%	61.9%	91.4%	81.8%	72.5%	73.2%	62.6%	65.5%	55.5%
Benefit Richness Adjustment	1.042	1.032	0.998	0.991	0.965	1.119	1.054	1.004	1.007	0.966	0.975	0.950
Changes in Utilization management practices specific to the Plan	1.0000	1.0000	0.9907	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
Specific Benchmark Adjustment	1.00006	1.00006	1.00000	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006	1.00006
For Catastrophic Plan only - Impact of the specific eligibility	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.660
Expected Claims Cost PMPM	$383.43	$372.01	$324.71	$317.88	$275.83	$472.40	$398.18	$336.03	$340.40	$279.26	$294.91	$160.56
Vaccines for Vermonters	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86	$0.86
Administrative Charges for BCBSVT	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22	$28.22
Administrative Charges for Outside Vendors	$1.33	$1.50	$1.33	$1.50	$1.50	$1.33	$1.33	$1.33	$1.50	$1.33	$1.50	$1.33
Blue For You Reward Program	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VITL, HCCA and New tax of 0.5% starting 7/2014	$3.91	$3.84	$3.52	$3.44	$3.09	$4.45	$4.01	$3.58	$3.61	$3.12	$3.26	$2.79
PCOR	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18	$0.18
HHS Risk Adjustment Fee	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08	$0.08
Federal Insurer Fee	$8.57	$8.34	$7.36	$7.22	$6.35	$10.41	$8.88	$7.60	$7.69	$6.42	$6.75	$3.98
Contribution to Reserve	$2.14	$2.09	$1.84	$1.81	$1.59	$2.60	$2.22	$1.90	$1.92	$1.61	$1.69	$0.99
Required Premium - Per Member Per Month	**$428.73**	**$417.11**	**$368.09**	**$361.18**	**$317.70**	**$520.53**	**$443.96**	**$379.77**	**$384.46**	**$321.07**	**$337.43**	**$198.99**

EXHIBIT XV

BLUE CROSS BLUE SHIELD OF VERMONT
2014 VERMONT EXCHANGE PRODUCTS RATE FILING
TRANSITIONAL REINSURANCE DETAILS

Product	CSR Variation Type	Individual Membership	Reinsurance (Ind + Gpr 1)	Reinsurance (SML - Gpr 1)	
Standard Plan – Bronze Deductible	Standard Bronze On Exchange Plan	1,484	$57.60	$38.16	
Standard Plan – Bronze Deductible	Zero Cost Sharing Plan Variation	17	$63.33	$42.01	
Standard Plan – Bronze Deductible	Limited Cost Sharing Plan Variation	5	$57.60	$38.16	
Standard Plan – Bronze HDHP	Standard Bronze On Exchange Plan	1,484	$57.70	$38.24	
Standard Plan – Bronze HDHP	Zero Cost Sharing Plan Variation	17	$63.33	$42.01	
Standard Plan – Bronze HDHP	Limited Cost Sharing Plan Variation	5	$57.70	$38.24	
Non-Standard CDHP Plan – Bronze	Standard Bronze On Exchange Plan	318	$57.70	$38.24	
Non-Standard CDHP Plan – Bronze	Zero Cost Sharing Plan Variation	18	$63.33	$42.01	
Non-Standard CDHP Plan – Bronze	Limited Cost Sharing Plan Variation	1	$57.70	$38.24	
Standard Plan – Catastrophic	Standard Catastrophic On Exchange Plan	2,845	$58.15	$38.54	
Standard Plan – Gold	Standard Gold On Exchange Plan	1,198	$58.53	$38.80	
Standard Plan – Gold	Zero Cost Sharing Plan Variation	0	$62.74	$41.63	
Standard Plan – Gold	Limited Cost Sharing Plan Variation	4	$58.53	$38.80	
Non-Standard Co-payment Plan – Gold	Standard Gold On Exchange Plan	66	$60.12	$39.82	
Non-Standard Co-payment Plan – Gold	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Non-Standard Co-payment Plan – Gold	Limited Cost Sharing Plan Variation	1	$60.12	$39.82	
Non-Standard CDHP Plan – Gold	Standard Gold On Exchange Plan	66	$60.03	$39.77	
Non-Standard CDHP Plan – Gold	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Non-Standard CDHP Plan – Gold	Limited Cost Sharing Plan Variation	1	$60.03	$39.77	
Standard Plan – Platinum	Standard Platinum On Exchange Plan	215	$61.15	$40.55	
Standard Plan – Platinum	Zero Cost Sharing Plan Variation	0	$62.74	$41.63	
Standard Plan – Platinum	Limited Cost Sharing Plan Variation	0	$61.15	$40.55	
Standard Plan – Silver Deductible	Standard Silver On Exchange Plan	2,068	$58.15	$38.52	
Standard Plan – Silver Deductible	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Standard Plan – Silver Deductible	Limited Cost Sharing Plan Variation	19	$58.15	$38.52	
Standard Plan – Silver Deductible	73% AV Level Silver Plan	263	$59.08	$39.15	
Standard Plan – Silver Deductible	77% AV Level Silver Plan	3,554	$60.00	$39.77	
Standard Plan – Silver Deductible	87% AV Level Silver Plan	2,445	$61.83	$41.00	
Standard Plan – Silver Deductible	94% AV Level Silver Plan	4,322	$62.70	$41.58	
Standard Plan – Silver HDHP	Standard Silver On Exchange Plan	2,068	$58.19	$38.56	
Standard Plan – Silver HDHP	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Standard Plan – Silver HDHP	Limited Cost Sharing Plan Variation	19	$58.19	$38.56	
Standard Plan – Silver HDHP	73% AV Level Silver Plan	263	$60.14	$39.88	
Standard Plan – Silver HDHP	77% AV Level Silver Plan	3,553	$60.95	$40.41	
Standard Plan – Silver HDHP	87% AV Level Silver Plan	2,444	$62.36	$41.35	
Standard Plan – Silver HDHP	94% AV Level Silver Plan	4,323	$62.89	$41.71	
Non-Standard Co-payment Plan – Silver	Standard Silver On Exchange Plan	232	$58.23	$38.55	
Non-Standard Co-payment Plan – Silver	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Non-Standard Co-payment Plan – Silver	Limited Cost Sharing Plan Variation	1	$58.23	$38.55	
Non-Standard Co-payment Plan – Silver	73% AV Level Silver Plan	30	$58.92	$39.02	
Non-Standard Co-payment Plan – Silver	77% AV Level Silver Plan	398	$59.01	$39.08	
Non-Standard Co-payment Plan – Silver	87% AV Level Silver Plan	274	$61.24	$40.60	
Non-Standard Co-payment Plan – Silver	94% AV Level Silver Plan	483	$62.57	$41.48	
Non-Standard CDHP Plan – Silver	Standard Silver On Exchange Plan	232	$58.18	$38.52	
Non-Standard CDHP Plan – Silver	Zero Cost Sharing Plan Variation	0	$63.33	$42.01	
Non-Standard CDHP Plan – Silver	Limited Cost Sharing Plan Variation	2	$58.18	$38.52	
Non-Standard CDHP Plan – Silver	73% AV Level Silver Plan	29	$58.91	$39.01	
Non-Standard CDHP Plan – Silver	77% AV Level Silver Plan	398	$59.01	$39.08	
Non-Standard CDHP Plan – Silver	87% AV Level Silver Plan	274	$61.24	$40.60	
Non-Standard CDHP Plan – Silver	94% AV Level Silver Plan	483	$62.57	$41.48	
		35,922	$60.48	$40.09	$54.62
			71.3%	28.7%	
			$31.03	Expected Recoveries	

2014 Enrollment as of 4/22/2014

	FEMALE														MALE														Grand Total
Plan/Age Group -->	**A 0-1**	**B 2-6**	**C 7-18**	**D 19-22**	**E 23-24**	**F 25-29**	**G 30-34**	**H 35-39**	**I 40-44**	**J 45-49**	**K 50-54**	**L 55-59**	**M 60-64**	**N 65+**	**A 0-1**	**B 2-6**	**C 7-18**	**D 19-22**	**E 23-24**	**F 25-29**	**G 30-34**	**H 35-39**	**I 40-44**	**J 45-49**	**K 50-54**	**L 55-59**	**M 60-64**	**N 65+**	
Catastrophic		2	1	4	5	26	3								1		1	3	6	33	3								88
Non-Standard Bronze CDHP	9	39	177	66	27	94	90	84	101	139	143	189	152	16	10	29	170	59	40	78	100	106	131	116	164	157	157	17	2,660
Non-Standard Bronze CDHP - CSR 100%									1																				1
Non-Standard Gold	11	34	167	73	40	83	106	96	115	151	157	169	178	22	17	42	146	74	23	56	74	85	99	105	165	136	143	19	2,586
Non-Standard Silver	11	34	79	20	16	66	47	64	70	78	113	115	138	4	6	22	67	31	25	63	63	68	75	72	97	96	91	9	1,640
Non-Standard Silver - CSR 73%	1	2	6	10	3	18	22	9	20	17	29	26	31	1		2	3	7	3	14	9	9	14	17	28	30	19		350
Non-Standard Silver - CSR 77%		1	2	21	11	26	31	26	33	30	38	53	60	1			5	8	3	24	28	25	23	34	28	36	45	1	593
Non-Standard Silver - CSR 87%	2	1	5	21	16	53	39	37	48	58	57	60	75	2		2	6	16	14	42	46	29	33	36	52	36	41	1	828
Non-Standard Silver - CSR 94%		1		6	7	9	15	15	9	8	9	10	15		1			5	4	9	10	13	8	7	6	11	9		187
Standard Bronze	9	25	111	53	37	86	77	67	104	117	157	146	133	17	6	33	132	65	44	129	128	103	128	151	155	177	138	28	2,556
Standard Bronze CDHP	12	65	214	85	55	133	139	131	162	185	244	245	188	15	22	68	214	100	58	150	151	163	163	215	222	240	194	26	3,859
Standard Gold	28	84	334	162	89	176	200	208	271	323	473	502	599	41	23	87	392	136	87	141	177	191	264	282	411	442	507	56	6,686
Standard Platinum	55	135	646	335	152	259	311	307	481	591	837	962	1,116	138	69	181	651	339	151	255	237	306	350	494	655	862	986	173	12,034
Standard Silver	47	125	429	198	100	246	279	236	283	413	471	511	465	50	50	119	386	204	123	254	279	290	321	404	479	516	461	66	7,805
Standard Silver - CSR 100%									1				1																2
Standard Silver - CSR 73%	1	2	13	14	4	16	21	12	36	46	72	71	81	3	1	2	16	16	11	16	25	19	27	48	58	76	58	2	767
Standard Silver - CSR 77%		4	11	32	5	44	43	50	54	72	98	137	148	2	1	2	11	30	12	43	37	53	48	51	66	88	120	2	1,264
Standard Silver - CSR 87%		4	8	37	16	64	63	75	75	99	148	148	205	4	3	1	9	46	16	68	45	66	57	78	101	127	143	2	1,708
Standard Silver - CSR 94%			3	11	12	29	22	23	26	26	37	41	63	2	1		2	9	9	19	23	16	20	27	34	32	35	2	524
Standard Silver CDHP	35	123	492	207	84	184	193	219	261	397	440	503	398	41	39	118	506	219	98	209	167	184	262	330	406	453	404	53	7,025
Standard Silver CDHP - CSR 100%									1																				1
Standard Silver CDHP - CSR 73%		1	5	4	3	14	7	18	17	29	35	34	38			1	11	12	3	7	8	9	12	25	30	34	36		393
Standard Silver CDHP - CSR 77%		2	5	12	5	17	23	18	17	35	43	55	62	1		4	10	13	5	19	16	16	34	23	31	42	47		555
Standard Silver CDHP - CSR 87%	1		10	18	8	35	27	32	26	52	46	67	80	1	1	4	13	16	6	27	15	32	18	39	51	47	48	2	722
Standard Silver CDHP - CSR 94%	1	3	3	9	1	13	9	18	5	18	12	15	11	3	1		4	4	5	12	7	9	13	8	10	12	5		211
Grand Total	**223**	**687**	**2,721**	**1,398**	**696**	**1,691**	**1,767**	**1,745**	**2,217**	**2,884**	**3,659**	**4,059**	**4,237**	**364**	**252**	**717**	**2,755**	**1,412**	**746**	**1,668**	**1,648**	**1,792**	**2,100**	**2,562**	**3,249**	**3,650**	**3,687**	**459**	**55,045**

Projected 2015 Enrollment

	FEMALE														MALE														Grand Total
Plan/Age Group -->	**A 0-1**	**B 2-6**	**C 7-18**	**D 19-22**	**E 23-24**	**F 25-29**	**G 30-34**	**H 35-39**	**I 40-44**	**J 45-49**	**K 50-54**	**L 55-59**	**M 60-64**	**N 65+**	**A 0-1**	**B 2-6**	**C 7-18**	**D 19-22**	**E 23-24**	**F 25-29**	**G 30-34**	**H 35-39**	**I 40-44**	**J 45-49**	**K 50-54**	**L 55-59**	**M 60-64**	**N 65+**	
Catastrophic	-	2	1	4	5	26	3	-	-	-	-	-	-	-	1	-	1	3	6	33	3	-	-	-	-	-	-	-	88
Non-Standard Bronze CDHP	10	42	187	70	29	98	94	88	105	146	148	197	157	17	11	31	180	63	43	82	105	111	138	121	171	165	164	18	2,791
Non-Standard Bronze CDHP - CSR 100%	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Non-Standard Gold	12	36	181	79	43	87	112	102	121	161	167	179	189	25	19	45	158	81	25	60	79	90	106	112	177	146	152	21	2,765
Non-Standard Silver	12	36	84	21	17	69	50	67	73	82	118	119	143	4	7	23	71	33	27	66	66	71	79	76	101	100	95	9	1,719
Non-Standard Silver - CSR 73%	1	2	6	10	3	18	22	9	20	17	29	26	31	1	-	2	3	7	3	14	9	9	14	17	28	30	19	-	350
Non-Standard Silver - CSR 77%	-	1	2	21	11	26	31	26	33	30	38	53	60	1	-	-	5	8	3	24	28	25	23	34	28	36	45	1	593
Non-Standard Silver - CSR 87%	2	1	5	21	16	53	39	37	48	58	57	60	75	2	-	2	6	16	14	42	46	29	33	36	52	36	41	1	828
Non-Standard Silver - CSR 94%	-	1	-	6	7	9	15	15	9	8	9	10	15	-	1	-	-	5	4	9	10	13	8	7	6	11	9	-	187
Standard Bronze	10	27	120	57	40	89	80	70	109	124	164	153	138	19	7	36	144	70	47	137	135	108	137	160	166	189	145	30	2,711
Standard Bronze CDHP	14	70	233	93	60	139	148	139	171	197	258	261	199	16	25	75	233	107	62	161	163	173	175	229	238	259	209	28	4,135
Standard Gold	31	90	362	176	96	184	213	219	286	342	499	526	619	45	25	95	422	145	94	150	190	203	282	300	436	469	529	60	7,088
Standard Platinum	62	145	701	365	164	273	333	327	508	633	887	1,016	1,171	151	76	195	705	365	161	274	255	327	378	528	699	925	1,044	189	12,857
Standard Silver	52	134	466	215	109	259	298	251	299	443	501	543	493	55	55	129	418	221	134	274	300	310	346	433	515	558	490	72	8,373
Standard Silver - CSR 100%	-	-	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Standard Silver - CSR 73%	1	2	13	14	4	16	21	12	36	46	72	71	81	3	1	2	16	16	11	16	25	19	27	48	58	76	58	2	767
Standard Silver - CSR 77%	-	4	11	32	5	44	43	50	54	72	98	137	148	2	1	2	11	30	12	43	37	53	48	51	66	88	120	2	1,264
Standard Silver - CSR 87%	-	4	8	37	16	64	63	75	75	99	148	148	205	4	3	1	9	46	16	68	45	66	57	78	101	127	143	2	1,708
Standard Silver - CSR 94%	-	-	3	11	12	29	22	23	26	26	37	41	63	2	1	-	2	9	9	19	23	16	20	27	34	32	35	2	524
Standard Silver CDHP	39	133	533	224	91	194	206	234	276	426	469	539	427	45	43	128	550	237	106	225	181	196	284	353	437	489	434	58	7,557
Standard Silver CDHP - CSR 100%	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Standard Silver CDHP - CSR 73%	-	1	5	4	3	14	7	18	17	29	35	34	38	-	-	1	11	12	3	7	8	9	12	25	30	34	36	-	393
Standard Silver CDHP - CSR 77%	-	2	5	12	5	17	23	18	17	35	43	55	62	1	-	4	10	13	5	19	16	16	34	23	31	42	47	-	555
Standard Silver CDHP - CSR 87%	1	-	10	18	8	35	27	32	26	52	46	67	80	1	1	4	13	16	6	27	15	32	18	39	51	47	48	2	722
Standard Silver CDHP - CSR 94%	1	3	3	9	1	13	9	18	5	18	12	15	11	3	1	-	4	4	5	12	7	9	13	8	10	12	5	-	211
Grand Total	**248**	**736**	**2,939**	**1,499**	**745**	**1,756**	**1,859**	**1,830**	**2,317**	**3,044**	**3,835**	**4,250**	**4,406**	**397**	**278**	**775**	**2,972**	**1,507**	**796**	**1,762**	**1,746**	**1,885**	**2,232**	**2,705**	**3,435**	**3,871**	**3,868**	**497**	**58,190**

Vaccine	Number of Claims	Imputed Cost of the Vaccine	Total Amount imputed
Hepatatis A for Adult	49	$21.42	$1,049.58
Hepatatis A for Adult	120	$34.44	$4,132.80
Hepatatis A for Adult	15	$21.42	$321.30
Hepatatis A for Adult	24	$34.44	$826.56
Hepatatis A for Adult	1	$34.44	$34.44
Hepatatis B for Adult	16	$44.74	$715.84
Hepatatis B for Adult	84	$71.95	$6,043.80
HPV for Adult	48	$96.09	$4,612.32
HPV for Adult	176	$147.49	$25,958.24
HPV for Adult	1	$96.09	$96.09
MMR for Adult	4	$36.81	$147.24
MMR for Adult	16	$59.29	$948.64
Tdap for Adult	1,143	$27.30	$31,203.90
Tdap for Adult	1,996	$37.83	$75,508.68
Varicella for Adult	5	$60.27	$301.35
Varicella for Adult	20	$97.11	$1,942.20
Tdap for Adult	2	$37.83	$75.66
Pneumococcal for Adult	118	$21.16	$2,496.88
Pneumococcal for Adult	358	$36.46	$13,052.68
Meningococcal for Adult	2	$115.63	$231.26
Meningococcal for Adult	45	$115.63	$5,203.35
H. Zoster for Adult	166	$116.56	$19,348.96
H. Zoster for Adult	488	$182.23	$88,928.24
Hepatatis B for Adult	6	$28.12	$168.72
Hepatatis B for Adult	14	$39.35	$550.90
Hepatatis B for Adult	51	$28.12	$1,434.12
Hepatatis B for Adult	135	$39.35	$5,312.25
Hepatatis A for Child	2	$14.66	$29.32
Hepatatis A for Child	15	$23.59	$353.85
Hepatatis B for Child	253	$14.66	$3,708.98
Hepatatis B for Child	736	$17.12	$12,600.32
Hepatatis A for Child	6	$14.66	$87.96
Hepatatis A for Child	22	$23.59	$518.98
HIB for Child	48	$9.26	$444.48
HIB for Child	54	$14.67	$792.18
HIB for Child	199	$9.26	$1,842.74
HIB for Child	361	$14.67	$5,295.87
HPV for Child	284	$111.87	$31,771.08
HPV for Child	831	$178.59	$148,408.29
Influenza (0.25ml) for Child	79	$12.02	$949.58
Influenza (0.25ml) for Child	213	$18.63	$3,968.19
Influenza (0.5ml) for Child	58	$11.29	$654.82
Influenza (0.5ml) for Child	87	$16.80	$1,461.60
Influenza (0.5ml) for Child	45	$11.29	$508.05
Influenza (0.5ml) for Child	101	$16.80	$1,696.80
Influenza (5ml) for Child	205	$9.57	$1,961.85
Influenza (5ml) for Child	729	$13.96	$10,176.84
Influenza (Flumist) for Child	127	$16.15	$2,051.05
Influenza (Flumist) for Child	429	$26.32	$11,291.28
Pneumococcal for Child	26	$100.03	$2,600.78
Pneumococcal for Child	44	$162.74	$7,160.56
PCV13 for Child	246	$100.03	$24,607.38
PCV13 for Child	476	$162.74	$77,464.24
Rotavirus for Child	15	$91.83	$1,377.45
Rotavirus for Child	26	$145.18	$3,774.68
Rotavirus for Child	102	$91.83	$9,366.66
Rotavirus for Child	192	$145.18	$27,874.56
Dtap-IPV for Child	48	$35.24	$1,691.52
Dtap-IPV for Child	143	$56.62	$8,096.66
Dtap-IPV-HIB for Child	9	$54.07	$486.63
Dtap-IPV-HIB for Child	76	$86.93	$6,606.68
Dtap for Child	72	$15.28	$1,100.16
Dtap for Child	153	$24.48	$3,745.44
MMR for Child	111	$19.54	$2,168.94
MMR for Child	277	$30.83	$8,539.91
MMR for Child	14	$30.83	$431.62
IPV for Child	1	$12.32	$12.32
IPV for Child	2	$19.52	$39.04
IPV for Child	27	$12.32	$332.64
IPV for Child	65	$19.52	$1,268.80
TDap for Child	1	$30.45	$30.45
TDap for Child	4	$48.51	$194.04
Tdap for Child	115	$30.45	$3,501.75
Tdap for Child	295	$48.51	$14,310.45
Varicella for Child	131	$71.75	$9,399.25
Varicella for Child	317	$115.63	$36,654.71
Td for Child	8	$16.98	$135.84
Td for Child	1	$27.28	$27.28
DTaP-Hep B-IPV for Child	183	$52.63	$9,631.29
DTaP-Hep B-IPV for Child	275	$83.10	$22,852.50
PCV23 for Child	6	$35.54	$213.24
PCV23 for Child	17	$60.60	$1,030.20
Meningococcal for Child	7	$84.50	$591.50
Meningococcal for Child	34	$130.99	$4,453.66
MCV 4 for Child	125	$84.50	$10,562.50
MCV 4 for Child	506	$130.99	$66,280.94
Hepatatis B for Child	49	$10.65	$521.85
Hepatatis B for Child	168	$17.12	$2,876.16
Hepatatis B for Child	14	$17.12	$239.68
TOTAL	**14,368**		**$903,474.07**

Inputs	
Medical Allowed	$452.18
Pharmacy Allowed	$90.21
Medical Adjustment Coefficient 1	1.0782
Medical Adjustment Coefficient 2	-0.9525
Medical Adjustment Coefficient 3	1.0353
Pharmacy Adjustment Coefficient 1	0.6784
Pharmacy Adjustment Coefficient 2	0.4304
GDR Adjustment for Non-Integrated plans	1.0178
GDR Adjustment for Integrated plans	0.9876

Product	Projected Membership	Medical AV	Medical Benefit Richness Factor *	Normalized Medical Benefit Richness Factor	Pharmacy AV	Pharmacy Benefit Richness Factor *	Normalized Pharmacy Benefit Richness Factor	Normalized Overall Benefit Richness Factor *
Non-Standard Gold	2,765	0.8426	0.9982	1.0283	0.7325	0.9158	0.9331	1.0125
Non-Standard Silver	3,677	0.7578	0.9327	0.9608	0.7200	0.9074	0.9246	0.9548
Non-Standard Bronze CDHP	2,792	0.6548	0.8739	0.9002	0.7291	0.9135	0.9308	0.9053
Standard Platinum	12,857	0.9357	1.0881	1.1209	0.8782	1.0444	1.0641	1.1114
Standard Gold	7,088	0.8437	0.9991	1.0293	0.8641	1.0347	1.0542	1.0334
Standard Silver	12,638	0.7543	0.9303	0.9583	0.8091	0.9967	1.0155	0.9678
Standard Silver CDHP	9,439	0.7711	0.9419	0.9703	0.7631	0.9363	0.9540	0.9676
Standard Bronze	2,711	0.6611	0.8768	0.9033	0.7442	0.9519	0.9698	0.9143
Standard Bronze CDHP	4,135	0.6891	0.8909	0.9178	0.7507	0.9280	0.9455	0.9224
Catastrophic	88	0.6751	0.8837	0.9103	0.7037	0.8965	0.9134	0.9108
	58,190		**0.9707**	**1.0000**		**0.9815**	**1.0000**	**1.0000**

* These factors can be found on Exhibit 6c

Projected 2014 BCBSVT ACL	$	20,917,724
Target RBC %		600%
Target capital	$	125,506,344
Estimated Benefit trend		5.9%
Estimated membership trend		0.0%
Estimated increase in ACL	$	1,234,540
Estimated increase in capital to maintain target	$	7,407,238
Investment Income	$	4,218,318
Tax rate		20.0%
Inv Income net of tax	$	3,374,654
Additional Required	$	4,032,583
Grossed up for FIT	$	5,040,729

2014 forecast premium			CTR proportions		
Exchange	$	246,083,508	1.00	$	246,083,508
Cost Plus (equiv prem)	$	319,974,080	0.25	$	79,993,520
Other Insured	$	212,022,587	1.00	$	212,022,587
	$	778,080,175	0.69	$	538,099,615
Required Insured CTR factor to maintain target for trend increases		0.94%			

Data Collection Template

Company Legal Name:	**Blue Cross and Blue Shield of V**	State:	**VT**
HIOS Issuer ID:	**13627**	Market:	**Combined**
Effective Date of Rate Change(s):	**1/1/2014**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$159,016,820	$374.18	100.00%
Incurred Claims in Experience Period	$142,765,022	335.94	89.78%
Allowed Claims:	$177,842,311	418.48	111.84%
Index Rate of Experience Period		$412.30	
Experience Period Member Months	424,973		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	51.45	$16,833.42	$72.17	1.004	1.075	1.015	1.022	54.01	$18,631.67	$83.86	0.00	$0.00	$0.00
Outpatient Hospital	Visits	2,520.05	740.02	155.41	1.004	1.075	1.015	1.022	2,645.49	819.07	180.57	0.00	0.00	0.00
Professional	Visits	6,886.86	159.94	91.79	1.004	1.075	1.015	1.022	7,229.68	177.03	106.65	0.00	0.00	0.00
Other Medical	Visits	1,240.65	157.53	16.29	1.004	1.075	1.015	1.022	1,302.41	174.36	18.92	0.00	0.00	0.00
Capitation	Other	12,000.00	15.56	15.56	1.004	1.075	1.015	1.022	12,597.36	17.22	18.08	0.00	0.00	0.00
Prescription Drug	Prescriptions	9,769.33	82.63	67.27	1.004	1.075	1.045	1.000	9,813.10	96.96	79.29	0.00	0.00	0.00
Total				$418.48							$487.37			$0.00

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	100.00%	0.00%	$487.37	$369,740,326
Paid to Allowed Average Factor in Projection Period			0.713	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$347.46	$263,597,674
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$347.46	$263,597,674
Projected ACA reinsurance recoveries, net of rein prem, PMPM			25.78	19,557,842
Projected Incurred Claims			$321.68	$244,039,832
Administrative Expense Load		8.29%	30.25	22,952,609
Profit & Risk Load		0.50%	1.82	1,383,724
Taxes & Fees		3.02%	11.03	8,368,564
Single Risk Pool Gross Premium Avg. Rate, PMPM			$364.79	$276,744,728
Index Rate for Projection Period			$461.59	
% increase over Experience Period			-2.51%	
% Increase, annualized:			-1.26%	
Projected Member Months				758,644

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Product-Plan Data Collection

Company Legal Name: **Blue Cross and Blue Shield of Vermont** State: **VT**
HIOS Issuer ID: **13627** Market: **Combined**
Effective Date of Rate Change(s): **1/1/2014**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	Terminated Product	BCBSVT EPO Standard (Small Group)					CBSVT EPO-CDHP Standard (Small Group)		BCBSVT EPO Standard (Individual)					BCBSVT EPO-CDHP Standard (Individual)		CBSVT EPO Accountable Blue (Small Group)		BCBSVT EPO-CDHP-Accountable Blue (Small Group)			CBSVT EPO Accountable Blue (Individua		BCBSVT EPO-CDHP-Accountable Blue (Individual)		
Product ID:	13627VT017	13627VT032					13627VT033		13627VT034					13627VT035		13627VT036		13627VT037			13627VT038		13627VT039		
Metal:	Catastrophic	Platinum	Gold	Silver	Bronze		Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Silver	Bronze	Gold	Silver	Gold	Silver	Bronze	Gold	Silver	Gold	Silver	Bronze
AV Metal Value	0.000	0.881	0.802	0.718	0.618		0.687	0.609	0.670	0.881	0.802	0.718	0.618	0.687	0.609	0.808	0.709	0.788	0.690	0.616	0.808	0.709	0.788	0.690	0.616
AV Pricing Value	0.000	1.000	0.852	0.729	0.616		0.738	0.647	0.380	1.000	0.852	0.729	0.616	0.738	0.647	0.823	0.706	0.801	0.693	0.609	0.823	0.706	0.801	0.693	0.609
Plan Type:	PPO	EPO	EPO	EPO	EPO		EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO	EPO
Plan Name	Terminated Products	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1		BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	BCBSVT EPO Catastrophic Plan	BCBSVT EPO Standard Platinum Plan	BCBSVT EPO Standard Gold Plan	BCBSVT EPO Standard Silver Plan 1	BCBSVT EPO Standard Bronze Plan 1	BCBSVT EPO Standard Silver CDHP Plan 2	BCBSVT EPO Standard Bronze CDHP Plan 2	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Gold CDHP	Blue Rewards Non-Standard Silver CDHP	Blue Rewards Non-Standard Bronze CDHP	Blue Rewards Non-Standard Gold	Blue Rewards Non-Standard Silver	Blue Rewards Non-Standard Gold CDHP	Blue Rewards Non-Standard Silver CDHP	Blue Rewards Non-Standard Bronze CDHP
Plan ID (Standard Component ID):	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004		13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
Exchange Plan?	No	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2	-2.11%	0.00%					0.00%		0.00%					0.00%		0.00%		0.00%			0.00%		0.00%		
Historical Rate Increase - Calendar Year - 1	-6.67%	0.00%					0.00%		0.00%					0.00%		0.00%		0.00%			0.00%		0.00%		
Historical Rate Increase - Calendar Year 0	8.10%	0.00%					0.00%		0.00%					0.00%		0.00%		0.00%			0.00%		0.00%		
Effective Date of Proposed Rates	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014		1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014	1/1/2014
Rate Change % (over prior filing)	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	-999.00%	-999.00%	-999.00%	-999.00%		-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	#VALUE!	0.00%					0.00%		0.00%					0.00%		0.00%		0.00%			0.00%		0.00%		

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
Inpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Average Current Rate PMPM	$360.15		$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$190.94	$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$411.40	$353.52	$400.25	$346.88	$305.02	$411.40	$353.52	$400.25	$346.88	$305.02
Projected Member Months	758,664	0	1,968	39,492	77,220	49,464	77,220	49,464	34,140	2,580	14,424	152,052	18,072	152,040	18,072	2,208	8,640	2,208	8,640	11,076	804	17,016	804	17,016	4,044

Section III: Experience Period Information

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
OK	$ 374.18	Premium Information	Average Rate PMPM	$374.18	$374.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OK	424,973		Member Months	424,973	424,973	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OK	$159,016,820		Total Premium (TP)	$159,016,397	$159,016,397	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			EHB basis or full portion of TP, [see instructions]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OK	$177,842,311	Claims Information	Total Allowed Claims (TAC)	$177,842,311	$177,842,311	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			EHB basis or full portion of TAC, [see instructions]	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Allowed Claims which are not the issuer's obligation:	$35,077,289	$35,077,289	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
OK	$142,765,022		Total Incurred claims, payable with issuer funds	$142,765,022	$142,765,022	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			Net Amt of Rein	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Net Amt of Risk Adj	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
OK	$ 335.94		Incurred Claims PMPM	$335.94	$335.94	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
OK	$ 418.48		Allowed Claims PMPM	$418.48	$418.48	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
			EHB portion of Allowed Claims, PMPM	$0.00	$0.00	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

Warning Alert	Wsht 1 Total		Plan ID (Standard Component ID):	Total	13627VT0170001	13627VT0320001	13627VT0320002	13627VT0320003	13627VT0320004	13627VT0330001	13627VT0330002	13627VT0340001	13627VT0340002	13627VT0340003	13627VT0340004	13627VT0340005	13627VT0350001	13627VT0350002	13627VT0360001	13627VT0360002	13627VT0370001	13627VT0370002	13627VT0370003	13627VT0380001	13627VT0380002	13627VT0390001	13627VT0390002	13627VT0390003
OK	$ 364.79	Premium Information	Average Rate PMPM	$360.15	$0.00	$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$190.94	$521.20	$444.57	$380.23	$321.44	$368.98	$323.87	$411.40	$353.52	$400.25	$346.88	$305.02	$411.40	$353.52	$400.25	$346.88	$305.02
OK	758,644		Member Months	758,664	-	1,968	39,492	77,220	49,464	77,220	49,464	34,140	2,580	14,424	152,052	18,072	152,040	18,072	2,208	8,640	2,208	8,640	11,076	804	17,016	804	17,016	4,044
WARNING	$276,744,728		Total Premium (TP)	$273,233,612	$0	$1,025,731	$17,557,111	$29,361,097	$15,899,557	$28,492,395	$16,020,130	$6,518,761	$1,344,709	$6,412,534	$57,814,214	$5,809,009	$56,099,246	$5,853,061	$908,368	$3,054,406	$883,743	$2,997,067	$3,378,378	$330,764	$6,015,483	$321,798	$5,902,558	$1,233,492
			EHB basis or full portion of TP, [see instructions]	99.99%	0.00%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%
			state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TP	0.01%	100.00%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
OK	350,182,484	Claims Information	Total Allowed Claims (TAC)	$350,188,272	$0	$908,400	$18,228,933	$35,643,629	$22,831,863	$35,643,629	$22,831,863	$15,758,528	$1,190,890	$6,657,909	$70,184,993	$8,341,772	$70,179,454	$8,341,772	$1,019,181	$3,988,098	$1,019,181	$3,988,098	$5,112,521	$371,115	$7,854,338	$371,115	$7,854,338	$1,866,652
			EHB basis or full portion of TAC, [see instructions]	99.99%	0.00%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%
			state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
			Other benefits portion of TAC	0.01%	100.00%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
			Allowed Claims which are not the issuer's obligation	$104,297,812	$0	-$21,292	$2,503,812	$9,695,332	$9,018,733	$9,357,831	$8,244,526	$10,277,030	-$27,913	$914,488	$19,090,840	$3,295,054	$18,424,820	$3,012,192	$172,556	$1,182,602	$197,783	$1,241,623	$2,057,387	$62,833	$2,329,069	$72,019	$2,445,307	$751,180
			Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0																							
			insured person, as %	0.00%	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OK	244,039,832		Total Incurred claims, payable with issuer funds	$245,890,461	$0	$929,692	$15,725,121	$25,948,297	$13,813,131	$26,285,798	$14,587,338	$5,481,497	$1,218,803	$5,743,420	$51,094,153	$5,046,719	$51,754,633	$5,329,580	$846,624	$2,805,496	$821,398	$2,746,476	$3,055,134	$308,282	$5,525,269	$299,096	$5,409,032	$1,115,471
OK	19,557,842		Net Amt of Rein	$19,561,801	$0	$50,744	$1,018,283	$1,991,082	$1,275,406	$1,991,082	$1,275,406	$880,284	$66,524	$371,916	$3,920,591	$465,978	$3,920,281	$465,978	$56,932	$222,778	$56,932	$222,778	$285,590	$20,731	$438,750	$20,731	$438,750	$104,273
			Net Amt of Risk Adj	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OK	$ 321.68		Incurred Claims PMPM	$324.11	#DIV/0!	$472.40	$398.18	$336.03	$279.26	$340.40	$294.91	$160.56	$472.40	$398.18	$336.03	$279.26	$340.40	$294.91	$383.44	$324.71	$372.01	$317.88	$275.83	$383.44	$324.71	$372.01	$317.88	$275.83
WARNING	$ 487.37		Allowed Claims PMPM	$461.59	#DIV/0!	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59	$461.59
			EHB portion of Allowed Claims, PMPM	$461.53	#DIV/0!	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53	$461.53

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

June 16, 2014

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

Subject: Your 06/11/2014 Questions re: Blue Cross and Blue Shield of Vermont 2015 Exchange Filing (SERFF Tracking #: BCVT-129572217)

Dear Mr. Hammerquist:

In response to your request dated June 11, 2014, here are *your questions* and our answers:

1. *General*
   a. *Please provide the final 2014 URRT and describe if the PMPMs are directly comparable to the 2015 URRT. If any of the PMPMs are not comparable, please describe why and include a numerical example.*

Please see *Unified_Rate_Review_Template_BCBSVT_2014_Final_Amended_Rates.xlsx* for the final 2014 URRT. Please note that the PMPMs are not directly comparable from 2014 to 2015. Based upon guidance provided for 2015, we use a plan level adjustment to develop the PMPM for each plan, then apply a single factor to convert to Consumer Adjusted Premium Rates (a concept that was absent in 2014). Last year, in the absence of more specific guidance, we developed contract conversion factors varying by type of plan (CDHP vs. Non-CDHP) that we applied to the PMPMs in the URRT in order to calculate the Single Rates. From the rates, we then calculated the PMPM for the URRT based on projected members and contracts in each tier.

In other words, the Plan Level Adjusted Index Rate from the 2015 filing is not directly comparable to the PMPM from the Rate Build-up from the 2014 filing.
Numerical examples are below.

2014 URRT

	2014 Standard Silver Deductible		2014 Standard Silver CDHP	
Tier	Rate	Projected Contracts	Rate	Projected Contracts
PMPM from the Rate Build up	$379.77		$384.46	
Contract Conversion Factor	1.1196		1.0738	
Single	$425.19	8,161	$412.83	11,677
Couple	$850.38	1,763	$825.66	0
Adult and Child(ren)	$820.62	175	$796.76	175
Family	$1,194.78	1,801	$1,160.05	1,801
Per Contract Total	$610.47	11,900	$516.32	13,653
Per Member Total - Shown in URRT	$380.23	19,106	$368.98	19,105

2015 URRT

	2015 Standard Silver Deductible		2015 Standard Silver CDHP	
Tier	Rate	Projected Contracts	Rate	Projected Contracts
Plan Level Adjusted Index Rate	$418.56		$391.37	
Contract Conversion Factor	1.1246		1.1246	
Single	$470.70	4,632	$440.12	3,460
Couple	$941.40	1,466	$880.24	1,095
Adult and Child(ren)	$908.46	258	$849.44	193
Family	$1,322.67	1,130	$1,236.74	844
Per Contract Total	$706.54	7,487	$660.66	5,592
Per Member Total - Shown in URRT	$418.56	12,638	$391.37	9,439

2. *Changes to Initially Filed Rates in 2014*
   a. *Please provide a breakdown of the changes that happened during the interrogatories with the actuaries or due to a decision made by the Board to the assumptions and rates that were initially filed in 2014.*

Please see attached *Exhibits for Detail Explanation of Order Calculation – 2014 Exchange Filing.pdf* and *BCBSVT 2014 Exchange Filing – Method for applying the GMCB corrected Order.pdf* for the breakdown of the changes due the decision made by the GMCB for the 2014 rates.

3. *Reason for Rate Increase*

The section in question was intended to be a high-level summary of the approximate impact of various meaningful items, and involved a series of covariant calculations separate from the actual rate development.

   a. *Please provide the percentage of the increase that is due to changes in the amounts providers are paid that are projected to occur before the end of 2014 beyond the original assumptions for 2014. In other words, please split the 2.9% increase from the top of page 5 of the Actuarial Memorandum into those that have already occurred and those that are projected to occur.*

The 2.9% increase splits into 0.9% for increases that have already exceeded the unit cost trend assumption from the 2014 filing, and 2.0% for increases expecting to occur through the balance of 2014. This 2.0% consists primarily of a full year of pharmacy unit cost increases and the impact of an additional round of GMCB hospital budget increases on approximately one calendar quarter of facility charges.

   b. *Please reconcile the 4.8% increase in 2015 due to amounts providers are paid with the trend exhibits provided.*

There are some very minor inconsistencies between the figures in the "Reasons for Rate Increase" section and the information provided, and calculated more precisely, for the

Actuarial Data Set. (Note that the Actuarial Data Set is the only source of trend information split between the two projection years.).

The projected unit cost increase for 2015 is 5.0%, as can be calculated from information provided in the Actuarial Data Set. It may have been more precise to use this figure to represent the increase in 2015 due to amounts providers are paid.

c. *Please provide the calculation of the 2.5% decrease due to "new members" who have or will enroll in the qualified health plans who will be significantly healthier on average than those previously insured in individual and small group products.*

The 2.5% decrease is not a factor that was applied explicitly within the rate development. Rather, it is an approximation of the impact of a number of changes within the base data, as well as several assumptions described within the Actuarial Memorandum. These include:

- For 2014 rates, the GMCB ordered a utilization reduction of 1%, and a further adjustment due to an assumption that healthy uninsured would enroll through Vermont Health Connect. These assumptions were not part of our rate development process. The impact on 2014 rates of these two adjustments was approximately 1.9%, so the removal of these ordered reductions increases 2015 rates relative to 2014 by about 1.9%.
- Exhibit 2B from the Actuarial Memorandum illustrates the calculation of the -0.8% rate impact due to the assumed impact of new entrants.
- The Change in Pool Morbidity (1+b9 from Exhibit 5 of the Actuarial Memorandum) is the impact of continuing members having lower claims costs than the overall experience base. For purposes of display in this section, we split this -5.7% impact into –3.5% due to the assumptions that new members would have claims costs similar to that of continuing (rather than all base period) members, adjusted for demographics, and that individuals enrolled in our Access to Care plan would not ultimately enroll in a QHP, and –2.3% attributable to an observation of claims costs for the portion of projected membership representing continuing members who did enroll in a QHP. The latter impact is discussed below.

d. *Provide a more detailed quantitative breakdown of the other adjustments used in the 2014 rate development that cumulatively have the effect of reducing the required rate increase by 1.8%.*

The other adjustments include the impact of all assumptions and methodology used in the rate development, as described throughout the Actuarial Memorandum. The impact of these items is generally quite small, and several pieces are challenging to quantify. They include:

- The requested 1.0% CTR represents is greater than the 2014 ordered CTR of 0.5%. This has a rate impact of about 0.6%.
- Administrative charges are lower than those filed last year. The rate impact is about -0.6%.
- The membership mix in our base experience was different from that underlying the base experience used in the 2014 rate development. This has a rate impact of about 1.4%.
- The enrollment split between Individual and Small Group differed significantly from our expectation. Transitional Reinsurance recoveries using our actual enrollment mix will

be less than those expected using the assumptions underlying our 2014 rate development. This has a 1.5% rate impact.

- We have observed that continuing members (that is, those members in a BCBSVT product in 2013 who enrolled in a QHP during 2014) had a lower average claims cost that the overall base membership. The rate impact of adjusting for this observation is -2.3%.
- Utilization trend in the 2015 rate filing is 0.0% for medical and 1.9% for pharmacy. The overall utilization trend of about 0.3% is lower than last year's assumption of 1.6%. This had an impact of –1.0% on rates.
- The contract conversion factor was updated to reflect actual enrollment, as described in Section 3.4.6 of the Actuarial Memorandum. The rate impact was -1.5%, as calculated by taking the ratio of the factors from the 2015 and 2014 filings.
- The minor mis-estimation of the 2015 unit cost increase, as described above in our response to Question 3b, lends 0.2% of impact to this "other adjustment" category.
- Changes not described above account for a balance of less than a tenth of a percent impact on rates. A more detailed analysis of this small impact is unavailable at this time.

e. Provide quantitative and qualitative support for the 4.0% increase in rates that is attributed to the reduction in the transitional reinsurance program. How many member months were used to develop this estimate?

This 4.0% estimated increase was calculated by applying the proposed 2015 reinsurance parameters to the transitional reinsurance estimate included in the 2014 rate filing. As described in the letter attached to question 2 (BCBSVT Exchange Filing – Method for applying the GMCB corrected Order.pdf), the expected transitional recoveries in the 2014 Exchange Filing were calculated by splitting our experience period into two models: Individuals including Groups of One and Small Groups excluding Groups of One. The models had 262,979 and 470,618 member months respectively. The claims in each model were trended to 2014 using the trends in the 2014 Exchange filing. Two distinct sets of PMPM costs were weighted based on projected membership. To calculate the impact of the 2015 reinsurance parameters, we used the total experience (all 733,597 member months) and modeled both the 2014 parameters and the 2015 parameters. The ratio of the two results for expected recoveries was applied to the 2014 expected recoveries to estimate the impact of the new transitional reinsurance parameters.

Input	2014 Program	2015 Program
Reinsurance Program Parameters	$60,000 attachment point 80% recovery $250,000 reinsurance cap	$70,000 attachment point 50% recovery $250,000 reinsurance cap
Expected Recoveries on Individual Members	$54.62 PMPM	$26.26 PMPM
Expected Recoveries spread over Single Risk Pool	$31.03	$14.92
Reinsurance Fee	$5.25	$3.67
Reduction of Projected Allowed Claims	-$25.78	-$11.25
Rate Impact vs. 2014		4.0%

Please note that the 2015 PMPM figures in the above tables do not match the estimates in the 2015 Exchange Filing. The above calculation is intended to be an estimate of the impact of the change in parameters on the rate increase, using 2014 filing membership and experience assumptions. The result would be different if a different order of operations were chosen. For the 2015 Exchange Filing, we updated the experience period, membership projections and parameters to generate an entirely independent, updated estimate of the reduction of projected allowed claims due to the Transitional Reinsurance program.

f. Provide quantitative and qualitative support for the 0.8% increase in rates that is attributed to benefit leveraging.

The actuarial values for each benefit plan were calculated as described in Section 3.8.1.1 of the Actuarial Memorandum. To generate the 2014 values, one year of trend was first removed from the underlying cost projections. Results are as follows:

Benefit Plan	Actuarial Value			Members
	2014	2015	Change	
Non-Standard Gold	81.8%	82.4%	0.7%	2,765
Non-Standard Silver	74.4%	75.2%	1.0%	3,677
Non-Standard Bronze CDHP	65.9%	66.7%	1.3%	2,792
Standard Platinum	92.4%	92.6%	0.3%	12,857
Standard Gold	84.2%	84.7%	0.6%	7,088
Standard Silver	75.6%	76.3%	1.0%	12,638
Standard Silver CDHP	76.3%	77.0%	0.8%	9,439
Standard Bronze	66.6%	67.5%	1.3%	2,711
Standard Bronze CDHP	69.2%	69.9%	1.1%	4,135

Using projected membership from the 2015 filing as weights, we calculate an average change of 0.8%. (Note that recreating the Catastrophic model would have involved a great deal of effort. The projected 88 members in the Catastrophic plan rendered that plan irrelevant as part of this approximation.)

4. Changes in the Morbidity of the Population Insured

a. Provide a comparison of the 2014 enrollment by age, gender and plan to the projected 2015 membership by age, gender and plan.

Please see *Reponses to BCBSVT 2015 Exchange Filing Inquiries - 06.11.2014.xlsx*, tabs "Q4a - 2014 Enrollment" and "Q4a - 2015 Projected." The difference between the two tabs is the addition to the projected membership of the 3,145 Small Group members with renewal dates of May 2014 and beyond.

b. Describe the year to date paid claims and earned premiums that are available and discuss whether or not they should be considered in the rate development.

Year to date March results were the most recent published financials when we finalized our assumptions for the 2015 filing. The exchange had a monthly average of 30,262 members during Q1. As of April 22, 2014, there were 55,045 members enrolled in a QHP product. The delay in the start of the Exchange has caused unexpected results for both paid claims and earned premiums.

BCBSVT enabled a contingency plan to extend 2013 benefits for any individual or small group employer who had not gone through the Exchange as of January 1, 2014. Many members subsequently made it through the Vermont Health Connect (VHC) during Q1 and were retroactively enrolled back to January 1. This created issues for any member who had claims before the retroactive enrollment was effectuated, as the claims were paid under their 2013 benefit but premium was booked to the Exchange line of business. Another part of the contingency plan was to carry over to their QHP product any member out-of-pocket costs accumulated during Q1 for members electing to extend their 2013 plan. This helped to create a seamless transition for the member but created higher than expected plan payments in the Exchange line of business since members were not starting their benefit accumulators at $0.

There was also a group of members who had signed up through VHC but had not yet been effectuated because premiums had not been received and processed. To make sure they did not have any gap in coverage, BCBSVT enrolled these members in an "access to care" group whereby members could fill their prescriptions or see their doctors and receive, once effectuated, the medical benefits for which they signed up. Through the end of Q1, there were many members who had received care without the receipt of premium.

Due to the significant issues listed above, we did not consider year to date 2014 financials when developing the 2015 rates. Many of the items that are impacting the 2014 results are "one-time" issues that BCBSVT expects to be remedied by the 2015 enrollment period.

5. *Changes in Benefits*
   a. *In Exhibit 5, should the change in the Benefit Adjustment factor (1+c1) from the 2014 to 2015 filings be shown in the "Reason for Rate Increase" illustration? If so, please demonstrate the impact.*

The Benefit Adjustment factor (1+c1) impact measures a change from the base period to the projection period, rather than a change from the previous to the current filing. It is of questionable utility to attempt to separate the Benefit Adjustment factor from the balance of changes due to the update in base experience data. The impact of using updated experience is captured within the "Other Adjustments" in the "Reason for Rate Increase" illustration. Please see our answer to Q3d for details.

   b. *Describe the source of the each of the benefits listed below in more detail. Is the data based on insured members? Were adjustments made to the data to fit the population that will be covered?*
      i. *Pediatric Vision Benefit*

As described in the Actuarial Memorandum, the estimate for the Pediatric Vision Benefit was provided by our vision vendor VSP. We have forwarded this question to the vendor and will provide additional information when it becomes available.

ii. Pediatric Dental Benefit

As described in the Actuarial Memorandum, the estimate for the Pediatric Dental Benefit was provided by George N. Berry, F.S.A., of Milliman. In attachment C, Mr. Berry described the method used to calculate the estimates. The "estimates are based on manual rates using the Milliman Dental Cost Guidelines (DCGs)." Mr. Berry then adjusted the DCG for age/gender and area: "The DCGs contain starting data by age/gender category. We used the average claims costs for ages 0-21 based on the BCBSVT age mix within the 0-21 age band…We adjusted the national average starting data to statewide Vermont based on area factors contained in the DCGs."

6. Changes in Demographics

a. In Exhibit 5, please explain the necessity of the Changes in demographics (1+c3) after adjustments were made for Impact of the Health Status of the newly insured (1+b3) and Changes in pool morbidity (1+b9).

The Change in Pool Morbidity measures the impact of removing from the starting claims costs members who had not enrolled in BCBSVT QHPs by April 22, 2014. The Change in Demographics then adjusts for the overall demographic difference between the projected period population and the continuing members (i.e. those who had enrolled in a BCBSVT QHP by the date above). Finally, we adjusted for the morbidity impact of the new members based on the experience projection category to which they belong, as described in Section 3.4.2 of the Actuarial Memorandum. Since the overall change in demographics is adjusted for in (1+c3), the new member morbidity impact needs to be normalized for demographics – conceptually the new member should be assigned the claim cost impact of a similar (age, sex) continuing member in the category. This was accomplished through the mechanism illustrated in Exhibit 2B accompanying the Memorandum. Through this normalization, we believe that we have maintained the independence of each of these three adjustments. Each is necessary in order to accurately reflect the demographics and morbidity of the projected population relative to the base period population.

7. Other Adjustments

a. From Exhibit 5, how much of the pharmacy rebates (e1) in the experience period is estimated? How do the estimated experience period pharmacy rebates compare to the actual 2012 pharmacy rebates?

For the experience period of CY 2013, 74% of the pharmacy rebates ($1,861,231 of $2,509,837) were estimated. The actual pharmacy rebates for CY 2012 were $2,604,160, or $3.57 PMPM.

b. Provide quantitative support for the cost of the Vermont Vaccine Purchasing Program Payments for children and adults.

As described in the actuarial memorandum, we imputed a charge for each claim where the vaccine is provided by the state. . The amount imputed was calculated by comparing the

assessment charges by the state to actual experience. We are assessed by the state annually and we updated the rates on 5/1/2013, which is why each vaccine appears twice. Please see *Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.11.2014.xlsx*, tab "Q7b" for the details of the number of claims and the amount imputed for the experience period.

c. This question involves Confidential and Proprietary information and will be provided under separate cover.

d. *In Exhibit 5, provide the calculation of the net cost of reinsurance (e5). Were any adjustments made to the claims data used in the BCBSVT Large Claims and Stop Loss Filing (BCVT-129374060)?*

As described in the BCBSVT Large Claims and Stop Loss Filing (BCVT-129374060), BCBSVT has purchased reinsurance for claims in excess of $600,000 for 2014, and expects to purchase similar reinsurance in future years with limits approximately equal to the 2014 limit increased by trend. We estimate that the target loss ratio for the reinsurance is approximately 75%, which implies a cost of reinsurance of approximately 33% of claims above the reinsurance limit. For each pricing period starting quarter, we determined an annual cost of reinsurance for the trended reinsurance limit by multiplying the expected annual claims cost above the limit by 33%. Dividing this by 12 produces the PMPM cost of reinsurance. For the projection period starting on January 1, 2015, the calculation was:

2014 Reinsurance Limit	(a)	$600,000
Trend	(b)	1.041
2015 Reinsurance Limit	(c) = (a) x (b), rounded to the nearest 5,000	$625,000
Expected Claims above the limit	(d)	$39.10
Cost of Reinsurance	(e)	33%
PMPM	(f) = (d) x (e) / 12	$1.08

8. *Contract Conversion Factor*
   a. *From Exhibit 5, please discuss the appropriateness of reducing the projected index rate by the Changes in Family Tiering (1+c6) and/or any guidance provided by CCIIO about this adjustment factor. Was any consideration given to making this adjustment in the 'cost-sharing design of the plan' to avoid reducing the allowed costs? Demonstrate compliance with the definition of the projected index rate in the Part I Instructions.*

Based on guidance provided to us by our reviewing actuaries during the rate review process for the 2014 Exchange filing, it was our understanding that Plan Level adjustments, other than the Paid to Allowed Ratio, needed to average to 1.000 across all plans. To achieve this, we were to include the Changes in Family Tiering (1+c6) factor in the index rate. We have maintained this methodology in the 2015 filing in the face of apparently contradictory instructions and/or guidance.

If the non-normalized adjustment were applied as a plan level adjustment without the (1+c6) factor in the Index Rate, impact on rates would be minimal (less than $0.03 on Single Rates).

9. Projected Risk Adjustments PMPM:

a. Based on the support provided, the risk adjustment in cell V35 on WS 1 of the URRT should be -$0.08. If this is correct, please update the URRT accordingly.

Yes, the risk adjustment in cell V35 on WS1 of the URRT should be -$0.08. Per your guidance, we will update the URRT accordingly at the end of the review process.

10. Benefit Richness Adjustment

a. Provide qualitative and quantitative support for the benefit richness adjustment factors for medical and pharmacy in Exhibit 6C.

Medical Benefit Richness Adjustment: An independent analysis was performed to measure the correlation between the benefit design and the quantity of medical services consumed. Group claims and membership data from January 2009 through August 2013 were examined, and a modeled paid-to-allowed ratio was assigned to every benefit in the experience period. The correlation used the paid-to-allowed ratio as the independent variable and the utilization frequency (defined as Professional and Outpatient visits + Inpatient Admissions) as the dependent variable. A 2nd order polynomial was found to best fit the data. The polynomial was then normalized such that the paid-to-allowed ratio underlying the base BRV benefit (manual rate) returned a utilization adjustment of 1.00. In other words, if a simulated benefit has a paid-to-allowed ratio less than that of the average benefit, then utilization will be reduced (i.e. factor < 1.00). If a simulated benefit has a paid-to-allowed ratio greater than the average, then the benefit will have induced utilization (i.e. factor > 1.00). The final polynomial used for the medical benefit richness adjustment was $1.0782 \times (AV_{med})^2 - 0.9525 \times (AV_{med}) + 1.0353$.

Pharmacy Benefit Richness Adjustment: Independent analysis was performed to measure the correlation between the benefit design and the quantity of pharmacy prescriptions consumed. The pharmacy benefits are adjusted in two ways. First, the generic utilization varies with the benefit designs. Group claims and membership data from January 2009 through August 2013 were examined, and a table was created to adjust the base generic utilization up or down depending on the difference in the Generic and Brand copays of the member's drug plan. The adjustments used for this were 1.0178 for non-integrated plans and 0.9876 for integrated plans.

Second, a separate analysis was done to adjust for the overall pharmacy benefit. A modeled paid-to-allowed ratio was assigned to every benefit in the experience period. The correlation used the paid-to-allowed ratio as the independent variable and utilization frequency (defined as number of scripts) as the dependent variable. A line was found to best fit the data. The line was then normalized such that the paid-to-allowed ratio underlying the base BRV benefit (manual rate) returned a utilization adjustment of 1.00. The final line used for the pharmacy benefit richness adjustment was $0.6784 \times (AV_{rx}) + 0.4304$.

Please see Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.11.2014.xlsx, tab "Q10a" for the details.

b. Please discuss the changes in the benefit richness adjustments from the prior filing.

For the 2014 Exchange Filing, the induced utilization factors were derived from the same methodology as described in our 2014 Benefit Relativity Filing (SERFF # BCVT-128829812). Two analyses were done at that time to measure the relationship between the paid-to-allowed ratios and the utilization frequency, one for non-integrated plans and one for integrated plans. Different polynomials were applied to non-integrated plans and integrated plans. In their order, the GMCB modified the induced utilization factors to the standard HHS Induced Utilization Factors.

c. Were any steps taken to assure that the benefit richness adjustments did not include any differences in utilization due to differing health status of people with different cost-sharing designs, per page 26 of the Part I Instructions?

As described above, the benefit richness adjustments were calculated using group experience over a 56-month experience period. The use of group data minimizes the potential for selection bias within the experience period data, while the extremely long period examined serves to minimize any impact of random differences in health status among those enrolled in various benefit designs.

No explicit or implicit adjustments were made to reflect differences in health status among the actual or assumed enrollees in any particular benefit design, in accordance with the Instructions.

11. Impact of Specific Eligibility Categories for the Catastrophic Plan

a. Please elaborate on which adjustment for the catastrophic plan causes the method described on the bottom of page 24 in the Actuarial Memorandum to skew the Plan Adjusted Index Rate.

The process of converting our projected fee-for-service experience allowed charges, paid to allowed ratios and other claims expenses to the definitions of the Plan Adjusted Index Rate creates the "skew" factor described at the bottom page 24 of the memo. It is a combination of all adjustments that adds to the "skew" factor. Tables 1 and 2 below illustrate how each component is slightly different after we calibrated/normalized all adjustments to the Plan Adjusted Index Rate definition. Since the Catastrophic plan has its own specific plan level adjustment, it is the only plan that needs an additional balancing item.

Table 1

	From Exhibit 6 B/E	
(a)	$492.65	Projected Allowed for Experience EHB (Projected FFS Experience Allowed)
(b)	67.99%	Paid to Allowed Ratio
(c)	0.9109	Benefit Richness Adjustment
(d)	0.9469	Tier Ratio Adjustment
(e)*	0.6013	For Catastrophic Only - Impact of Eligibility
(f)	($6.52)	Non-system claims + additional EHB not in experience + transitional reinsurance program
(a)x(b)x…(e) + (f)	**$167.18**	Expected Claims Cost

Table 2

	From Exhibit 6A	
(a)	$493.19	Market Adjusted Index Rate
(b)	66.59%	Paid to Allowed Ratio
(c)	0.9091	Benefit Richness Adjustment
(d)	0.9459	Tier Ratio Adjustment
(e)**	0.6013	For Catastrophic Only - Impact of Eligibility
(f)**	0.9846	balancing item to get back to $167.18
(a)x(b)x…(f)	**$167.18**	Expected Claims Cost

*(e) in Table1 = 0.6581 x 0.9137 as described on page 24 of the memo
** (e) x (f) in Table2 = 0.5920 as seen in Exhibit 6A

Exhibits 6B, 6C and 6D illustrate the differences due to the normalization of items (a), (b), (c) and (d) of Tables 1 and 2 above.

12. This question involves Confidential and Proprietary information and will be provided under separate cover.

13. Administrative Expense Load

a. Please provide the total administrative costs and member months for the combined BCBSVT individual members, BCBSVT small group members and TVHP small group members for the prior 5 years.

We started reporting our expenses for Large Group and Small Group separately in 2011. To help with your review, we are providing 5 years of data for the Enterprise and 3 years of data for BCBSVT small group, TVHP small group and Individuals. Please note that the individual line does not include our Medicare Supplement products.

Total Enterprise

Year	Member Months	Operating Expenses	PMPM
2009	1,864,180	$62,131,729	$33.33
2010	1,798,360	$60,732,076	$33.77
2011	1,919,868	$59,730,786	$31.11
2012	2,172,794	$59,660,007	$27.46
2013	2,340,495	$64,234,940	$27.45

BCBSVT small group, TVHP small group and Individual products

Year	Member	Operating	PMPM

	Months	Expenses	
2011	513,626	$14,924,564	$29.06
2012	738,317	$19,002,034	$25.74
2013	736,695	$21,905,701	$29.74

b. Please provide a comparison of the 2014 and 2015 administrative expenses, and justify the differences.

The following information was provided in the Actuarial dataset on June 4, 2014:

	PMPM in 2014 Exchange Filing	PMPM for CY 2013	PMPM in 2015 Exchange Filing
Payroll and Benefits	$14.40	$14.31	$12.79
Outsourced Services (EDP, claims, etc.)	$6.10	$6.07	$6.92
Auditing and consulting	$2.21	$2.61	$1.81
Marketing & Advertising	$0.49	$0.84	$0.33
Legal Expenses	$0.22	$0.21	$0.11
Other General Admin Expense	$5.70	$5.32	$4.82
Taxes, Licenses & Fees	$0.50	$0.44	$0.45
TOTAL	**$29.62**	**$29.81**	**$27.22**

For the 2014 Exchange Filing, we used the October 2011 – September 2012 experience trended to calendar year 2014 using a 2.6% trend rate.

For the 2015 Exchange Filing, we used the calendar year 2013 experience period and removed one-time expenses that were related to the VHC startup, as we do not expect those expenses to be recurring in 2015. No trend was applied to the 2013 experience period.

The difference between the 2014 Exchange Filing and the 2015 Exchange Filing is attributable to additional operating efficiencies realized during 2013 or expected to be realized during 2014.

14. Profit (or Contribution to Surplus) & Risk Margin

a. Provide quantitative support for the requested contribution to reserve.

There are three types of events that affect the surplus of insurers:

1. Random fluctuations from expected. For this purpose these are defined as deviations from expected results that are symmetrically distributed about the best estimate, which is the expected level. Typically a contribution to reserve is not required to maintain surplus with respect to these events since it is expected that favorable fluctuations will offset unfavorable ones over time.
2. Benefit trend increases the need for surplus over time. The impact of benefit trend on surplus is illustrated in Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.11.2014.xlsx, Q14 tab, which demonstrates that a contribution to reserve of about 1% is required to maintain surplus relative to required capital levels in the face of

current benefit trend assumptions. (Please note that the result is sensitive to the magnitude of the benefit trend.)

3. Exceptional or non-recurring events which are typically not provided for in pricing (and hence do not generate offsetting favorable events). Pertinent examples include the extension of existing small group and individual products without required rate increases, and the additional administrative burden of contingency plans for VHC operations. These types of events are not typically reflected in pricing (and costs for these specific events have not been included within this filing). Maintenance of adequate surplus is the mechanism used by Insurance companies to address these contingencies.

In normal circumstances, CTR would include some additional margin to protect member reserves against the occurrence of exceptional events. Because of the already-significant rate increase in this newly-established market, BCBSVT has intentionally lowered its CTR requirement for the Exchange to only that necessary to avoid depletion of RBC through increases in required capitalization due to ongoing benefit trend.

15. This question involves Confidential and Proprietary information and will be provided under separate cover.

16. Exhibit 6A

a. We note that several exhibits use the Plan Level Adjusted Index Rate as the average premium. Please discuss if the Plan Level Adjusted Index Rate is the expected premium or if it is 3.6% lower than the actual expected premium due to the Changes in Family Tiering adjustment discussed above.

The Plan Level Adjusted Index Rate is the average expected premium on a per member per month basis.

The adjustment for "family tiering" is actually an adjustment for the couple, adult and child(ren) and family tiers for aggregate deductibles and for the adult and child(ren) and family tiers for stacked deductible plans. Since the state has defined the contract factors as 1, 2, 1.93 and 2.81, we adjusted every plan based on the four tier ratios needed compared to the mandated tiers (as shown in Exhibit 2D). Simply applying single conversion factor (1.1246) to the Plan Level Adjusted Index Rate would create more revenue than is required given the benefit designs and our child to adult relationships. As explained in our answer to question 8, we adjusted the Index Rate for this because of our understanding of plan level adjustments averaging out to 1.00.

Applying the Change in Family tiering as only a plan level adjustment, rather than as a normalized plan level adjustment and an adjustment to the Index Rate, would have minimal impact on the Plan Level Adjusted Index Rate.

17. Exhibit 6B

a. Please discuss the difference between the AV Metal Value and the Paid to Allowed Ratio for EHB Portion in Exhibit 6B for the plans listed below. Note that we are not suggesting that the AV Metal Values and the Paid to Allowed Ratios should reconcile. However, large discrepancies merit further review.

i. Standard Bronze CDHP

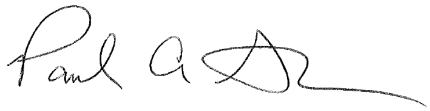
ii. Standard Silver CDHP

As you point out, the AV Metal Values and the Paid to Allowed ratio will not necessarily reconcile. BCBSVT did not calculate the AV Metal Value for the Standard plans. The methodology used differs greatly for aggregate plans to the methodology used to calculate the paid to allowed ratio. Both plans that have large discrepancies are aggregate CDHPs that were certified to be in their respective metal levels by the State's actuary, Wakely Consulting. Wakely adjusted their AV Metal Values for aggregate benefits. We did not adjust our Paid to Allowed ratios for aggregate benefits, instead making a separate plan-level adjustment described as the Family Multiplier Adjustment.

Also, as explained in Attachment B, BCBSVT did not update the underlying model for the AV Metal Value since the Federal AV Calculator was not updated. Therefore, the Metal AVs are in 2014 terms. For the Paid to Allowed Ratios, updated experience trended to 2015 was used. Therefore some differences due to leveraging exist as well.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,



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Paul Schultz, F.S.A., M.A.A.A.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

July 2, 2014

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

Subject: Your 06/30/2014 Questions re: Blue Cross and Blue Shield of Vermont 2015 Exchange Filing (SERFF Tracking #: BCVT-129572217)

Dear Mr. Hammerquist:

In response to your request dated June 30, 2014, here are *your questions* and our answers:

1. *Pediatric Dental*
   a. *Provide quantitative support for the $42.49 allowed charges for pediatric dental. How does this figure reconcile to the projected dental costs found in the Milliman report?*

      The report from Milliman contains the expected paid claims for each proposed benefit. The underlying allowed charges were provided to us in a separate communication. To calculate the average allowed charges, we applied the projected membership weights to each of the plans.

Plan	Projected Allowed Charges per Child	Portion of the Projected Membership
Standard Platinum	$45.04	22.1%
Standard Gold	$44.15	12.2%
Standard Silver	$43.04	21.7%
Standard Bronze	$41.67	4.7%
Standard Silver CDHP	$40.28	16.2%
Standard Bronze CDHP	$39.60	7.1%
Blue Rewards Gold	$43.49	4.8%
Blue Rewards Silver	$42.68	6.3%
Blue Rewards Bronze CDHP	$35.68	4.8%
Blue Rewards Catastrophic	$33.71	0.2%
Average Allowed Charges	**$42.49**	

   b. *We note that "there is a considerable amount of uncertainty" in the projected pediatric dental claims costs. Was any margin included in the pediatric dental claims costs to reflect this uncertainty?*

      No additional margin was included to reflect this uncertainty.

c. *Provide the benefit richness adjustments used in 2015 for each pediatric dental plan. Why was this adjustment assumed to be prohibited in 2014 but not in 2015?*

From our consultant:

We apply the benefit richness adjustment in two steps:

First we apply an adjustment that reflects the impact of the dental coinsurance levels and no annual maximum benefit relative to the benefit level underlying the Milliman Dental Cost Guidelines which reflect 100/80/50 coinsurance and a $1500 annual maximum benefit. These factors are the same for all plans: Class 1: 1.05, Class 2: 1.09, and Class 3: 1.10.

Second, we apply an adjustment to reflect the impact of the deductible on utilization levels. These factors only apply to the classes to which the deductible applies. The factors are shown below:

Plan	Factor
Platinum	0.960
Gold - Standard	0.920
Silver - Standard	0.870
Silver - Standard CDHP	0.870
Bronze - Standard	0.810
Bronze - Standard CDHP	0.855
Gold - Blue	0.890
Silver - Blue	0.855
Bronze - Blue CDHP	0.765
Catastrophic - Blue	0.720

d. *Please clarify how these projected dental amounts are representative of the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT, in light of the medical claims being applied to the deductible and out-of-pocket maximum prior to the dental claims.*

From attachment C:

By assuming the medical benefits apply to the deductible and out-of-pocket maximum prior to any dental claims, the projected net claims cost for dental services is overstated. However, our understanding is that BCBSVT is not reflecting the impact of dental costs on the deductible and out-of-pocket maximum in its development of the medical costs, and these projected dental amounts are intended to represent the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT.

Milliman is correct in stating that the development of medical costs and the tier factors, BCBSVT based the calculations on the distributions of medical claims so that the estimate needed is the incremental increase in total claims due to dental, not the amount of claims paid for dental services. That is the amount paid for a medical claim processed after a claim for dental services would be different (higher) than the amount paid for the medical claim in the absence of any dental claims.

2. *Pediatric Vision*
   a. *Per the response to question 5b dated June 16th, 2014, please provide support for the projected allowed claims for pediatric vision. We have included the question below for your convenience.*

      Describe the source of the each of the benefits listed below in more detail. Is the data based on insured members? Were adjustments made to the data to fit the population that will be covered?

      The expected paid claims cost for pediatric vision benefits was provided by our vision vendor, VSP. The initial rating was developed using fee data applicable to Vermont, along with utilization patterns derived from the child populations of two jumbo groups with plans that were similar to the Exchange offerings.

   b. *We note that it was "assumed that the paid benefits would not be materially different from the allowed charges." Please clarify if this means that zero cost sharing was assumed for pediatric vision benefits.*
      We assumed that the rate impact of variations in cost sharing with respect to this benefit would be minimal. We assumed the expected paid claims were a reasonable estimate of the allowed charges and that there was no difference between the allowed and paid amounts. The benefit is integrated with the medical plan and, as such, is subject to the same cost sharing provisions. However, unlike most medical treatments subject to cost sharing, there is a significant amount of discretion available to the insured with respect to the scheduling of these procedures. In particular the insured can schedule these later in the plan year when the cost sharing may be reduced due to family deductibles and out-of-pocket limitations not totally dependent on the individual's own experience.

   c. *Please provide a quantitative estimate of the cost sharing for pediatric vision benefits.*

      Zero. As noted in (b) we assumed no material rate impact due to cost sharing variations with respect to this benefit.

3. *Pharmacy Trend*
   a. *Please provide quantitative and further qualitative support for the adjustment made to account for the expected May 2014 launch of generic Copaxone.*

   Every month, our Pharmacy Benefit Manager sends us their Patent Expiration Report. Their report projected that a generic version of Copaxone was expected to be launched in May 2014. We used that information to support the adjustment to the Specialty Trend.

   To calculate the two percent dampening of the expected specialty trends, we split the specialty experience between Copaxone and Other Specialty. We first used 24 months regression on Monthly data to project the cost of Copaxone and Other Specialty. We then adjusted the cost of Copaxone by 10 percent upon generic launch and a total of 30 percent upon multi-source availability (as explained on page 15 of the Actuarial Memorandum) to account for lower expected allowed charges for generic Copaxone. Using

average days supply in calendar year 2013 as weights, we calculated expected cost trends with and without the adjustment.

See attached *Responses to BCBSVT 2015 Exchange Filing Inquiries – 06.30.2014.xlsx*, Tab Q3 for the detailed calculation.

4. *Medical Trend*
   a. *Please provide a quantitative demonstration of the expected cost shift due to the proposed 1.6% increase for Medicaid rates.*

As noted on page 16 of the actuarial memorandum, we chose not to further increase our medical trend for the potential upward impact the then-proposed 1.6% increase for Medicaid would have on Commercial rates increases.

To estimate the impact, we used data from the GMCB's 2012 Vermont Health Care Expenditure Analysis[1]. The weights from slide 18 were used to calculate the overall cost increases.

Payer	% of Total Expenditure	2014 Cost Increase	2015 Cost Increase
Medicaid	25%	3.0%	1.6%
Medicare	21%	2.5%	2.5%
Private Insurer and OOP	51%	5.1%	5.4%
Other Government Payers	3%	4.0%	3.8%
GMCB's Target		**4.0%**	**3.8%**

- Other Government Payers were set to the target.
- 2014 Medicare was estimated to achieve the total target of 4.0%.
- 2015 Medicare was set equal to the estimated 2014 Medicare increase. Please note that a lower increase would result in additional cost shift to private insurers.
- 2015 Private Insurer and OOP was calculated to achieve a total target of 3.8%

  We estimate that due to the 1.6% increase to Medicaid and with constant Medicare increases, the Commercial rates would increase by about 5.4%, or 0.3% more than the 2014 increases to achieve the targeted 3.8% overall increase.

5. *Base Experience Period*
   a. *We note that the fourth quarter of 2013 was impacted by a significant increase in utilization leading up to the implementation of Vermont Health Connect. Was any consideration given to using a different base experience period? For example, the experience from October 1, 2012 to September 30, 2013 would exclude the increased utilization leading up to the implementation of Vermont Health Connect.*

The "significant increase in utilization" was a phenomenon observed within the pharmacy experience. An analogous increase in medical claims was not in evidence. As stated in the

[1] http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_2012_Expenditure_Analysis_Res_Prov_2014_2_20.pdf

Actuarial Memorandum, "While there may have been a 'rush to services' in advance of moving to Vermont Health Connect, this effect would be more profound on prescription drugs where claims are more frequent and the timing of which is more subject to manipulation." It did not appear that there was an increase in fourth quarter medical utilization beyond that expected due to the seasonal pattern of benefits with relatively high deductibles.

In order to maximize our experience base, we thought it prudent to use calendar 2013 experience as the baseline for medical claims. Particularly given the absence of evidence for a "rush to services," there was no basis for us to believe that using Q4 2012 data, with an extra year of trend, would lead to a more accurate result than using the most recent experience available to us at the time of the filing. In fact, the additional variables of a less consistent population and additional required trend argue that such a change would in all likelihood be less accurate.

The increase in fourth quarter 2013 utilization for prescription drugs may have partially been a one-time event due to the advent of Vermont Health Connect. We have not been able to complete a study identifying or measuring this impact, largely due to the lack of credible data available for calendar 2014. While we were careful to exclude this quarter from the trend analysis, as we felt that resulting trends might be overstated, we are less hasty to exclude the data from the base experience, for a variety of reasons:

- Given that we could not positively identify or measure the impact of Vermont Health Connect on pharmacy utilization, we cannot definitively conclude that the uptick in utilization was a one-time event. It would be imprudent to exclude this period altogether on the basis of incomplete evidence.
- Excluding fourth quarter 2013 would involve using a different set of membership than we employed for medical base experience. Beyond making the calculations significantly more difficult (all factors would need to be calculated twice and blended), using different bases introduces a serious issue with consistency in that the two populations may have differing underlying morbidity.
- Benefits for nearly all members change as of January 1. Including data that crosses benefit years leads to yet another set of adjustments that must be made in order to properly reflect induced utilization across a broad array of plan designs.
- The impact of such a change in methodology would be minimal with respect to the combined medical/pharmacy benefit. Given the questionable additional accuracy of such an approach, as discussed in the previous bullet points, the computational difficulties in starting with separate sets of cross-benefit year base period experience outweigh any additional precision that might arguably be gained through such an approach.

6. Population Risk Morbidity

a. Please provide quantitative support for the average age-gender factors used to calculate the factors below shown in Exhibit 5:

i. (1+b9) The Impact of the Health Status of the Newly Insured

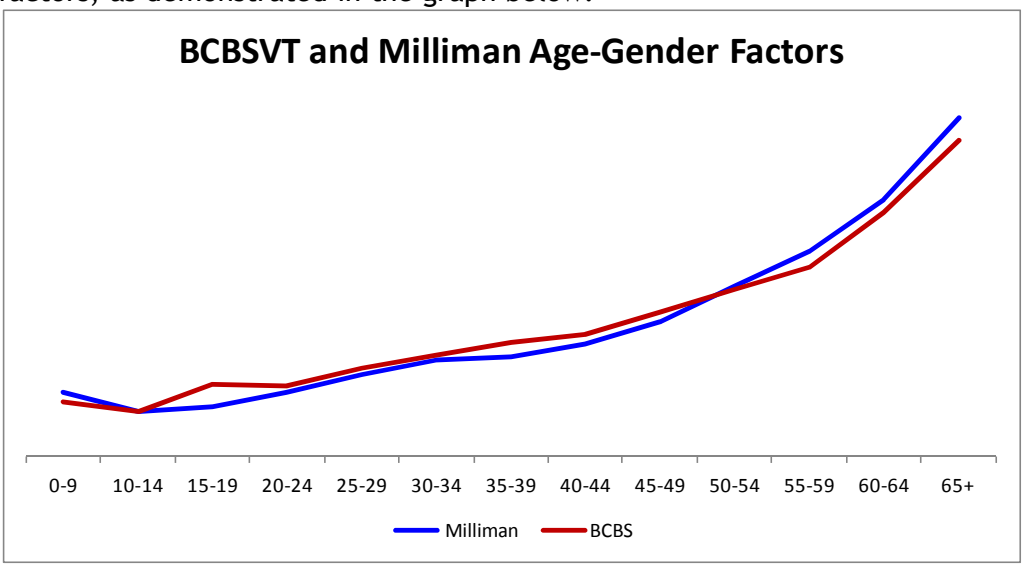
ii. (1+c3) Changes in demographics (age, gender, region, etc.)

As described in the actuarial memorandum, we used Milliman Health Cost Guidelines age-gender factors to calculate the factors (1+b9) and (1+c3) on Exhibit 5. These guidelines are proprietary and we cannot share them.

Per our phone discussion, we will instead provide how age-gender factors calculated using the experience period from the filing compare to the Milliman Health Cost Guidelines:

Age Category	Member Months	Ratio of BCBSVT to Milliman
Ages 20-24	54,720	1.109
Ages 40-44	58,738	1.077
Ages 60-64	99,352	0.951

The member months used from our own experience fall well short of a credible figure necessary to produce an age curve, particularly at any level of detail and without graduation. Nonetheless, our results for a single year of claims track quite closely with the Milliman factors, as demonstrated in the graph below.



The Milliman Health Cost Guidelines are a widely-accepted industry standard in health care pricing.

7. Other Adjustments

a. We note that in the response to question 7a dated June 16th, 2014 that 74% of the CY 2013 pharmacy rebates were estimated. Has the company received any additional information regarding the CY 2013 rebates since the initial filing was made? Is this lag associated with the CY 2013 rebates typical for the Company?

We have not received any additional information regarding CY 2013 rebates since the time of the initial filing. A six to nine month reporting lag is typical for pharmacy rebates. We understand that our PBM implemented a new claims platform during 2013, problems with which are leading to the current extended reporting lag.

8. *Transitional Reinsurance Recoveries*
   a. *Please provide additional quantitative support for the expected reinsurance recoveries for individual members. The additional support should include the frequency and average allowed claims used in the calculation for both the 2014 and 2015 reinsurance recoveries split into the following categories:*
      i. *< $60,000*
      ii. *$60,000 - $70,000*
      iii. *$70,000 - $250,000*
      iv. *$250,000 +*

Table 1 shows a comparison of continuance tables underlying the 2014 filing as well as the 2015 filing. The 2014 model consisted of a blend of small group and individual experience since it was expected that the 2014 individual exchange market would be comprised of both types of members. It was assumed that the morbidity of those moving from small groups to the individual market would reflect that of the average small group. The 2015 model also assumed a blend of small group and individual experience; however, the small group experience used in the model was comprised of the experience of the specific 6,500+ small group members that had already migrated to the individual exchange market. The allowed charge PMPM of the migrating members is higher than that of the average small group. Note that the tables are roughly proportional except at the very high claim levels.

Table 1

	Allowed E[Allowed Charge PMPM > D]		Frequency % of Claimants > D	
D	2014	2015	2014	2015
-	$ 553.16	$ 640.54	-	-
60,000	$ 87.86	$ 104.70	1.3%	1.6%
70,000	$ 76.97	$ 90.09	1.0%	1.3%
250,000	$ 16.35	$ 16.64	0.1%	0.1%

Table 2 illustrates the expected drop in transitional reinsurance recoveries using both the 2014 and 2015 models. Despite the difference in the underlying population of the respective models, the expected difference due to the parameter changes is similar.

Table 2

		PMPM	
	Transitional Reinsurance Benefits	2014 Filing	2015 Filing
2014 Benefit	$(E[X - 60K]_+ - E[X - 250K]_+) \times 80\%$	$ 57.21	$ 70.45
2015 Benefit	$(E[X - 70K]_+ - E[X - 250K]_+) \times 50\%$	$ 30.31	$ 36.73
	% Change in 2015 Benefit/2014 Benefit	-47.0%	-47.9%

Table 3 shows the calculation from expected allowed charges for individuals only to the expected reinsurance recoveries built into the Market Wide Adjusted Index Rate.

Table 3

	2014 Filing	2015 Filing
Individual Allowed	$ 57.21	$ 36.73
Individual Benefit Paid*	$ 54.62	$ 34.54
% Individual	56.80%	40.43%
Total Expected Recovery	$ 31.02	$ 13.96

*Benefit paid amounts come from our re-adjudication model

9. *Benefit Richness Adjustment*
   a. *Please provide further support that the "use of group data minimizes the potential for selection bias within the experience period data." To what degree do the members of the groups in the experience period data have choices between plans with different actuarial values?*

BCBSVT has a set of underwriting rules that minimizes the potential for selection bias.

For Small Group, the number of products offered depends on the number of covered active subscribers.

Number of covered active subscribers	Number of Products offered
Less than 5	1
Between 5 and 24	2
25 or more	3

For Large Groups, although we have recommendations for the maximum number of products offered, groups can negotiate the number of products they want to offer. We have strict guidelines that dictate that premium between the leanest and richest plans must be within 20%, to limit the potential for selection.

We also have requirements for all groups:

- A group cannot offer both a HSA plan with preventive riders and a HSA plan without preventive riders
- A group cannot offer both a plan with drug coverage and a plan without drug coverage
- The choice of plan offered should never include identical, or nearly identical medical benefits, together with meaningfully different prescription drug plans.
- A group cannot offer both a plan with a vision material rider and a plan without a vision material rider

The analysis done to calculate the Induced Utilization formula used group data from August 2012 to July 2013. This experience period includes 1,563,348 member months. Note that one of our associations was reported as only one group rather than the many groups in each association. Small Groups within the associations would have to follow the UW guidelines about the number of products they can offer. We know that they had only 1

or 2 product options and have estimated the split based in information provided by our sales department.

Below is the distribution of membership by the number of products they could choose from.

Number of Products Available	Member Months
1	577,329
2	332,577
3	157,946
4	77,664
5	33,917
6	203,198
7	51,946
8	95,215
9	1,405
10	25,677
12	6,475
Total	1,563,348

68% of the membership had three options or less and 99% of the members with six product choices could only choose plans with paid to allowed ratios between 82.5% and 98.8%.

10. Administrative Expenses

a. Please provide the CY 2013 Supplemental Health Care Exhibit and reconcile to the 2013 figures provided in the previous response.

Please find attached both BCBSVT and TVHP Supplemental Health Care Exhibits for 2013. Administrative expenses are contained in lines 1.05, 1.06, 1.07, 6.1 to 6.5, 8.1, 8.2, 10.1 to 10.4 and 12. Please note that a portion of the federal income taxes are included in line 1.05 per the instructions for the Supplemental Health Care Exhibit.

The expenses in those exhibits are on a statutory basis. In our previous answer 13, we provided administrative expenses, net of broker commissions, on a GAAP basis.

Below is the reconciliation from the Supplemental Health Care Exhibit and our previous answer 13.

Supplemental Health Care	Line	BCBSVT	TVHP	TOTAL
Federal Taxes and Assessments	1.05	($1,741,945)	$319,235	
State Insurance	1.06	$55,473	$13,216	
Regulatory authority licenses and fees	1.07	$164,408	$244,666	
Improve health outcomes	6.1	$2,208,384	$570,062	
Activities to prevent hospital readmissions	6.2	$146,014	$41,654	
Improve patient safety and reduce medical errors	6.3	$104,813	$29,734	
Wellness and health promotion activities	6.4	$1,969,812	$571,691	
Health Information Technology expenses related to health improvement	6.5	$655,931	$163,934	
Cost containment expenses not included in quality of care expenses in Line 6.6	8.1	$5,358,397	$837,020	
All other claims adjustment expenses	8.2	$25,678,883	$5,608,128	
Direct sales salaries and benefits	10.1	$853,861	$502,284	
Agents and brokers fees and commissions	10.2	$2,673,723	$5,747,833	
Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)	10.3	$0	$0	
Other general and administrative expenses	10.4	$17,127,462	$5,265,196	
Income from fees of uninsured (Cost Plus Reimbursements)	12	($19,558,061)	$0	
Total Administrative Expenses from Supplemental Health Care Exhibits	**(A)**	**$35,697,155**	**$19,914,653**	**$55,611,808**
Federal Income Taxes included in line 1.05	(B)	($3,042,344)	$0	($3,042,344)
Statutory to GAAP	(C)	$14,713,733	($711,389)	$14,002,344
Broker Commissions	(D)	$2,673,723	$5,747,833	$8,421,556
GAAP Administrative Expenses (net of Broker Commission) = (A)-(B)+(C)-(D)		**$50,779,509**	**$13,455,431**	**$64,234,940**

The majority of the difference between Statutory and GAAP reporting is the treatment of Cost Plus reimbursements, partially offset by an item for expenses paid to other Blues plans when our members use their networks.

11. Taxes and Fees

a. We note that the 2014 estimate of the Federal Insurer Fee was increased by 41.25%. Why was the increase applied to the rounded 2014 estimate, rather than the actual unrounded 2014 estimate?

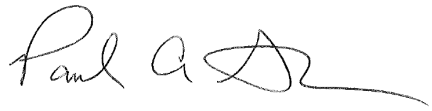
This question is misleading in that the "actual" estimate was the rounded percentage, rather than the unrounded calculation. The 2014 estimate was rounded up to account for unknowns in the actual amount BCBSVT will be assessed. Specifically, large groups are incentivized to become self-insured as a means of avoiding federal and state fees and

mandates. This could result in misestimation of the BCBSVT share of total insured premiums. More importantly, as our own groups increasingly shift to self-insurance, the premium base for the collection of the federal assessment dwindles. Therefore, it is necessary to collect a higher percentage than the unrounded calculation in order to fully fund the federal assessment. Lacking a means to perform a more specific estimate of this impact, we simply rounded up to the nearest whole percentage in the 2014 Exchange filing.

The 41.25% increase is, factually, the amount by which the total federal industry assessment increases from 2014 to 2015. In the absence of any additional information regarding the BCBSVT estimated or actual assessment, we applied this percentage to our previous estimate. This ensures consistency from year to year, particularly with respect to the still-unknown impact of the ongoing shift toward self-insurance.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,



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Paul Schultz, F.S.A., M.A.A.A.

		ORIGINAL DATA								
		COPAXONE			ALL OTHER SPECIALTY			TOTAL		
	Members	DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY
10/1/2011	42,747	841	$104,533	$124.30	12,714	$665,070	$52.31	13,555	$769,604	$56.78
11/1/2011	42,728	778	$93,664	$120.39	11,602	$646,393	$55.71	12,380	$740,057	$59.78
12/1/2011	42,763	778	$93,761	$120.51	13,546	$741,041	$54.71	14,324	$834,801	$58.28
1/1/2012	60,442	900	$122,116	$135.68	15,227	$734,911	$48.26	16,127	$857,027	$53.14
2/1/2012	60,483	960	$132,591	$138.11	14,257	$732,487	$51.38	15,217	$865,078	$56.85
3/1/2012	60,785	900	$124,180	$137.97	16,120	$839,887	$52.10	17,020	$964,067	$56.64
4/1/2012	60,990	1,020	$140,663	$137.90	15,698	$844,602	$53.80	16,718	$985,265	$58.93
5/1/2012	60,929	1,140	$157,375	$138.04	17,642	$904,849	$51.29	18,782	$1,062,224	$56.55
6/1/2012	60,891	1,080	$148,905	$137.87	17,281	$901,279	$52.16	18,361	$1,050,184	$57.20
7/1/2012	60,850	1,018	$140,723	$138.23	17,013	$897,703	$52.77	18,031	$1,038,425	$57.59
8/1/2012	60,836	1,048	$144,640	$138.00	17,183	$883,238	$51.40	18,231	$1,027,878	$56.38
9/1/2012	61,055	1,110	$153,246	$138.04	15,724	$857,777	$54.55	16,834	$1,011,023	$60.06
10/1/2012	60,917	1,138	$164,016	$144.10	18,175	$983,599	$54.12	19,313	$1,147,616	$59.42
11/1/2012	61,059	988	$143,152	$144.87	16,022	$860,419	$53.70	17,010	$1,003,570	$59.00
12/1/2012	61,186	1,018	$147,497	$144.86	17,750	$971,655	$54.74	18,769	$1,119,152	$59.63
1/1/2013	60,791	958	$152,503	$159.15	17,799	$962,273	$54.06	18,757	$1,114,776	$59.43
2/1/2013	60,577	808	$128,766	$159.33	15,474	$927,665	$59.95	16,282	$1,056,432	$64.88
3/1/2013	60,635	960	$152,657	$158.98	18,023	$1,084,286	$60.16	18,983	$1,236,943	$65.16
4/1/2013	60,560	1,198	$191,241	$159.57	17,496	$1,005,600	$57.48	18,695	$1,196,841	$64.02
5/1/2013	60,431	1,018	$162,320	$159.40	18,637	$1,087,148	$58.33	19,655	$1,249,468	$63.57
6/1/2013	60,739	988	$154,134	$155.93	17,484	$1,023,216	$58.52	18,473	$1,177,350	$63.73
7/1/2013	61,204	1,049	$158,686	$151.34	18,589	$1,169,562	$62.92	19,637	$1,328,247	$67.64
8/1/2013	61,332	1,139	$173,183	$152.07	18,154	$1,125,276	$61.99	19,293	$1,298,459	$67.30
9/1/2013	61,148	989	$149,417	$151.10	17,771	$1,175,694	$66.16	18,760	$1,325,112	$70.64
10/1/2013	60,840	1,141	$173,599	$152.11	18,826	$1,201,083	$63.80	19,967	$1,374,682	$68.85
11/1/2013	60,849	871	$135,001	$154.98	18,979	$1,173,653	$61.84	19,850	$1,308,655	$65.93
12/1/2013	60,315	1,074	$168,499	$156.83	22,965	$1,238,544	$53.93	24,039	$1,407,043	$58.53
1/1/2014	59,706	662	$115,934	$175.13	14,728	$1,094,060	$74.29	15,390	$1,209,994	$78.62
2/1/2014	59,400	1,066	$190,995	$179.21	16,502	$1,184,674	$71.79	17,567	$1,375,668	$78.31
3/1/2014	59,503	404	$71,290	$176.52	15,755	$1,170,548	$74.30	16,159	$1,241,838	$76.85
4/1/2014										
5/1/2014										
6/1/2014										
7/1/2014										
8/1/2014										
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6/1/2015										
7/1/2015										
8/1/2015										
9/1/2015										
10/1/2015										
11/1/2015										
12/1/2015										

REGRESSIONS						
COPAXONE		OTHER SPECIALTY		TOTAL		Projected Cost of Generic Copaxone
36 months on Monthly		36 months on Monthly		36 months on Monthly		
$126.61		$50.11		$54.73		
$127.99		$50.55		$55.21		
$129.34		$50.98		$55.68		
$130.74		$51.44		$56.16		
$132.16		$51.89		$56.65		
$133.51		$52.32		$57.11		
$134.96		$52.79		$57.61		
$136.38		$53.24		$58.10		
$137.86		$53.71		$58.60		
$139.31		$54.17		$59.10		
$140.82		$54.65		$59.61		
$142.36		$55.14		$60.13		
$143.85		$55.61		$60.64		
$145.42		$56.11		$61.17		
$146.95		$56.59		$61.69		
$148.54		$57.09		$62.22		100%
$150.16		$57.59		$62.77		100%
$151.63		$58.06		$63.26		100%
$153.28		$58.57		$63.81		100%
$154.89		$59.07		$64.35		100%
$156.58		$59.60		$64.91		100%
$158.22		$60.11		$65.46		100%
$159.94		$60.64		$66.03		100%
$161.68		$61.18		$66.61		100%
$163.38		$61.71		$67.17		100%
$165.16		$62.25		$67.75		100%
$166.89		$62.79		$68.33		100%
$168.71		$63.34		$68.92		100%
$170.54		$63.91		$69.52		100%
$172.22		$64.42		$70.07		100%
$174.09		$64.99		$70.68		100%
$175.92		$65.55		$71.28		90%
$177.83		$66.13		$71.90		90%
$179.70		$66.70		$72.50		90%
$181.66		$67.29		$73.14		90%
$183.63		$67.88		$73.77		90%
$185.56		$68.47		$74.40		90%
$187.58		$69.07		$75.05		70%
$189.55		$69.67		$75.68		70%
$191.61		$70.28		$76.34		70%
$193.69		$70.91		$77.00		70%
$195.60		$71.48		$77.61		70%
$197.72		$72.11		$78.29		70%
$199.80		$72.73		$78.95		70%
$201.97		$73.37		$79.64		70%
$204.10		$74.00		$80.31		70%
$206.32		$74.66		$81.01		70%
$208.56		$75.32		$81.71		70%
$210.75		$75.97		$82.40		70%
$213.04		$76.64		$83.12		70%
$215.28		$77.30		$83.82		70%
Regression Output		Regression Output		Regression Output		
1.00035	8.32049E-05	1.0003	0.000447053	1.00028	0.000594368	
4E-05	1.653405994	4E-05	1.838843213	3.6E-05	1.492937146	
77.41%	0.041459157	64.90%	0.046108995	73.05%	0.0374354	
75.4078	22	40.671	22	59.633	22	

TREND CALCULATION WITH ADJUSTED COST FOR COPAXONE

COPAXONE			ALL OTHER SPECIALTY			TOTAL		
DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY
1,016	$150,957	$148.54	18,350	$1,047,551	$57.09	19,366	$1,198,507	$61.89
1,016	$152,598	$150.16	18,350	$1,056,842	$57.59	19,366	$1,209,440	$62.45
1,016	$154,095	$151.63	18,350	$1,065,305	$58.06	19,366	$1,219,400	$62.97
1,016	$155,770	$153.28	18,350	$1,074,754	$58.57	19,366	$1,230,524	$63.54
1,016	$157,408	$154.89	18,350	$1,083,978	$59.07	19,366	$1,241,386	$64.10
1,016	$159,119	$156.58	18,350	$1,093,593	$59.60	19,366	$1,252,712	$64.69
1,016	$160,793	$158.22	18,350	$1,102,978	$60.11	19,366	$1,263,771	$65.26
1,016	$162,541	$159.94	18,350	$1,112,761	$60.64	19,366	$1,275,302	$65.85
1,016	$164,308	$161.68	18,350	$1,122,631	$61.18	19,366	$1,286,939	$66.45
1,016	$166,036	$163.38	18,350	$1,132,266	$61.71	19,366	$1,298,302	$67.04
1,016	$167,841	$165.16	18,350	$1,142,308	$62.25	19,366	$1,310,149	$67.65
1,016	$169,606	$166.89	18,350	$1,152,112	$62.79	19,366	$1,321,718	$68.25
1,016	$136,307	$134.13	18,350	$1,289,687	$70.28	19,366	$1,425,995	$73.63
1,016	$137,789	$135.59	18,350	$1,301,126	$70.91	19,366	$1,438,916	$74.30
1,016	$139,141	$136.92	18,350	$1,311,546	$71.48	19,366	$1,450,687	$74.91
1,016	$140,654	$138.41	18,350	$1,323,179	$72.11	19,366	$1,463,832	$75.59
1,016	$142,133	$139.86	18,350	$1,334,535	$72.73	19,366	$1,476,668	$76.25
1,016	$143,678	$141.38	18,350	$1,346,371	$73.37	19,366	$1,490,049	$76.94
1,016	$145,189	$142.87	18,350	$1,357,926	$74.00	19,366	$1,503,116	$77.62
1,016	$146,767	$144.42	18,350	$1,369,971	$74.66	19,366	$1,516,738	$78.32
1,016	$148,363	$145.99	18,350	$1,382,122	$75.32	19,366	$1,530,485	$79.03
1,016	$149,923	$147.53	18,350	$1,393,984	$75.97	19,366	$1,543,907	$79.72
1,016	$151,553	$149.13	18,350	$1,406,348	$76.64	19,366	$1,557,901	$80.45
1,016	$153,147	$150.70	18,350	$1,418,417	$77.30	19,366	$1,571,564	$81.15

CY 2013 Total Allowed Charges for Specialty Drugs	$15,108,150
CY 2015 Total Allowed Charges for Specialty Drugs	$17,969,857
2yrs Trend	1.1894
Annual Trend	1.0906

TREND CALCULATION WITH NON ADJUSTED COST FOR COPAXONE

COPAXONE			ALL OTHER SPECIALTY			TOTAL		
DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY	DAYS	ALLOWED	COST PER DAY
1,016	$150,957	$148.54	18,350	$1,047,551	$57.09	19,366	$1,198,507	$61.89
1,016	$152,598	$150.16	18,350	$1,056,842	$57.59	19,366	$1,209,440	$62.45
1,016	$154,095	$151.63	18,350	$1,065,305	$58.06	19,366	$1,219,400	$62.97
1,016	$155,770	$153.28	18,350	$1,074,754	$58.57	19,366	$1,230,524	$63.54
1,016	$157,408	$154.89	18,350	$1,083,978	$59.07	19,366	$1,241,386	$64.10
1,016	$159,119	$156.58	18,350	$1,093,593	$59.60	19,366	$1,252,712	$64.69
1,016	$160,793	$158.22	18,350	$1,102,978	$60.11	19,366	$1,263,771	$65.26
1,016	$162,541	$159.94	18,350	$1,112,761	$60.64	19,366	$1,275,302	$65.85
1,016	$164,308	$161.68	18,350	$1,122,631	$61.18	19,366	$1,286,939	$66.45
1,016	$166,036	$163.38	18,350	$1,132,266	$61.71	19,366	$1,298,302	$67.04
1,016	$167,841	$165.16	18,350	$1,142,308	$62.25	19,366	$1,310,149	$67.65
1,016	$169,606	$166.89	18,350	$1,152,112	$62.79	19,366	$1,321,718	$68.25
1,016	$194,725	$191.61	18,350	$1,289,687	$70.28	19,366	$1,484,412	$76.65
1,016	$196,842	$193.69	18,350	$1,301,126	$70.91	19,366	$1,497,968	$77.35
1,016	$198,773	$195.60	18,350	$1,311,546	$71.48	19,366	$1,510,319	$77.99
1,016	$200,934	$197.72	18,350	$1,323,179	$72.11	19,366	$1,524,112	$78.70
1,016	$203,047	$199.80	18,350	$1,334,535	$72.73	19,366	$1,537,582	$79.40
1,016	$205,254	$201.97	18,350	$1,346,371	$73.37	19,366	$1,551,626	$80.12
1,016	$207,413	$204.10	18,350	$1,357,926	$74.00	19,366	$1,565,340	$80.83
1,016	$209,668	$206.32	18,350	$1,369,971	$74.66	19,366	$1,579,639	$81.57
1,016	$211,947	$208.56	18,350	$1,382,122	$75.32	19,366	$1,594,069	$82.31
1,016	$214,176	$210.75	18,350	$1,393,984	$75.97	19,366	$1,608,160	$83.04
1,016	$216,504	$213.04	18,350	$1,406,348	$76.64	19,366	$1,622,852	$83.80
1,016	$218,781	$215.28	18,350	$1,418,417	$77.30	19,366	$1,637,199	$84.54

CY 2013 Total Allowed Charges for Specialty Drugs	15,108,150
CY 2015 Total Allowed Charges for Specialty Drugs	18,713,277
2yrs Trend	1.2386
Annual Trend	1.1129

Impact of the launch of a Generic Copaxone on Specialty Trend 0.9799

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed by April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013 NAIC Company Code 53295

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Business (Excluded by Statute)	Other Health Business	Aggregate (2% Rule)	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.01 Health premiums earned (From Part 2, Line 1.11)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564	XXX	425,042,564
1.02 Federal high risk pools														XXX	
1.03 State high risk pools														XXX	
1.04 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564	XXX	425,042,564
1.05 Federal taxes and federal assessments	(36,088)	(798,667)	(236,993)							(8,469)	117,333		(962,884)	(779,061)	(1,741,945)
1.06 State insurance, premium and other taxes (Similar local taxes of $.....)	6,967	7,597	13,975							312	2,226		31,077	24,396	55,473
1.06A Community Benefit Expenditures (informational only)															
1.07 Regulatory authority licenses and fees	20,985	23,284	41,363							2,326	6,381		94,339	70,069	164,408
1.08 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)	94,708,284	88,880,784	220,578,888							3,351,936	18,360,140		425,880,032	XXX	426,564,628
1.09 Net assumed less ceded reinsurance premiums earned	(388,054)	(425,436)	(751,056)								(1,793,833)		(3,358,379)	XXX	(3,358,379)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	94,320,230	88,455,348	219,827,832							3,351,936	16,566,307		422,521,653	XXX	423,206,249
2. Claims:															
2.1 Incurred claims excluding prescription drugs	71,672,264	72,540,153	171,739,421								16,214,527		332,166,365	XXX	332,166,365
2.2 Prescription drugs	19,803,234	13,188,281	35,559,867							2,731,395	22,929		71,305,706	XXX	71,305,706
2.3 Pharmaceutical rebates	1,171,380	1,742,333	2,104,918										5,018,631	XXX	5,018,631
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)														XXX	
3. Incurred medical incentive pools and bonuses														XXX	
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)	33,444	25,951	71,871								23,075		154,341	156,325	310,666
5.0 Total Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)	90,304,118	83,986,101	205,194,370							2,731,395	16,237,456		398,453,440	XXX	398,453,440
5.1 Net assumed less ceded reinsurance claims incurred	(634,925)	(818,996)	(915,813)								(1,740,834)		(4,110,568)	XXX	(4,110,568)
5.2 Other adjustments due to MLR calculations - Claims	(2,471,000)	(2,828,000)	(308,000)							(108,000)	(435,000)		(6,150,000)	XXX	(6,150,000)
5.3 Rebates Paid										XXX	XXX	XXX		XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX	XXX		XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX	XXX		XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	87,198,193	80,339,105	203,970,557							2,623,395	14,061,622		388,192,872	XXX	388,192,872

53295201321646100 2013 Document Code: 216

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1	2	3	4	5	6	7	8		Business	Other		Subtotal		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	(Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes	320,352	305,268	621,934							25	17,085		1,264,664	943,720	2,208,384
6.2 Activities to prevent hospital readmissions	20,107	21,733	41,973										83,813	62,201	146,014
6.3 Improve patient safety and reduce medical errors	12,098	11,973	20,454								4,131		48,656	56,157	104,813
6.4 Wellness and health promotion activities	276,301	299,652	477,788							3,946	36,879		1,094,566	875,246	1,969,812
6.5 Health Information Technology expenses related to health improvement	82,167	80,014	184,312								25,236		371,729	284,202	655,931
6.6 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 to 6.5)	711,025	718,640	1,346,461							3,971	83,331		2,863,428	2,221,526	5,084,954
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6) / Line 1.8	0.961	0.953	0.937							XXX	XXX	XXX	XXX	XXX	XXX
8. Claim Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	917,336	939,829	2,393,360							26	116,466		4,367,017	991,380	5,358,397
8.2 All other claims adjustment expenses	3,090,200	3,164,749	6,859,393							573,791	1,078,735		14,766,868	10,912,015	25,678,883
8.3 Total claims adjustment expenses (Lines 8.1 + 8.2)	4,007,536	4,104,578	9,252,753							573,817	1,195,201		19,133,885	11,903,395	31,037,280
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.042	0.046	0.042							0.171	0.065		XXX	XXX	XXX
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits		202,775	291,878										494,653	359,208	853,861
10.2 Agents and brokers fees and commissions		876,928	1,437,269										2,314,197	359,526	2,673,723
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses	2,544,991	2,925,927	3,944,417							162,077	741,612		10,319,024	6,808,438	17,127,462
10.4A Community Benefit Expenditures (informational only)															
10.5 Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	2,544,991	4,005,630	5,673,564							162,077	741,612		13,127,874	7,527,172	20,655,046
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)	(141,515)	(712,605)	(415,503)							(11,324)	484,541		(796,406)	XXX	(21,763,903)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	19,558,061	19,558,061
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	7,332,038	XXX	7,332,038
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,277,932	XXX	1,277,932
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	5,257,700	XXX	3,848,264
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 6.5)	25,000	27,510	59,583								6,317		118,410	(277)	118,133
16A. ICD-10 Implementation Expenses (informational only: already included in Line 6.5)	25,000	27,510	59,583								6,317		118,410	(277)	118,133
O. OTHER INDICATORS:															
O1. Number of Certificates / Policies	17,451	10,658	20,623							3,440	28,574		80,746	9,097	89,843
O2. Number of Covered Lives	19,502	19,695	43,032							3,440	51,467		137,136	20,111	157,247
O3. Number of Groups	XXX	635	103	XXX						3,440	4,928		9,106	5	9,111
O4. Member Months	223,664	244,691	523,114							39,973	627,351		1,658,793	213,060	1,871,853

(a) Is run off business reported in Columns 1 through 9? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013** **NAIC Company Code 53295**

	Business Subject to MLR									10	11	12	13
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government			
	1	2	3	4	5	6	7	8		Business	Other		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	Total (a)
1. Health Premiums Earned													
1.01 Direct premiums written	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564
1.02 Unearned premium prior year													
1.03 Unearned premium current year													
1.04 Change in unearned premium (Lines 1.2 - 1.3)													
1.05 Paid rate credits													
1.06 Reserve for rate credits current year			6,610,374										6,610,374
1.07 Reserve for rate credits prior year			5,696,329										5,696,329
1.08 Change in reserve for rate credits (Lines 1.6 - 1.7)			914,045										914,045
1.09 Premium balances written off													
1.10 Group conversion charges													
1.11 TOTAL direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564
1.12 Assumed premiums earned from non-affiliates													
1.13 Net assumed less ceded premiums earned from affiliates													
1.14 Ceded premiums earned to non-affiliates	388,054	425,436	751,056								1,793,833		3,358,379
1.15 Other adjustments due to MLR calculation - Premiums													
1.16 Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)	94,312,094	87,687,562	218,732,132							3,346,105	16,692,247		420,770,140
2. Direct Claims Incurred:													
2.01 Paid claims during the year	89,157,361	82,637,873	204,009,013							2,595,759	17,552,203		395,952,209
2.02 Direct claim liability current year	7,579,000	7,361,000	10,958,437							377,226	3,557,386		29,833,049
2.03 Direct claim liability prior year	6,492,000	6,069,744	9,629,711							241,590	4,872,133		27,305,178
2.04 Direct claim reserves current year													
2.05 Direct claim reserves prior year													
2.06 Direct contract reserves current year													
2.07 Direct contract reserves prior year													
2.08 Paid rate credits													
2.09 Reserve for rate credits current year			6,610,374										6,610,374
2.10 Reserve for rate credits prior year			5,696,329										5,696,329
2.11 Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)													
2.11A Paid medical incentive pools and bonuses current year													
2.11B Accrued medical incentive pools and bonuses current year													
2.11C Accrued medical incentive pools and bonuses prior year													
2.12 Net healthcare receivables (Lines 2.12a - 2.12b)	(59,757)	(56,972)	1,057,414										940,685
2.12A Healthcare receivables current year	1,153,164	866,242	3,892,206										5,911,612
2.12B Healthcare receivables prior year	1,212,921	923,214	2,834,792										4,970,927
2.13 Group conversion charge													
2.14 Multi-option coverage blended rate adjustment													
2.15 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)	90,304,118	83,986,101	205,194,370							2,731,395	16,237,456		398,453,440
2.16 Assumed Incurred Claims from non-affiliates													
2.17 Net Assumed less Ceded Incurred Claims from affiliates													
2.18 Ceded Incurred Claims to non-affiliates	634,925	818,996	915,813								1,740,834		4,110,568
2.19 Other Adjustments due to MLR calculation - Claims	(2,471,000)	(2,828,000)	(308,000)							(108,000)	(435,000)		(6,150,000)
2.20 Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)	87,198,193	80,339,105	203,056,512							2,623,395	14,061,622		387,278,827
3. Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)	151,350	140,961	342,435							4,568	447,065		1,086,379

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013 NAIC Company Code 53295

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1. Individual Comprehensive Coverage Expenses:										
1.01 Salaries (including $..... for affiliated services)	153,669	13,705		88,585	30,723	286,682	309,288	1,162,358	1,261,312	3,019,640
1.02 Outsourced services	143,786	6,007	5,585	147,162	16,588	319,128	607,915	919,858	210,471	2,057,372
1.03 EDP Equipment and Software (incl $..... for affiliated services)	1,029	152		604	27,478	29,263	10	544,698	152,329	726,300
1.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.05 Accreditation and Certification (incl $..... for affiliated services)	2,563	XXX	XXX	XXX	XXX	2,563			540	3,103
1.06 Other Expenses (incl $..... for affiliated services)	19,305	243	6,513	39,950	7,378	73,389	123	463,286	917,545	1,454,343
1.07 Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)	320,352	20,107	12,098	276,301	82,167	711,025	917,336	3,090,200	2,542,197	7,260,758
1.08 Reimbursements by uninsured plans and fiscal intermediaries										
1.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	189,839	189,839
1.10 TOTAL (Lines 1.7 to 1.9)	320,352	20,107	12,098	276,301	82,167	711,025	917,336	3,090,200	2,732,036	7,450,597
1.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							33,444	13,849	553	47,846
2. Small Group Comprehensive Coverage Expenses:										
2.01 Salaries (including $..... for affiliated services)	158,210	14,785		153,716	30,268	356,979	279,057	1,143,798	1,671,967	3,451,801
2.02 Outsourced services	122,566	6,495	4,857	99,037	18,014	250,969	660,308	933,711	240,575	2,085,563
2.03 EDP Equipment and Software (incl $..... for affiliated services)	1,069	164		901	23,676	25,810	98	607,487	170,106	803,501
2.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.05 Accreditation and Certification (incl $..... for affiliated services)	2,800	XXX	XXX	XXX	XXX	2,800			590	3,390
2.06 Other Expenses (incl $..... for affiliated services)	20,623	289	7,116	45,998	8,056	82,082	366	479,753	1,919,300	2,481,501
2.07 Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	305,268	21,733	11,973	299,652	80,014	718,640	939,829	3,164,749	4,002,538	8,825,756
2.08 Reimbursements by uninsured plans and fiscal intermediaries										
2.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	218,146	218,146
2.10 TOTAL (Lines 2.7 to 2.9)	305,268	21,733	11,973	299,652	80,014	718,640	939,829	3,164,749	4,220,684	9,043,902
2.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							25,951	10,747	298	36,996
3. Large Group Comprehensive Coverage Expenses:										
3.01 Salaries (including $..... for affiliated services)	349,229	31,645		258,385	68,634	707,893	670,673	2,628,797	2,254,347	6,261,710
3.02 Outsourced services	204,657	9,351	10,168	142,987	34,096	401,259	1,722,019	2,006,111	315,159	4,444,548
3.03 EDP Equipment and Software (incl $..... for affiliated services)	2,354	352		1,550	59,119	63,375	141	1,161,252	230,861	1,455,629
3.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.05 Accreditation and Certification (incl $..... for affiliated services)	5,991	XXX	XXX	XXX	XXX	5,991			1,262	7,253
3.06 Other Expenses (incl $..... for affiliated services)	59,703	625	10,286	74,866	22,463	167,943	527	1,063,233	2,866,475	4,098,178
3.07 Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	621,934	41,973	20,454	477,788	184,312	1,346,461	2,393,360	6,859,393	5,668,104	16,267,318
3.08 Reimbursements by uninsured plans and fiscal intermediaries										
3.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	396,873	396,873
3.10 TOTAL (Lines 3.7 to 3.9)	621,934	41,973	20,454	477,788	184,312	1,346,461	2,393,360	6,859,393	6,064,977	16,664,191
3.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							71,871	29,763	4,396	106,030

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.01 Salaries (including $################ for affiliated services)										
4.02 Outsourced services										
4.03 EDP equipment and software (including $################ for affiliated services)										
4.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
4.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
4.06 Other expenses (including $################ for affiliated services)										
4.07 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.08 Reimbursements by uninsured plans and fiscal intermediaries										
4.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.01 Salaries (including $################ for affiliated services)										
5.02 Outsourced services										
5.03 EDP Equipment and Software (including $################ for affiliated services)										
5.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
5.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
5.06 Other expenses (including $################ for affiliated services)										
5.07 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.08 Reimbursements by uninsured plans and fiscal intermediaries										
5.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.01 Salaries (including $################ for affiliated services)										
6.02 Outsourced services										
6.03 EDP equipment and software (including $################ for affiliated services)										
6.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
6.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
6.06 Other expenses (including $################ for affiliated services)										
6.07 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.08 Reimbursements by uninsured plans and fiscal intermediaries										
6.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.01 Salaries (including $################ for affiliated services)										
7.02 Outsourced services										
7.03 EDP equipment and software (including $################ for affiliated services)										
7.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
7.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
7.06 Other expenses (including $################ for affiliated services)										
7.07 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.08 Reimbursements by uninsured plans and fiscal intermediaries										
7.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.01 Salaries (including $################ for affiliated services)										
8.02 Outsourced services										
8.03 EDP equipment and software (including $################ for affiliated services)										
8.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
8.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
8.06 Other expenses (including $################ for affiliated services)										
8.07 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.08 Reimbursements by uninsured plans and fiscal intermediaries										
8.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.01 Salaries (including $################ for affiliated services										
9.02 Outsourced services										
9.03 EDP equipment and software (including $################ for affiliated services)										
9.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
9.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
9.06 Other expenses (including $################ for affiliated services)										
9.07 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.08 Reimbursements by uninsured plans and fiscal intermediaries										
9.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed by April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

53295201321659100 2013 Document Code: 216

NAIC Group Code 4745

BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013

NAIC Company Code 53295

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Business (Excluded by Statute)	Other Health Business	Aggregate (2% Rule)	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.01 Health premiums earned (From Part 2, Line 1.11)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564	XXX	425,042,564
1.02 Federal high risk pools														XXX	
1.03 State high risk pools														XXX	
1.04 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564	XXX	425,042,564
1.05 Federal taxes and federal assessments	(36,088)	(798,667)	(236,993)							(8,469)	117,333		(962,884)	(779,061)	(1,741,945)
1.06 State insurance, premium and other taxes (Similar local taxes of $.....)	6,967	7,597	13,975							312	2,226		31,077	24,396	55,473
1.06A Community Benefit Expenditures (informational only)															
1.07 Regulatory authority licenses and fees	20,985	23,284	41,363							2,326	6,381		94,339	70,069	164,408
1.08 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)	94,708,284	88,880,784	220,578,888							3,351,936	18,360,140		425,880,032	XXX	426,564,628
1.09 Net assumed less ceded reinsurance premiums earned	(388,054)	(425,436)	(751,056)								(1,793,833)		(3,358,379)	XXX	(3,358,379)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)	94,320,230	88,455,348	219,827,832							3,351,936	16,566,307		422,521,653	XXX	423,206,249
2. Claims:															
2.1 Incurred claims excluding prescription drugs	71,672,264	72,540,153	171,739,421								16,214,527		332,166,365	XXX	332,166,365
2.2 Prescription drugs	19,803,234	13,188,281	35,559,867							2,731,395	22,929		71,305,706	XXX	71,305,706
2.3 Pharmaceutical rebates	1,171,380	1,742,333	2,104,918										5,018,631	XXX	5,018,631
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)														XXX	
3. Incurred medical incentive pools and bonuses														XXX	
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)	33,444	25,951	71,871								23,075		154,341	156,325	310,666
5.0 Total Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)	90,304,118	83,986,101	205,194,370							2,731,395	16,237,456		398,453,440	XXX	398,453,440
5.1 Net assumed less ceded reinsurance claims incurred	(634,925)	(818,996)	(915,813)								(1,740,834)		(4,110,568)	XXX	(4,110,568)
5.2 Other adjustments due to MLR calculations - Claims	(2,471,000)	(2,828,000)	(308,000)							(108,000)	(435,000)		(6,150,000)	XXX	(6,150,000)
5.3 Rebates Paid										XXX	XXX	XXX		XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX	XXX		XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX	XXX		XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)	87,198,193	80,339,105	203,970,557							2,623,395	14,061,622		388,192,872	XXX	388,192,872

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1	2	3	4	5	6	7	8		Business	Other		Subtotal		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	(Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes	320,352	305,268	621,934							25	17,085		1,264,664	943,720	2,208,384
6.2 Activities to prevent hospital readmissions	20,107	21,733	41,973										83,813	62,201	146,014
6.3 Improve patient safety and reduce medical errors	12,098	11,973	20,454								4,131		48,656	56,157	104,813
6.4 Wellness and health promotion activities	276,301	299,652	477,788							3,946	36,879		1,094,566	875,246	1,969,812
6.5 Health Information Technology expenses related to health improvement	82,167	80,014	184,312								25,236		371,729	284,202	655,931
6.6 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 to 6.5)	711,025	718,640	1,346,461							3,971	83,331		2,863,428	2,221,526	5,084,954
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6) / Line 1.8	0.961	0.953	0.937							XXX	XXX	XXX	XXX	XXX	XXX
8. Claim Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6	917,336	939,829	2,393,360							26	116,466		4,367,017	991,380	5,358,397
8.2 All other claims adjustment expenses	3,090,200	3,164,749	6,859,393							573,791	1,078,735		14,766,868	10,912,015	25,678,883
8.3 Total claims adjustment expenses (Lines 8.1 + 8.2)	4,007,536	4,104,578	9,252,753							573,817	1,195,201		19,133,885	11,903,395	31,037,280
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)	0.042	0.046	0.042							0.171	0.065		XXX	XXX	XXX
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits		202,775	291,878										494,653	359,208	853,861
10.2 Agents and brokers fees and commissions		876,928	1,437,269										2,314,197	359,526	2,673,723
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses	2,544,991	2,925,927	3,944,417							162,077	741,612		10,319,024	6,808,438	17,127,462
10.4A Community Benefit Expenditures (informational only)															
10.5 Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)	2,544,991	4,005,630	5,673,564							162,077	741,612		13,127,874	7,527,172	20,655,046
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)	(141,515)	(712,605)	(415,503)							(11,324)	484,541		(796,406)	XXX	(21,763,903)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	19,558,061	19,558,061
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	7,332,038	XXX	7,332,038
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,277,932	XXX	1,277,932
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	5,257,700	XXX	3,848,264
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 6.5)	25,000	27,510	59,583								6,317		118,410	(277)	118,133
16A. ICD-10 Implementation Expenses (informational only: already included in Line 6.5)	25,000	27,510	59,583								6,317		118,410	(277)	118,133
O. OTHER INDICATORS:															
O1. Number of Certificates / Policies	17,451	10,658	20,623							3,440	28,574		80,746	9,097	89,843
O2. Number of Covered Lives	19,502	19,695	43,032							3,440	51,467		137,136	20,111	157,247
O3. Number of Groups	XXX	635	103	XXX						3,440	4,928		9,106	5	9,111
O4. Member Months	223,664	244,691	523,114							39,973	627,351		1,658,793	213,060	1,871,853

(a) Is run off business reported in Columns 1 through 9? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013** **NAIC Company Code 53295**

	Business Subject to MLR									10	11	12	13
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government			
	1	2	3	4	5	6	7	8		Business	Other		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	Total (a)
1. Health Premiums Earned													
1.01 Direct premiums written	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564
1.02 Unearned premium prior year													
1.03 Unearned premium current year													
1.04 Change in unearned premium (Lines 1.2 - 1.3)													
1.05 Paid rate credits													
1.06 Reserve for rate credits current year			6,610,374										6,610,374
1.07 Reserve for rate credits prior year			5,696,329										5,696,329
1.08 Change in reserve for rate credits (Lines 1.6 - 1.7)			914,045										914,045
1.09 Premium balances written off													
1.10 Group conversion charges													
1.11 TOTAL direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)	94,700,148	88,112,998	220,397,233							3,346,105	18,486,080		425,042,564
1.12 Assumed premiums earned from non-affiliates													
1.13 Net assumed less ceded premiums earned from affiliates													
1.14 Ceded premiums earned to non-affiliates	388,054	425,436	751,056								1,793,833		3,358,379
1.15 Other adjustments due to MLR calculation - Premiums													
1.16 Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)	94,312,094	87,687,562	218,732,132							3,346,105	16,692,247		420,770,140
2. Direct Claims Incurred:													
2.01 Paid claims during the year	89,157,361	82,637,873	204,009,013							2,595,759	17,552,203		395,952,209
2.02 Direct claim liability current year	7,579,000	7,361,000	10,958,437							377,226	3,557,386		29,833,049
2.03 Direct claim liability prior year	6,492,000	6,069,744	9,629,711							241,590	4,872,133		27,305,178
2.04 Direct claim reserves current year													
2.05 Direct claim reserves prior year													
2.06 Direct contract reserves current year													
2.07 Direct contract reserves prior year													
2.08 Paid rate credits													
2.09 Reserve for rate credits current year			6,610,374										6,610,374
2.10 Reserve for rate credits prior year			5,696,329										5,696,329
2.11 Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)													
2.11A Paid medical incentive pools and bonuses current year													
2.11B Accrued medical incentive pools and bonuses current year													
2.11C Accrued medical incentive pools and bonuses prior year													
2.12 Net healthcare receivables (Lines 2.12a - 2.12b)	(59,757)	(56,972)	1,057,414										940,685
2.12A Healthcare receivables current year	1,153,164	866,242	3,892,206										5,911,612
2.12B Healthcare receivables prior year	1,212,921	923,214	2,834,792										4,970,927
2.13 Group conversion charge													
2.14 Multi-option coverage blended rate adjustment													
2.15 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)	90,304,118	83,986,101	205,194,370							2,731,395	16,237,456		398,453,440
2.16 Assumed Incurred Claims from non-affiliates													
2.17 Net Assumed less Ceded Incurred Claims from affiliates													
2.18 Ceded Incurred Claims to non-affiliates	634,925	818,996	915,813								1,740,834		4,110,568
2.19 Other Adjustments due to MLR calculation - Claims	(2,471,000)	(2,828,000)	(308,000)							(108,000)	(435,000)		(6,150,000)
2.20 Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)	87,198,193	80,339,105	203,056,512							2,623,395	14,061,622		387,278,827
3. Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)	151,350	140,961	342,435							4,568	447,065		1,086,379

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: BLUE CROSS AND BLUE SHIELD OF VERMONT 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013 NAIC Company Code 53295

Supp83 Grand Total

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1. Individual Comprehensive Coverage Expenses:										
1.01 Salaries (including $..... for affiliated services)	153,669	13,705		88,585	30,723	286,682	309,288	1,162,358	1,261,312	3,019,640
1.02 Outsourced services	143,786	6,007	5,585	147,162	16,588	319,128	607,915	919,858	210,471	2,057,372
1.03 EDP Equipment and Software (incl $..... for affiliated services)	1,029	152		604	27,478	29,263	10	544,698	152,329	726,300
1.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.05 Accreditation and Certification (incl $..... for affiliated services)	2,563	XXX	XXX	XXX	XXX	2,563			540	3,103
1.06 Other Expenses (incl $..... for affiliated services)	19,305	243	6,513	39,950	7,378	73,389	123	463,286	917,545	1,454,343
1.07 Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)	320,352	20,107	12,098	276,301	82,167	711,025	917,336	3,090,200	2,542,197	7,260,758
1.08 Reimbursements by uninsured plans and fiscal intermediaries										
1.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	189,839	189,839
1.10 TOTAL (Lines 1.7 to 1.9)	320,352	20,107	12,098	276,301	82,167	711,025	917,336	3,090,200	2,732,036	7,450,597
1.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							33,444	13,849	553	47,846
2. Small Group Comprehensive Coverage Expenses:										
2.01 Salaries (including $..... for affiliated services)	158,210	14,785		153,716	30,268	356,979	279,057	1,143,798	1,671,967	3,451,801
2.02 Outsourced services	122,566	6,495	4,857	99,037	18,014	250,969	660,308	933,711	240,575	2,085,563
2.03 EDP Equipment and Software (incl $..... for affiliated services)	1,069	164		901	23,676	25,810	98	607,487	170,106	803,501
2.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.05 Accreditation and Certification (incl $..... for affiliated services)	2,800	XXX	XXX	XXX	XXX	2,800			590	3,390
2.06 Other Expenses (incl $..... for affiliated services)	20,623	289	7,116	45,998	8,056	82,082	366	479,753	1,919,300	2,481,501
2.07 Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	305,268	21,733	11,973	299,652	80,014	718,640	939,829	3,164,749	4,002,538	8,825,756
2.08 Reimbursements by uninsured plans and fiscal intermediaries										
2.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	218,146	218,146
2.10 TOTAL (Lines 2.7 to 2.9)	305,268	21,733	11,973	299,652	80,014	718,640	939,829	3,164,749	4,220,684	9,043,902
2.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							25,951	10,747	298	36,996
3. Large Group Comprehensive Coverage Expenses:										
3.01 Salaries (including $..... for affiliated services)	349,229	31,645		258,385	68,634	707,893	670,673	2,628,797	2,254,347	6,261,710
3.02 Outsourced services	204,657	9,351	10,168	142,987	34,096	401,259	1,722,019	2,006,111	315,159	4,444,548
3.03 EDP Equipment and Software (incl $..... for affiliated services)	2,354	352		1,550	59,119	63,375	141	1,161,252	230,861	1,455,629
3.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.05 Accreditation and Certification (incl $..... for affiliated services)	5,991	XXX	XXX	XXX	XXX	5,991			1,262	7,253
3.06 Other Expenses (incl $..... for affiliated services)	59,703	625	10,286	74,866	22,463	167,943	527	1,063,233	2,866,475	4,098,178
3.07 Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	621,934	41,973	20,454	477,788	184,312	1,346,461	2,393,360	6,859,393	5,668,104	16,267,318
3.08 Reimbursements by uninsured plans and fiscal intermediaries										
3.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	396,873	396,873
3.10 TOTAL (Lines 3.7 to 3.9)	621,934	41,973	20,454	477,788	184,312	1,346,461	2,393,360	6,859,393	6,064,977	16,664,191
3.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							71,871	29,763	4,396	106,030

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

Supp84 Grand Total

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.01 Salaries (including $################ for affiliated services)										
4.02 Outsourced services										
4.03 EDP equipment and software (including $################ for affiliated services)										
4.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
4.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
4.06 Other expenses (including $################ for affiliated services)										
4.07 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.08 Reimbursements by uninsured plans and fiscal intermediaries										
4.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.01 Salaries (including $################ for affiliated services)										
5.02 Outsourced services										
5.03 EDP Equipment and Software (including $################ for affiliated services)										
5.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
5.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
5.06 Other expenses (including $################ for affiliated services)										
5.07 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.08 Reimbursements by uninsured plans and fiscal intermediaries										
5.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.01 Salaries (including $################ for affiliated services)										
6.02 Outsourced services										
6.03 EDP equipment and software (including $################ for affiliated services)										
6.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
6.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
6.06 Other expenses (including $################ for affiliated services)										
6.07 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.08 Reimbursements by uninsured plans and fiscal intermediaries										
6.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.01 Salaries (including $################ for affiliated services)										
7.02 Outsourced services										
7.03 EDP equipment and software (including $################ for affiliated services)										
7.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
7.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
7.06 Other expenses (including $################ for affiliated services)										
7.07 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.08 Reimbursements by uninsured plans and fiscal intermediaries										
7.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.01 Salaries (including $################ for affiliated services)										
8.02 Outsourced services										
8.03 EDP equipment and software (including $################ for affiliated services)										
8.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
8.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
8.06 Other expenses (including $################ for affiliated services)										
8.07 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.08 Reimbursements by uninsured plans and fiscal intermediaries										
8.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.01 Salaries (including $################ for affiliated services										
9.02 Outsourced services										
9.03 EDP equipment and software (including $################ for affiliated services)										
9.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
9.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
9.06 Other expenses (including $################ for affiliated services)										
9.07 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.08 Reimbursements by uninsured plans and fiscal intermediaries										
9.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

Supp85 Grand Total

53295201321700100 2013 Document Code: 217

SUPPLEMENTAL HEALTH CARE EXHIBIT'S EXPENSE ALLOCATION REPORT

(To Be Filed by April 1)

NAIC Group Code: 4745 NAIC Company Code: 53295

Description of allocation methodology:

The expense allocations utilized in preparing the Supplemental Health Care Exhibit were built from the Plan's previously existing cost allocations used in the completion of the Analysis of Operations by Line of Business (page 7) and the Underwriting & Investment Exhibit - Part 3 (page 14). The existing system already allocated expenses by LOB and between the BAE, CCE, and GAE categories, by expense line and by cost center/department. For purposes of completing the Supplemental Health Care Exhibit, the Plan first identified all incurred QI expenses that were determined to meet the definitions developed by the NAIC. These expenses were allocated between the 5 QI categories by specifically identifying the costs associated with performing the QI activities, by department and by expense line, and aligning them based on our interpretation of the definitions and examples provided for each of the 5 categories in the instructions. As the QI expenses are a subset of the Plan's overall administrative costs, the QI items were allocated by LOB and BAE/CCE/GAE category in proportion to how the applicable expense line within the particular department was allocated in the overall cost accounting system. As the Plan's operations are confined to the State of Vermont, there was no allocation of expenses between states/jurisdictions.

Detailed Description of Quality Improvement Expenses:

1 Expense Type from Part 3	2 New	3 Detailed Description of Expense
Improve Health Outcomes		
Disease management		Through an external vendor, the Plan provides disease management services to virtually all of its members for specific diseases/conditions. The vendor guarantees a minimum ROI.
Case management / care coordination		BCBSVT maintains a staff of physicians and registered nurses who work with members to manage and coordinate their medical care to improve overall health outcomes. These activities include making and verifying appointments, helping to manage transitions from one setting to another, and providing coaching and support.
Pharmacy management		Through an external vendor, BCBSVT works with members and providers to encourage the most appropriate drug usage that will limit potential risk to the member while maximizing the benefit.
NCQA accreditation activities		BCBSVT is NCQA accredited, and performs many activities related to maintaining its accreditation. These include direct outreach to providers, educational programs, and review of utilization metrics to ensure proper care is being provided to members.
Better Beginnings program		The Plan provides a specialized program to work with expectant parents, which includes providing educational materials, credits for lactation consulting services and Red Cross CPR training, and other materials to encourage a successful pregnancy and healthy birth. There is a separate component to the program for parents of young children, which includes counseling and other educational materials related to vaccinations, etc. These programs are administered by registered nurses.
Activities to Prevent Hospital Readmission		
Case management		As part of the overall case management program, BCBSVT's registered nurse staff also actively works with members on discharge planning, and post discharge counseling to reduce the likelihood of future readmission.
Improve Patient Safety and Reduce Medical Errors		
Prospective drug utilization review		Through an external vendor, BCBSVT monitors prescription usage for potential adverse drug interactions, and advises on step therapy treatments.
Medical management review		The Plan's Quality Improvement department reviews data and works with providers on the identification and use of best clinical practices and to encourage evidence based medicine in addressing clinical errors and safety concerns.
Wellness & Health Promotion Activities		
Worksite wellness assessments		Wellness assessments and biometric screenings are performed at employer worksites.
Public health education events in conjunction with state health department		BCBSVT sponsors various events in conjunction with state and local health departments in order to encourage healthy lifestyles and physical activity. These include the Walk at Lunch program, a Hike, Bike and Paddle program, and many others that are open to members as well as to the community at large.

Detailed Description of Quality Improvement Expenses:

1 Expense Type from Part 3	2 New	3 Detailed Description of Expense
HIT Expenses for Health Care Quality Improvements		
HEDIS reporting		BCBSVT completes various reporting of HEDIS measures for public reporting mandated by VT law.
NCQA accreditation		As part of the NCQA accreditation process, the Plan performs many activities related to reporting and analysis of clinical effectiveness and related measures.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed by April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

95696201321646100 2013 Document Code: 216

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013 NAIC Company Code 95696

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Business (Excluded by Statute)	Other Health Business	Aggregate (2% Rule)	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.01 Health premiums earned (From Part 2, Line 1.11)		106,603,828	65,958,941								2,872,765		175,435,534	XXX	175,435,534
1.02 Federal high risk pools														XXX	
1.03 State high risk pools														XXX	
1.04 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)		106,603,828	65,958,941								2,872,765		175,435,534	XXX	175,435,534
1.05 Federal taxes and federal assessments		188,872	115,814								14,549		319,235		319,235
1.06 State insurance, premium and other taxes (Similar local taxes of $.....)		7,910	4,684								622		13,216		13,216
1.06A Community Benefit Expenditures (informational only)															
1.07 Regulatory authority licenses and fees		150,744	83,071								10,851		244,666		244,666
1.08 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)		106,256,302	65,755,372								2,846,743		174,858,417	XXX	174,858,417
1.09 Net assumed less ceded reinsurance premiums earned		(1,615,441)	(1,122,594)										(2,738,035)	XXX	(2,738,035)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)		104,640,861	64,632,778								2,846,743		172,120,382	XXX	172,120,382
2. Claims:															
2.1 Incurred claims excluding prescription drugs		82,123,365	51,489,340								2,326,934		135,939,639	XXX	135,939,639
2.2 Prescription drugs		14,371,676	9,024,403								3,461		23,399,540	XXX	23,399,540
2.3 Pharmaceutical rebates		937,351	609,994										1,547,345	XXX	1,547,345
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)														XXX	
3. Incurred medical incentive pools and bonuses		1,859,439	1,081,523										2,940,962	XXX	2,940,962
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)		31,629	20,437								5,454		57,520		57,520
5.0 Total Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)		97,417,129	60,985,272								2,330,395		160,732,796	XXX	160,732,796
5.1 Net assumed less ceded reinsurance claims incurred		(1,579,084)	(1,714,744)										(3,293,828)	XXX	(3,293,828)
5.2 Other adjustments due to MLR calculations - Claims														XXX	
5.3 Rebates Paid										XXX	XXX	XXX		XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX	XXX		XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX	XXX		XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)		95,838,045	59,270,528								2,330,395		157,438,968	XXX	157,438,968

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Business (Excluded by Statute)	Other Health Business	Aggregate (2% Rule)	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes		346,022	210,625								13,415		570,062		570,062
6.2 Activities to prevent hospital readmissions		25,985	14,984								685		41,654		41,654
6.3 Improve patient safety and reduce medical errors		17,356	10,963								1,415		29,734		29,734
6.4 Wellness and health promotion activities		339,474	208,231								23,986		571,691		571,691
6.5 Health Information Technology expenses related to health improvement		96,137	60,492								7,305		163,934		163,934
6.6 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 to 6.5)		824,974	505,295								46,806		1,377,075		1,377,075
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6) / Line 1.8		0.925	0.935							XXX	XXX	XXX	XXX	XXX	XXX
8. Claim Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6		495,975	296,398								44,647		837,020		837,020
8.2 All other claims adjustment expenses		3,255,656	2,068,190								284,282		5,608,128		5,608,128
8.3 Total claims adjustment expenses (Lines 8.1 + 8.2)		3,751,631	2,364,588								328,929		6,445,148		6,445,148
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)		0.035	0.036								0.116		XXX	XXX	XXX
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits		292,786	192,732								16,766		502,284		502,284
10.2 Agents and brokers fees and commissions		4,417,008	1,330,825										5,747,833		5,747,833
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses		3,306,860	1,717,490								240,846		5,265,196		5,265,196
10.4A Community Benefit Expenditures (informational only)															
10.5 Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)		8,016,654	3,241,047								257,612		11,515,313		11,515,313
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)		(3,790,443)	(748,680)								(116,999)		(4,656,122)	XXX	(4,656,122)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,835,610	XXX	1,835,610
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(2,820,512)	XXX	(2,820,512)
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 6.5)		28,290	18,623								2,172		49,085		49,085
16A. ICD-10 Implementation Expenses (informational only: already included in Line 6.5)		28,290	18,623								2,172		49,085		49,085
O. OTHER INDICATORS:															
O1. Number of Certificates / Policies		11,239	7,243								2,115		20,597		20,597
O2. Number of Covered Lives		21,849	14,395								2,115		38,359		38,359
O3. Number of Groups	XXX	3,160	96	XXX							2,115		5,371		5,371
O4. Member Months		268,340	179,709								20,593		468,642		468,642

(a) Is run off business reported in Columns 1 through 9? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013** **NAIC Company Code 95696**

	Business Subject to MLR									10	11	12	13
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government			
	1	2	3	4	5	6	7	8		Business	Other		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	Total (a)
1. Health Premiums Earned													
1.01 Direct premiums written		106,603,828	65,958,941								2,872,765		175,435,534
1.02 Unearned premium prior year													
1.03 Unearned premium current year													
1.04 Change in unearned premium (Lines 1.2 - 1.3)													
1.05 Paid rate credits			51,290										51,290
1.06 Reserve for rate credits current year			214,160										214,160
1.07 Reserve for rate credits prior year			520,411										520,411
1.08 Change in reserve for rate credits (Lines 1.6 - 1.7)			(306,251)										(306,251)
1.09 Premium balances written off													
1.10 Group conversion charges													
1.11 TOTAL direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)		106,603,828	65,958,941								2,872,765		175,435,534
1.12 Assumed premiums earned from non-affiliates													
1.13 Net assumed less ceded premiums earned from affiliates													
1.14 Ceded premiums earned to non-affiliates		1,615,441	1,122,594										2,738,035
1.15 Other adjustments due to MLR calculation - Premiums													
1.16 Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)		104,988,387	65,091,308								2,872,765		172,952,460
2. Direct Claims Incurred:													
2.01 Paid claims during the year		95,136,536	60,150,542								2,182,395		157,469,473
2.02 Direct claim liability current year		5,284,965	3,599,035								382,000		9,266,000
2.03 Direct claim liability prior year		4,863,811	3,590,867								234,000		8,688,678
2.04 Direct claim reserves current year													
2.05 Direct claim reserves prior year													
2.06 Direct contract reserves current year													
2.07 Direct contract reserves prior year													
2.08 Paid rate credits			51,290										51,290
2.09 Reserve for rate credits current year			214,160										214,160
2.10 Reserve for rate credits prior year			520,411										520,411
2.11 Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)		1,859,439	1,081,523										2,940,962
2.11A Paid medical incentive pools and bonuses current year		2,656,110	1,008,852										3,664,962
2.11B Accrued medical incentive pools and bonuses current year		2,039,295	1,277,705										3,317,000
2.11C Accrued medical incentive pools and bonuses prior year		2,835,966	1,205,034										4,041,000
2.12 Net healthcare receivables (Lines 2.12a - 2.12b)													
2.12A Healthcare receivables current year													
2.12B Healthcare receivables prior year													
2.13 Group conversion charge													
2.14 Multi-option coverage blended rate adjustment													
2.15 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)		97,417,129	60,985,272								2,330,395		160,732,796
2.16 Assumed Incurred Claims from non-affiliates													
2.17 Net Assumed less Ceded Incurred Claims from affiliates													
2.18 Ceded Incurred Claims to non-affiliates		1,579,084	1,714,744										3,293,828
2.19 Other Adjustments due to MLR calculation - Claims													
2.20 Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)		95,838,045	59,525,489								2,330,395		157,693,929
3. Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)		161,494	100,409								3,944		265,847

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Vermont DURING THE YEAR 2013 NAIC Company Code 95696

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1. Individual Comprehensive Coverage Expenses:										
1.01 Salaries (including $..... for affiliated services)										
1.02 Outsourced services										
1.03 EDP Equipment and Software (incl $..... for affiliated services)										
1.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.05 Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
1.06 Other Expenses (incl $..... for affiliated services)										
1.07 Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)										
1.08 Reimbursements by uninsured plans and fiscal intermediaries										
1.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
1.10 TOTAL (Lines 1.7 to 1.9)										
1.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
2. Small Group Comprehensive Coverage Expenses:										
2.01 Salaries (including $.....3,633,416 for affiliated services)	127,145	9,157		148,038	30,668	315,008	494,774	1,129,677	1,924,840	3,864,299
2.02 Outsourced services	193,508	16,617	9,554	142,313	29,144	391,136	1,086	1,004,303	343,685	1,740,210
2.03 EDP Equipment and Software (incl $.....817,141 for affiliated services)	873	82		836	27,921	29,712		606,771	183,598	820,081
2.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.05 Accreditation and Certification (incl $.....3,651 for affiliated services)	3,015	XXX	XXX	XXX	XXX	3,015			5,600	8,615
2.06 Other Expenses (incl $.....1,635,375 for affiliated services)	21,481	129	7,802	48,287	8,404	86,103	115	514,905	5,540,077	6,141,200
2.07 Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	346,022	25,985	17,356	339,474	96,137	824,974	495,975	3,255,656	7,997,800	12,574,405
2.08 Reimbursements by uninsured plans and fiscal intermediaries										
2.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	366,380	366,380
2.10 TOTAL (Lines 2.7 to 2.9)	346,022	25,985	17,356	339,474	96,137	824,974	495,975	3,255,656	8,364,180	12,940,785
2.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							31,629	13,098	327	45,054
3. Large Group Comprehensive Coverage Expenses:										
3.01 Salaries (including $.....2,206,452 for affiliated services)	75,398	5,023		91,613	19,206	191,240	295,608	736,631	1,122,190	2,345,669
3.02 Outsourced services	118,728	9,855	5,739	87,813	18,048	240,183	715	630,508	172,088	1,043,494
3.03 EDP Equipment and Software (incl $.....479,799 for affiliated services)	530	41		509	17,703	18,783		370,396	92,522	481,701
3.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.05 Accreditation and Certification (incl $.....2,403 for affiliated services)	1,985	XXX	XXX	XXX	XXX	1,985			3,122	5,107
3.06 Other Expenses (incl $.....840,382 for affiliated services)	13,984	65	5,224	28,296	5,535	53,104	75	330,655	1,839,754	2,223,588
3.07 Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	210,625	14,984	10,963	208,231	60,492	505,295	296,398	2,068,190	3,229,676	6,099,559
3.08 Reimbursements by uninsured plans and fiscal intermediaries										
3.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	214,940	214,940
3.10 TOTAL (Lines 3.7 to 3.9)	210,625	14,984	10,963	208,231	60,492	505,295	296,398	2,068,190	3,444,616	6,314,499
3.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							20,437	8,463	219	29,119

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.01 Salaries (including $################ for affiliated services)										
4.02 Outsourced services										
4.03 EDP equipment and software (including $################ for affiliated services)										
4.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
4.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
4.06 Other expenses (including $################ for affiliated services)										
4.07 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.08 Reimbursements by uninsured plans and fiscal intermediaries										
4.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.01 Salaries (including $################ for affiliated services)										
5.02 Outsourced services										
5.03 EDP Equipment and Software (including $################ for affiliated services)										
5.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
5.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
5.06 Other expenses (including $################ for affiliated services)										
5.07 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.08 Reimbursements by uninsured plans and fiscal intermediaries										
5.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.01 Salaries (including $################ for affiliated services)										
6.02 Outsourced services										
6.03 EDP equipment and software (including $################ for affiliated services)										
6.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
6.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
6.06 Other expenses (including $################ for affiliated services)										
6.07 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.08 Reimbursements by uninsured plans and fiscal intermediaries										
6.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.01 Salaries (including $################ for affiliated services)										
7.02 Outsourced services										
7.03 EDP equipment and software (including $################ for affiliated services)										
7.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
7.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
7.06 Other expenses (including $################ for affiliated services)										
7.07 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.08 Reimbursements by uninsured plans and fiscal intermediaries										
7.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.01 Salaries (including $################ for affiliated services)										
8.02 Outsourced services										
8.03 EDP equipment and software (including $################ for affiliated services)										
8.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
8.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
8.06 Other expenses (including $################ for affiliated services)										
8.07 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.08 Reimbursements by uninsured plans and fiscal intermediaries										
8.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.01 Salaries (including $################ for affiliated services										
9.02 Outsourced services										
9.03 EDP equipment and software (including $################ for affiliated services)										
9.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
9.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
9.06 Other expenses (including $################ for affiliated services)										
9.07 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.08 Reimbursements by uninsured plans and fiscal intermediaries										
9.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1

(To Be Filed by April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

95696201321659100 2013 Document Code: 216

NAIC Group Code 4745 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013 NAIC Company Code 95696

Supp80 Grand Total

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Individual	5 Small Group Employer	6 Large Group Employer	7 Small Group	8 Large Group	Student Health Plans	Business (Excluded by Statute)	Other Health Business	Aggregate (2% Rule)	Subtotal (Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
1. Premium:															
1.01 Health premiums earned (From Part 2, Line 1.11)		106,603,828	65,958,941								2,872,765		175,435,534	XXX	175,435,534
1.02 Federal high risk pools														XXX	
1.03 State high risk pools														XXX	
1.04 Premiums earned including state and federal high risk programs (Lines 1.1 + 1.2 + 1.3)		106,603,828	65,958,941								2,872,765		175,435,534	XXX	175,435,534
1.05 Federal taxes and federal assessments		188,872	115,814								14,549		319,235		319,235
1.06 State insurance, premium and other taxes (Similar local taxes of $.....)		7,910	4,684								622		13,216		13,216
1.06A Community Benefit Expenditures (informational only)															
1.07 Regulatory authority licenses and fees		150,744	83,071								10,851		244,666		244,666
1.08 Adjusted Premiums Earned (Lines 1.4 - 1.5 - 1.6 - 1.7)		106,256,302	65,755,372								2,846,743		174,858,417	XXX	174,858,417
1.09 Net assumed less ceded reinsurance premiums earned		(1,615,441)	(1,122,594)										(2,738,035)	XXX	(2,738,035)
1.10 Other adjustments due to MLR calculations - Premiums														XXX	
1.11 Risk Revenue														XXX	
1.12 Net adjusted premiums earned after reinsurance (Lines 1.8 + 1.9 + 1.10 + 1.11)		104,640,861	64,632,778								2,846,743		172,120,382	XXX	172,120,382
2. Claims:															
2.1 Incurred claims excluding prescription drugs		82,123,365	51,489,340								2,326,934		135,939,639	XXX	135,939,639
2.2 Prescription drugs		14,371,676	9,024,403								3,461		23,399,540	XXX	23,399,540
2.3 Pharmaceutical rebates		937,351	609,994										1,547,345	XXX	1,547,345
2.4 State stop-loss, market stabilization and claim/census based assessments (informational only)														XXX	
3. Incurred medical incentive pools and bonuses		1,859,439	1,081,523										2,940,962	XXX	2,940,962
4. Deductible Fraud and Abuse Detection/Recovery Expenses (for MLR use only)		31,629	20,437								5,454		57,520		57,520
5.0 Total Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 3) (From Part 2, Line 2.15)		97,417,129	60,985,272								2,330,395		160,732,796	XXX	160,732,796
5.1 Net assumed less ceded reinsurance claims incurred		(1,579,084)	(1,714,744)										(3,293,828)	XXX	(3,293,828)
5.2 Other adjustments due to MLR calculations - Claims														XXX	
5.3 Rebates Paid										XXX	XXX	XXX		XXX	
5.4 Estimated rebates unpaid prior year										XXX	XXX	XXX		XXX	
5.5 Estimated rebates unpaid current year										XXX	XXX	XXX		XXX	
5.6 Fee for service and co-pay revenue														XXX	
5.7 Net incurred claims after reinsurance (Lines 5.0 + 5.1 + 5.2 + 5.3 - 5.4 + 5.5 - 5.6)		95,838,045	59,270,528								2,330,395		157,438,968	XXX	157,438,968

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 1 (Continued)

(To Be Filed by April 1 - Not for Rebate Purposes)

	Business Subject to MLR									10	11	12	13	14	15
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government					
	1	2	3	4	5	6	7	8		Business	Other		Subtotal		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	(Cols. 1 thru 12)	Uninsured Plans	Total (Cols. 13 + 14)
6. Improving Health Care Quality Expenses Incurred:															
6.1 Improve health outcomes		346,022	210,625								13,415		570,062		570,062
6.2 Activities to prevent hospital readmissions		25,985	14,984								685		41,654		41,654
6.3 Improve patient safety and reduce medical errors		17,356	10,963								1,415		29,734		29,734
6.4 Wellness and health promotion activities		339,474	208,231								23,986		571,691		571,691
6.5 Health Information Technology expenses related to health improvement		96,137	60,492								7,305		163,934		163,934
6.6 Total of Defined Expenses Incurred for Improving Health Care Quality (Lines 6.1 to 6.5)		824,974	505,295								46,806		1,377,075		1,377,075
7. Preliminary Medical Loss Ratio: MLR (Lines 4 + 5.0 + 6.6) / Line 1.8		0.925	0.935							XXX	XXX	XXX	XXX	XXX	XXX
8. Claim Adjustment Expenses:															
8.1 Cost containment expenses not included in quality of care expenses in Line 6.6		495,975	296,398								44,647		837,020		837,020
8.2 All other claims adjustment expenses		3,255,656	2,068,190								284,282		5,608,128		5,608,128
8.3 Total claims adjustment expenses (Lines 8.1 + 8.2)		3,751,631	2,364,588								328,929		6,445,148		6,445,148
9. Claims Adjustment Expense Ratio (Line 8.3 / Line 1.8)		0.035	0.036								0.116		XXX	XXX	XXX
10. General and Administrative (G&A) Expenses:															
10.1 Direct sales salaries and benefits		292,786	192,732								16,766		502,284		502,284
10.2 Agents and brokers fees and commissions		4,417,008	1,330,825										5,747,833		5,747,833
10.3 Other taxes (excluding taxes on Lines 1.5 through 1.7 and Line 14 below)															
10.4 Other general and administrative expenses		3,306,860	1,717,490								240,846		5,265,196		5,265,196
10.4A Community Benefit Expenditures (informational only)															
10.5 Total general and administrative (Lines 10.1 + 10.2 + 10.3 + 10.4)		8,016,654	3,241,047								257,612		11,515,313		11,515,313
11. Underwriting Gain/(Loss) (Lines 1.12 - 5.7 - 6.6 - 8.3 - 10.5)		(3,790,443)	(748,680)								(116,999)		(4,656,122)	XXX	(4,656,122)
12. Income from fees of uninsured plans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
13. Net investment and other gain/(loss)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1,835,610	XXX	1,835,610
14. Federal income taxes (excluding taxes on Line 1.5 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
15. Net gain or (loss) (Lines 11 + 12 + 13 - 14)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	(2,820,512)	XXX	(2,820,512)
16. ICD-10 Implementation Expenses (informational only; already included in general expenses and Line 6.5)		28,290	18,623								2,172		49,085		49,085
16A. ICD-10 Implementation Expenses (informational only: already included in Line 6.5)		28,290	18,623								2,172		49,085		49,085
O. OTHER INDICATORS:															
O1. Number of Certificates / Policies		11,239	7,243								2,115		20,597		20,597
O2. Number of Covered Lives		21,849	14,395								2,115		38,359		38,359
O3. Number of Groups	XXX	3,160	96	XXX							2,115		5,371		5,371
O4. Member Months		268,340	179,709								20,593		468,642		468,642

(a) Is run off business reported in Columns 1 through 9? Yes[ ] No[X]
(b) If yes, show the amount of premiums and claims included: Premiums $..... Claims $.....

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 2

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 **BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013** **NAIC Company Code 95696**

	Business Subject to MLR									10	11	12	13
	Comprehensive Health Coverage			Mini-Med Plans			Expatriate Plans		9	Government			
	1	2	3	4	5	6	7	8		Business	Other		
	Individual	Small Group Employer	Large Group Employer	Individual	Small Group Employer	Large Group Employer	Small Group	Large Group	Student Health Plans	(Excluded by Statute)	Health Business	Aggregate (2% Rule)	Total (a)
1. Health Premiums Earned													
1.01 Direct premiums written		106,603,828	65,958,941								2,872,765		175,435,534
1.02 Unearned premium prior year													
1.03 Unearned premium current year													
1.04 Change in unearned premium (Lines 1.2 - 1.3)													
1.05 Paid rate credits			51,290										51,290
1.06 Reserve for rate credits current year			214,160										214,160
1.07 Reserve for rate credits prior year			520,411										520,411
1.08 Change in reserve for rate credits (Lines 1.6 - 1.7)			(306,251)										(306,251)
1.09 Premium balances written off													
1.10 Group conversion charges													
1.11 TOTAL direct premiums earned (Lines 1.1 + 1.4 - 1.9 + 1.10)		106,603,828	65,958,941								2,872,765		175,435,534
1.12 Assumed premiums earned from non-affiliates													
1.13 Net assumed less ceded premiums earned from affiliates													
1.14 Ceded premiums earned to non-affiliates		1,615,441	1,122,594										2,738,035
1.15 Other adjustments due to MLR calculation - Premiums													
1.16 Net premiums earned (Lines 1.11 - 1.5 - 1.8 + 1.12 + 1.13 - 1.14 + 1.15)		104,988,387	65,091,308								2,872,765		172,952,460
2. Direct Claims Incurred:													
2.01 Paid claims during the year		95,136,536	60,150,542								2,182,395		157,469,473
2.02 Direct claim liability current year		5,284,965	3,599,035								382,000		9,266,000
2.03 Direct claim liability prior year		4,863,811	3,590,867								234,000		8,688,678
2.04 Direct claim reserves current year													
2.05 Direct claim reserves prior year													
2.06 Direct contract reserves current year													
2.07 Direct contract reserves prior year													
2.08 Paid rate credits			51,290										51,290
2.09 Reserve for rate credits current year			214,160										214,160
2.10 Reserve for rate credits prior year			520,411										520,411
2.11 Incurred medical incentive pools and bonuses (Lines 2.11a + 2.11b - 2.11c)		1,859,439	1,081,523										2,940,962
2.11A Paid medical incentive pools and bonuses current year		2,656,110	1,008,852										3,664,962
2.11B Accrued medical incentive pools and bonuses current year		2,039,295	1,277,705										3,317,000
2.11C Accrued medical incentive pools and bonuses prior year		2,835,966	1,205,034										4,041,000
2.12 Net healthcare receivables (Lines 2.12a - 2.12b)													
2.12A Healthcare receivables current year													
2.12B Healthcare receivables prior year													
2.13 Group conversion charge													
2.14 Multi-option coverage blended rate adjustment													
2.15 TOTAL Incurred Claims (Lines 2.1 + 2.2 - 2.3 + 2.4 - 2.5 + 2.6 - 2.7 + 2.8 + 2.9 - 2.10 + 2.11 - 2.12 + 2.13 + 2.14)		97,417,129	60,985,272								2,330,395		160,732,796
2.16 Assumed Incurred Claims from non-affiliates													
2.17 Net Assumed less Ceded Incurred Claims from affiliates													
2.18 Ceded Incurred Claims to non-affiliates		1,579,084	1,714,744										3,293,828
2.19 Other Adjustments due to MLR calculation - Claims													
2.20 Net Incurred Claims (Lines 2.15 - 2.8 - 2.9 + 2.10 + 2.16 + 2.17 - 2.18 + 2.19)		95,838,045	59,525,489								2,330,395		157,693,929
3. Fraud and Abuse Recoveries that Reduced PAID Claims in Line 2.1 above (informational only)		161,494	100,409								3,944		265,847

(a) Column 13, Line 1.1 includes direct written premium of $..... for stand-alone dental and $..... for stand-alone vision policies.

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3

(To Be Filed By April 1 - Not for Rebate Purposes)

REPORT FOR: 1. CORPORATION: THE VERMONT HEALTH PLAN, LLC 2. LOCATION: Berlin, VT 05602

NAIC Group Code 4745 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2013 NAIC Company Code 95696

Supp83 Grand Total

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
1. Individual Comprehensive Coverage Expenses:										
1.01 Salaries (including $..... for affiliated services)										
1.02 Outsourced services										
1.03 EDP Equipment and Software (incl $..... for affiliated services)										
1.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
1.05 Accreditation and Certification (incl $..... for affiliated services)		XXX	XXX	XXX	XXX					
1.06 Other Expenses (incl $..... for affiliated services)										
1.07 Subtotal before reimbursements and taxes (Lines 1.1 to 1.6)										
1.08 Reimbursements by uninsured plans and fiscal intermediaries										
1.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
1.10 TOTAL (Lines 1.7 to 1.9)										
1.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
2. Small Group Comprehensive Coverage Expenses:										
2.01 Salaries (including $.....3,633,416 for affiliated services)	127,145	9,157		148,038	30,668	315,008	494,774	1,129,677	1,924,840	3,864,299
2.02 Outsourced services	193,508	16,617	9,554	142,313	29,144	391,136	1,086	1,004,303	343,685	1,740,210
2.03 EDP Equipment and Software (incl $.....817,141 for affiliated services)	873	82		836	27,921	29,712		606,771	183,598	820,081
2.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
2.05 Accreditation and Certification (incl $.....3,651 for affiliated services)	3,015	XXX	XXX	XXX	XXX	3,015			5,600	8,615
2.06 Other Expenses (incl $.....1,635,375 for affiliated services)	21,481	129	7,802	48,287	8,404	86,103	115	514,905	5,540,077	6,141,200
2.07 Subtotal before reimbursements and taxes (Lines 2.1 to 2.6)	346,022	25,985	17,356	339,474	96,137	824,974	495,975	3,255,656	7,997,800	12,574,405
2.08 Reimbursements by uninsured plans and fiscal intermediaries										
2.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	366,380	366,380
2.10 TOTAL (Lines 2.7 to 2.9)	346,022	25,985	17,356	339,474	96,137	824,974	495,975	3,255,656	8,364,180	12,940,785
2.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							31,629	13,098	327	45,054
3. Large Group Comprehensive Coverage Expenses:										
3.01 Salaries (including $.....2,206,452 for affiliated services)	75,398	5,023		91,613	19,206	191,240	295,608	736,631	1,122,190	2,345,669
3.02 Outsourced services	118,728	9,855	5,739	87,813	18,048	240,183	715	630,508	172,088	1,043,494
3.03 EDP Equipment and Software (incl $.....479,799 for affiliated services)	530	41		509	17,703	18,783		370,396	92,522	481,701
3.04 Other Equipment (excluding EDP) (incl $..... for affiliated services)										
3.05 Accreditation and Certification (incl $.....2,403 for affiliated services)	1,985	XXX	XXX	XXX	XXX	1,985			3,122	5,107
3.06 Other Expenses (incl $.....840,382 for affiliated services)	13,984	65	5,224	28,296	5,535	53,104	75	330,655	1,839,754	2,223,588
3.07 Subtotal before reimbursements and taxes (Lines 3.1 to 3.6)	210,625	14,984	10,963	208,231	60,492	505,295	296,398	2,068,190	3,229,676	6,099,559
3.08 Reimbursements by uninsured plans and fiscal intermediaries										
3.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	214,940	214,940
3.10 TOTAL (Lines 3.7 to 3.9)	210,625	14,984	10,963	208,231	60,492	505,295	296,398	2,068,190	3,444,616	6,314,499
3.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)							20,437	8,463	219	29,119

SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (6 to 9)
4. Individual Mini-Med Plans Expenses										
4.01 Salaries (including $################ for affiliated services)										
4.02 Outsourced services										
4.03 EDP equipment and software (including $################ for affiliated services)										
4.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
4.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
4.06 Other expenses (including $################ for affiliated services)										
4.07 Subtotal before reimbursements and taxes (Lines 4.1 to 4.6)										
4.08 Reimbursements by uninsured plans and fiscal intermediaries										
4.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
4.10 TOTAL (Lines 4.7 to 4.9)										
4.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
5. Small Group Mini-Med Plans Expenses										
5.01 Salaries (including $################ for affiliated services)										
5.02 Outsourced services										
5.03 EDP Equipment and Software (including $################ for affiliated services)										
5.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
5.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
5.06 Other expenses (including $################ for affiliated services)										
5.07 Subtotal before reimbursements and taxes (Lines 5.1 to 5.6)										
5.08 Reimbursements by uninsured plans and fiscal intermediaries										
5.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
5.10 TOTAL (Lines 5.7 to 5.9)										
5.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
6. Large Group Mini-Med Plans Expenses										
6.01 Salaries (including $################ for affiliated services)										
6.02 Outsourced services										
6.03 EDP equipment and software (including $################ for affiliated services)										
6.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
6.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
6.06 Other expenses (including $################ for affiliated services)										
6.07 Subtotal before reimbursements and taxes (Lines 6.1 to 6.6)										
6.08 Reimbursements by uninsured plans and fiscal intermediaries										
6.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
6.10 TOTAL (Lines 6.7 to 6.9)										
6.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

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SUPPLEMENTAL HEALTH CARE EXHIBIT - PART 3 (Continued)

(To Be Filed By April 1 - Not for Rebate Purposes)

All Expenses	Improving Health Care Quality Expenses						Claims Adjustment Expenses		9	10
	1 Improve Health Outcomes	2 Activities to Prevent Hospital Readmissions	3 Improve Patient Safety and Reduce Medical Errors	4 Wellness & Health Promotion Activities	5 HIT Expenses	6 Total (1 to 5)	7 Cost Containment Expenses	8 Other Claims Adjustment Expenses	General Administrative Expenses	Total Expenses (Cols. 6 to 9)
7. Small Group Expatriate Plans Expenses										
7.01 Salaries (including $################ for affiliated services)										
7.02 Outsourced services										
7.03 EDP equipment and software (including $################ for affiliated services)										
7.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
7.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
7.06 Other expenses (including $################ for affiliated services)										
7.07 Subtotal before reimbursements and taxes (Lines 7.1 to 7.6)										
7.08 Reimbursements by uninsured plans and fiscal intermediaries										
7.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
7.10 TOTAL (Lines 7.7 to 7.9)										
7.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
8. Large Group Expatriate Plans Expenses										
8.01 Salaries (including $################ for affiliated services)										
8.02 Outsourced services										
8.03 EDP equipment and software (including $################ for affiliated services)										
8.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
8.05 Accreditation and certification (including $################ for affiliated services)		XXX		X	XXX					
8.06 Other expenses (including $################ for affiliated services)										
8.07 Subtotal before reimbursements and taxes (Lines 8.1 to 8.6)										
8.08 Reimbursements by uninsured plans and fiscal intermediaries										
8.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
8.10 TOTAL (Lines 8.7 to 8.9)										
8.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										
9. Student Health Plans Expenses										
9.01 Salaries (including $################ for affiliated services										
9.02 Outsourced services										
9.03 EDP equipment and software (including $################ for affiliated services)										
9.04 Other equipment (excluding EDP) (including $################ for affiliated services)										
9.05 Accreditation and certification (including $################ for affiliated services)		XXX	XXX	XXX	XXX					
9.06 Other expenses (including $################ for affiliated services)										
9.07 Subtotal before reimbursements and taxes (Lines 9.1 to 9.6)										
9.08 Reimbursements by uninsured plans and fiscal intermediaries										
9.09 Taxes, licenses and fees (in total, for tying purposes)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
9.10 TOTAL (Lines 9.7 to 9.9)										
9.11 TOTAL fraud and abuse detection/recovery expenses included in Column 7 (informational only)										

NONE

Supp85 Grand Total

95696201321700100 2013 Document Code: 217

SUPPLEMENTAL HEALTH CARE EXHIBIT'S EXPENSE ALLOCATION REPORT

(To Be Filed by April 1)

NAIC Group Code: 4745 NAIC Company Code: 95696

Description of allocation methodology:

All management and administrative services are performed on behalf of TVHP by the parent company, BCBSVT. The expense allocations utilized in preparing TVHP's Supplemental Health Care Exhibit were built from BCBSVT's previously existing cost allocations used in the completion of the Analysis of Operations by Line of Business (page 7) and the Underwriting & Investment Exhibit - Part 3 (page 14). The existing system already allocated expenses between the BAE, CCE, and GAE categories, by expense line and by cost center/department. For purposes of completing the Supplemental Health Care Exhibit, TVHP first identified all incurred QI expenses that were determined to meet the definitions developed by the NAIC. These included both allocated expenses from BCBSVT, and direct expenses incurred by TVHP. The expenses were allocated between the 5 QI categories by specifically identifying the costs associated with performing the QI activities, by department and by expense line, and aligning them based on our interpretation of the definitions and examples provided for each of the 5 categories in the instructions. As the QI expenses are a subset of TVHP's overall administrative costs, the QI items were allocated by BAE/CCE/GAE category in proportion to how the applicable expense line within the particular department was allocated in the overall cost accounting system. As TVHP's operations are confined to the State of Vermont, there was no allocation of expenses between states/jurisdictions. With respect to the services described in the table below, with the exception of disease management, all functions are performed by BCBSVT on behalf of TVHP, and the associated costs represent TVHP's allocated share of BCBSVT expenses.

Detailed Description of Quality Improvement Expenses:

1 Expense Type from Part 3	2 New	3 Detailed Description of Expense
Improve Health Outcomes		
Disease management		Through an external vendor, TVHP provides disease management services to virtually all of its members for specific diseases/conditions. The vendor guarantees a minimum ROI.
Case management / care coordination		BCBSVT maintains a staff of physicians and registered nurses who work with members to manage and coordinate their medical care to improve overall health outcomes. These activities include making and verifying appointments, helping to manage transitions from one setting to another, and providing coaching and support.
Pharmacy management		Through an external vendor, BCBSVT works with members and providers to encourage the most appropriate drug usage that will limit potential risk to the member while maximizing the benefit.
NCQA accreditation activities		BCBSVT and TVHP are NCQA accredited, and BCBSVT performs many activities related to maintaining both accreditations. These include direct outreach to providers, educational programs, and review of utilization metrics to ensure proper care is being provided to members.
Better Beginnings program		BCBSVT and TVHP provide a specialized program to work with expectant parents, which includes providing educational materials, credits for lactation consulting services and Red Cross CPR training, and other materials to encourage a successful pregnancy and healthy birth. There is a separate component to the program for parents of young children, which includes counseling and other educational materials related to vaccinations, etc. These programs are administered by registered nurses.
Activities to Prevent Hospital Readmission		
Case management		As part of the overall case management program, BCBSVT's registered nurse staff also actively works with members on discharge planning, and post discharge counseling to reduce the likelihood of future readmission.
Improve Patient Safety and Reduce Medical Errors		
Prospective drug utilization review		Through an external vendor, BCBSVT monitors prescription usage for potential adverse drug interactions, and advises on step therapy treatments.
Medical management review		BCBSVT's Quality Improvement department reviews data and works with providers on the identification and use of best clinical practices and to encourage evidence based medicine in addressing clinical errors and safety concerns.
Wellness & Health Promotion Activities		
Worksite wellness assessments		Wellness assessments and biometric screenings are performed at employer worksites.
Public health education events in conjunction with state health department		BCBSVT sponsors various events in conjunction with state and local health departments in order to encourage healthy lifestyles and physical activity. These include the Walk at Lunch program, a Hike, Bike and Paddle program, and many others that are open to members as well as to the community at large.
HIT Expenses for Health Care Quality Improvements		
HEDIS reporting		BCBSVT completes various reporting of HEDIS measures for public reporting mandated by VT law.
NCQA accreditation		As part of the NCQA accreditation process, BCBSVT performs many activities related to reporting and analysis of clinical effectiveness and related measures.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

July 10, 2014

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

Subject: Your 07/08/2014 Questions re: Blue Cross and Blue Shield of Vermont 2015 Exchange Filing (SERFF Tracking #: BCVT-129572217)

Dear Mr. Hammerquist:

In response to your request dated July 8, 2014, here are *your questions* and our answers:

1. *Please provide an estimate of the 2014 financial impact of the federal changes in attachment point and percentage in the 2014 transitional reinsurance compared to the assumptions you used in your 2014 rate filing.*

   The Department of Health and Human Services (HHS) published their Final Rule establishing benefit and payment parameters for 2015 health care Exchanges on March 11, 2014. Within that rule, HHS decreased the 2014 attachment point to $45,000. This change was made in response to "updated information, including the actual premiums for reinsurance-eligible plans, as well as recent policy changes, suggest[ing] that our prior estimates of the uniform reinsurance payment parameters overestimated the total covered claims costs of individuals enrolled in reinsurance-eligible plans in 2014."[1] In particular, the transitional policy announced in November 2013 ensured that many beneficiaries would extend their 2013 benefits into the 2014 plan year, meaning that fewer individuals would be enrolled in QHPs.

   The combination of these two changes – that is, the impact on reinsurance recoveries of the transitional policy (plus any impact of actual vs. projected premiums) and the change in reinsurance parameters – was intended to be cost-neutral nationally, but it did have an upward impact on BCBSVT's projected recoveries due to the attributes of our projected population:

Transitional Reinsurance		
Attachment point	**Enrollment**	**Recoveries PMPM**
$60k	January 1	$31.02
$60k	Delayed	$28.95
$45k	Delayed	$40.49

[1] See https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015#h-53

It should be noted that HHS developed their Affordable Care Act Health Insurance Model (ACAHIM) to estimate "market enrollment, incorporating the effects of State and Federal policy choices, and accounting for the behavior of individuals and employers."[1] The output of this model was used both to adjust payment parameters for the 2014 benefit year and to establish the 2015 uniform reinsurance payment parameters.

HHS has modified § 153.230(d) "to provide that if HHS determines that the amount of reinsurance payments requested under the uniform payment parameters will not be equal the amount of reinsurance contributions collected for reinsurance payments, HHS will determine a uniform adjustment (up or down) to be applied to all requests for reinsurance payments."[1] The current coinsurance parameter of 50% represents HHS's best estimate of the final parameter: "We estimate that these uniform reinsurance payment parameters will result in total requests for reinsurance payments of approximately $6 billion for the 2015 benefit year."[1]

In other words, the updated premium and membership data that informed the change in 2014 parameters *has already been incorporated* into the parameters that have been established for 2015 and in HHS's judgment the ultimate result is equally likely to overestimate the payment requests as to underestimate.

Please see our July 2, 2014 response to Question 8 of Lewis & Ellis, Inc's actuarial inquiries of June 30, 2014 for a detailed reconciliation of our 2014 and 2015 transitional reinsurance recovery assumptions.

2. *Please provide a history of projected (as reflected in the rate filings) and actual incurred claims and earned premiums for the past three years for the individual and small group markets separately.*

There are 75 rate filings covering claims and premium incurred in calendar years 2011, 2012 and 2013. These filings cover periods from Q1 2010 to Q4 2013 for Catamount, Nongroup, Safety Net, BCBSVT Small Group Community, TVHP Small Group Community and seven Small Group Associations. To calculate the projected claims at the time of the filing, we used the projected loss ratio from each filing and applied it to the monthly gross premium for the cases to which each filing applied. The actual claims and premium come directly from our statutory financial results. Note that the definition of Small Group and Individual is as defined in the year it was reported, which is different from the definitions in the Exchange.

BCBSVT Small Group	Expected Claims (PMPM)	Actual Claims (PMPM)	Actual to Expected	Earned Premium (PMPM)
2011	$408.92	$425.32	104.0%	$476.58
2012	$303.00	$307.17	101.4%	$330.41
2013	$308.68	$339.51	110.0%	$358.29

BCBSVT Individual	Expected Claims (PMPM)	Actual Claims (PMPM)	Actual to Expected	Earned Premium (PMPM)
2011	$367.38	$341.73	93.0%	$384.88
2012	$369.39	$390.02	105.6%	$406.72
2013	$397.64	$401.28	100.9%	$421.70

TVHP Small Group	Expected Claims (PMPM)	Actual Claims (PMPM)	Actual to Expected	Earned Premium (PMPM)
2011	$297.22	$290.98	97.9%	$342.61
2012	$327.37	$320.14	97.8%	$372.92
2013	$351.67	$357.15	101.6%	$391.25

3. *Please provide the allowed and incurred cost by age cohort (20 and under and 5 year increments thereafter or by age, if easier) for individual and small groups in 2013.*

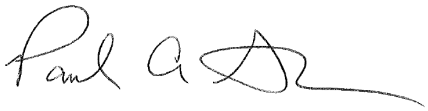
Below are the allowed and incurred costs by age cohort for the calendar year 2013. The information is on a Per Member Per Month (PMPM) basis. As described in the Actuarial Memorandum, the experience period used is composed of current members in Blue Cross and Blue Shield of Vermont (BCBSVT) Individual and Small Group products and The Vermont Health Plan (TVHP) Small Group products. This population will be the Single Risk Pool. Members with Medicare as their primary insurance or members without a pharmacy benefit were excluded. The total allowed PMPM ($445.21) matches Line A of Exhibit 5.

Line of Business	Age Group	Paid PMPM	Allowed PMPM
Individual	0-20	$151.05	$192.45
Individual	20-24	$178.44	$219.76
Individual	25-29	$279.20	$333.05
Individual	30-34	$286.18	$339.81
Individual	35-39	$322.36	$382.94
Individual	40-44	$328.36	$391.93
Individual	45-49	$435.13	$502.26
Individual	50-54	$516.34	$591.22
Individual	55-59	$505.61	$587.16
Individual	60-64	$603.57	$695.29
Individual	65+	$446.71	$598.65
Small Group	0-20	$145.22	$198.08
Small Group	20-24	$169.83	$228.83
Small Group	25-29	$157.84	$230.81
Small Group	30-34	$218.43	$307.51
Small Group	35-39	$258.87	$349.06
Small Group	40-44	$289.12	$381.09
Small Group	45-49	$346.55	$440.27
Small Group	50-54	$395.86	$503.40
Small Group	55-59	$484.46	$600.62

Small Group	60-64	$671.04	$801.91
Small Group	65+	$969.87	$1,131.49
Total		**$360.41**	**$445.21**

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.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

July 15, 2014

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

Subject: Your 07/01/2014 Questions re: Blue Cross and Blue Shield of Vermont 2015 Exchange Filing (SERFF Tracking #: BCVT-129572217)

Dear Mr. Hammerquist:

In response to your request dated July 11, 2014, here are *your questions* and our answers:

1. *Pediatric Dental*
   a. *Please provide the separate communication that contains the projected allowed pediatric charges in the response to question #1a date July 2nd.*

   Our consultant has updated the original document provided (Addendum C) to include the additional information that originally had been provided via email. Please see attached *VTX28_2015_Ped_Dental_Claims_2014-07-15*.pdf

   b. *Why was the benefit richness adjustment assumed to be prohibited in 2014, but not in 2015?*

   The due date for the 2014 filing was set before the final regulations were developed. DFR's reviewing actuary had indicated that such adjustments were not permitted. Subsequent guidance from CCIIO clarified that such an adjustment was permissible.

2. *Pediatric Vision*
   a. *Please provide the report for pediatric vision that was provided by the vision provider VSP.*

   The table below, provided by our vision provider, was used for our pediatric vision estimate. The table includes the monthly paid claims PMPM under two arrangements, Fully Insured and ASO. BCBSVT agreed to an ASO arrangement with VSP.

VSP VT Exchange – Pediatric Vision Essential Health Benefit

Plan Coverage For: BCBS VT – [Fully-Insured/Self-Insured] Signature Plan		
Monthly PMPM	• Risk: $3.63 pmpm// ASO: $0.34 pmpm admin, $3.10 expected claims cost	
Rate Details	• Rates assume a January 1, 2014 effective date, are guaranteed for two years and net of commissions.	
Frequency	• Exam available once every calendar year • Lenses available once every calendar year • Frames available once every calendar year	
Copayments	• Vary based on plan design	
WellVision Exam®	• Complete eye exam covered in full	
Lenses	• Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full • Polycarbonate lenses covered in full • Plastic or glass optional covered in full • Scratch and UV covered in full	
Frames	• Frames from a Pediatric Exchange Collection are covered in full	
Contact Lenses	• In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following service limitations: o Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) o Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) o Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses) o Dailies (one month supply) = 30 lenses per eye (total 60 lenses) • Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction	
Value-added Benefits		
Complementary Support for Wellness Initiative	• Under its Eye Health Management Program®, VSP collects HIPAA-compliant patient condition data and shares it with your health plan or disease management vendor • ICD-9 code-based reporting of certain chronic conditions supports your disease management efforts • Exam reminder letters sent to VSP members with certain conditions who have not had an eye exam in 14 months	
Open Access Reimbursement Schedule		
Open Access Schedule	N/A – no out-of-network benefit	N/A – no out-of-network benefit
Exclusions		
Plan Limitations	The following items are excluded under this plan: • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training, supplemental testing	Items not covered under the contact lens coverage: • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning

3. *Transitional Reinsurance Recoveries*
   a. *The Final Rule (5/27/2014) suggests that the attachment point may change from $70,000 to $45,000 for 2015. Please provide a recalculated projected reinsurance recoveries PMPM (and all quantitative support for the calculation) if you were to assume that the lower attachment point was in place at the time of the filing.*

The Final Rule that establishes the reinsurance parameters is the HHS Notice of Benefit and Payment Parameters for 2015[1]. That rule was finalized on March 11, 2014 and establishes the 2015 uniform reinsurance payment parameters, including a $70,000 attachment point.

[1] https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015

The rule dated May 27, 2014 and referenced in this question is *Exchange and Insurance Market Standards for 2015 and Beyond*. This rule finalizes the allocation of transitional reinsurance contributions in the event of a shortfall.[2] The preamble to the rule includes a response to a comment that states, "…we intend to propose to lower the 2015 attachment point from $70,000 to $45,000. We may also propose to modify the target 2015 coinsurance rate based on estimates of roll-over of funding from 2014 and estimates of collections and payments for 2015. These proposals will be subject to notice and comment rulemaking."

A reading of this comment and response in context, along with a reading of the Payment Parameters rule, makes it apparent that HHS will adjust the coinsurance percentage to achieve an overall payout commensurate with the funds on hand through assessments. We are unaware of any update to the estimated payment requests giving rise to the parameters promulgated in the Payment Parameters rule. We therefore assume that any change in attachment point would be accompanied by a change in coinsurance percentage in order to achieve the same estimated payout.

While our best estimate of projected transitional reinsurance recoveries at a lower attachment point is identical to that in our filing, we below demonstrate for illustrative purposes the hypothetical recovery calculation you have requested.

Table 1 shows the various Individual allowed charge PMPM's from our 2015 model at the various attachment points and coinsurance levels.

Table 1		Allowed
	Transitional Reinsurance Benefits	**2015 PMPM**
2015 Hypothetical	$(E[X - 45K]_+ - E[X - 250K]_+) \times 50\%$	$ 59.16
2015 Filed	$(E[X - 70K]_+ - E[X - 250K]_+) \times 50\%$	$ 36.73
2014 Filed	$(E[X - 60K]_+ - E[X - 250K]_+) \times 80\%$	$ 70.45

Table 2 shows a step-by-step calculation going from Individual allowed charges to total expected recoveries in the Exchange.

Table 2	2015 Filing	2015 Hypothetical
Individual Allowed	$ 36.73	$ 59.16
Individual Benefit Paid*	$ 34.54	$ 54.92
% Individual	40.43%	40.43%
Total Expected Recovery	$ 13.96	$ 22.20
*Benefit paid amounts come from our re-adjudication model		

[2] https://www.federalregister.gov/articles/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and#h-34

We were aware of the comment and response in question at the time of the filing. As noted above, our best estimate of recoveries remains unchanged using either attachment point. Furthermore, we believe that it would have been extremely imprudent to ignore promulgated regulation in favor of basing pricing upon an "intention to propose" at a future date a parameter change, likely to be accompanied by an unspecified change in other parameters, that would be subject to notice and comment prior to finalization.

b. In Table 1 in the response to question #8 dated July 2nd, please include an additional category for claims between $45,000 and $60,000.

The following table is similar to the table provided in question #8 dated July 2, 2014, with the addition of the $45,000 data point.

	Allowed		Frequency	
	E[Allowed Charge PMPM > D]		% of Claimants > D	
D	2014	2015	2014	2015
-	$ 553.16	$ 640.54	-	-
45,000	$ 110.55	$ 134.95	1.9%	2.4%
60,000	$ 87.86	$ 104.70	1.3%	1.6%
70,000	$ 76.97	$ 90.09	1.0%	1.3%
250,000	$ 16.35	$ 16.64	0.1%	0.1%

4. Taxes and Fees

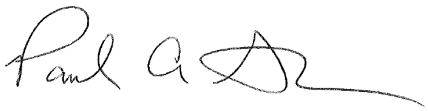
a. Was any attempt made to estimate the impact on the insurer fee of large groups moving to self-insurance by either BCBSVT or BlueCross BlueShield Association?

BCBSVT did not attempt to make such an estimate. We are not aware of any BCBSA estimates. Such estimates would require speculation on the actions of large groups for which no reliable experience information was available.

In the absence of the ability to make a more precise estimate, we rounded the calculation to 2.00% in 2014. Still lacking means to enhance the 2014 estimate of this impact, we have chosen to maintain the factor from the previous filing. The resulting change in estimate is simply proportional to the increase in the total federal industry assessment. We believe that this is a reasonable and appropriate approach.

Please let us know if you have any further questions, or if we can provide additional clarity on any of the items above.

Sincerely,



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July 15, 2014

Ms. Ruth Greene
Vice President, Treasurer & CFO
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

Re: Projected CY 2015 Net Claims Costs for Pediatric Dental

Dear Ruth:

As you requested, we have developed projected CY 2015 net claims costs for pediatric dental services. The estimates assume the pediatric dental coverage is integrated with the medical coverage, as opposed to being offered as a standalone plan. We assumed the integrated deductible applies to all dental services except Class 1 services, except for the CDHP plans and the Catastrophic plan where it also applies to Class 1 services. This is a significant change from the 2014 benefits where the integrated deductible applies to Class 1 services for all plans. We modeled results for each of the six standard medical plans specified by the State, as well as the four non-standard plans designed by Blue Cross and Blue Shield of Vermont (BCBSVT). The projection is appropriate for CY 2015; adjustments should be made for rates that apply to subsequent periods.

The projected CY 2015 net claims cost per child per month amounts are shown below for each plan:

Medical Plan	**Projected Dental Cost**	
	Allowed	**Net**
Standard Platinum	$45.04	$38.77
Standard Gold	$44.15	$33.62
Standard Silver	$43.04	$28.78
Standard Bronze	$41.67	$25.71
Standard Silver CDHP	$40.28	$16.56
Standard Bronze CDHP	$39.60	$13.70
Non-Standard Gold	$43.49	$31.83
Non-Standard Silver	$42.68	$28.54
Non-Standard Bronze CDHP	$35.68	$6.28
Non-Standard Catastrophic	$33.71	$4.94

It should be noted there is a considerable amount of uncertainty in these projections. BCBSVT does not have credible dental claims experience, and as a result, the estimates are based on manual rates using the Milliman Dental Cost Guidelines (DCGs). Beyond the normal level of uncertainty associated with manual rates, there are a number of elements in this pricing that create significant additional uncertainty, such as the integration of medical and dental benefits, potential pent-up demand for dental services, no annual maximum benefit limit, and uncertainty in identifying medically necessary orthodontia services.

It is our understanding that these estimates will be added without any adjustment to BCBSVT's estimates of medical costs to develop premium rates, and that normalization for the expected impact of various rating factors does not apply.

These estimates are intended to assist BCBSVT with its development of proposed CY 2015 rates for individual and small group business that will be sold on the Vermont Exchange for a 1/1/2015 effective date. The estimates may not be appropriate for any other use.

Development of Projected Claims for Non-Orthodontia Services

The projected claims costs for non-orthodontia are based on the Milliman Dental Cost Guidelines (DCGs). The DCG starting costs reflect national average billed charges. The methodology consists of the following steps:

- *Starting Costs* – The DCGs contain starting data by age/gender category. We used the average claims costs for ages 0-21 based on the BCBSVT age mix within the 0-21 age band.

- *Area* – We adjusted the national average starting data to statewide Vermont based on area factors contained in the DCGs.

- *Trend* – We trended the CY 2013 starting data to CY 2015 using a 5% annual trend.

- *Discounts* – We used the 2013 fee level data provided by BCBSVT to develop discount percentages, which were then applied to the projected 2015 billed charges.

- *Benefit Richness* – We made adjustments to reflect the expected impact of member cost sharing on projected utilization levels. These adjustments are based on the Milliman Dental Cost Guidelines and actuarial judgment.

- *Pent-Up Demand* – We assumed most members would not have prior dental coverage based on information provided by BCBSVT. The DCGs suggest a factor of 1.30 for new business; however that factor applies to a standard population. We reduced the DCG factor to 1.15 to reflect the expected lower impact for the mix of services expected for children. BCBSVT expects this level to moderate to 1.10 for members in their second year of coverage. Based on the expected mix of first and second year members in 2015, BCBSVT estimates an average factor of 1.11.

- *Projected Allowed Costs* – Applying the adjustments described above results in the projected allowed costs for non-orthodontia costs.

- *Projected Net Costs* – As mentioned above, the projections assume the dental benefits are integrated with medical, as specified by BCBSVT. The projections reflect the medical benefits for the six medical plans specified by the State and the four non-standard plans designed by BCBSVT. The medical benefits are shown in the attached tables. The dental coinsurance is 100/70/50% on Classes 1-3 services, respectively, except that Space Maintainers are covered at 100% and Bridges and Simple Repairs are covered at 70%. We developed the net costs in two steps.

  In the first step, we modeled the medical benefits and determined the portion of the deductible and out-of-pocket maximum that would be filled by medical claims, and the portion that would remain to be applied to dental services. We modeled the medical benefits using a child claims probability distribution from the Milliman Health Cost Guidelines (HCGs), scaled to match the projected CY 2015 child allowed PMPM of $266 provided by BCBSVT. We performed a simulation of 10,000 members and tabulated the remaining deductible and out-of-pocket maximum amounts.

  In the second step, we used the remaining deductible and out-of-pocket maximum amounts and the dental coinsurance percentages to develop dental net claims costs for the each of the modeled 10,000 members. The dental development is based on a child non-orthodontia dental claims probability distribution from the DCGs that is scaled to the projected dental allowed claims PMPM described above. The overall projected dental net claims cost is the average of the dental net claims cost for each of the 10,000 modeled members.

  By assuming the medical benefits apply to the deductible and out-of-pocket maximum prior to any dental claims, the projected net claims cost for dental services is overstated. However, our understanding is that BCBSVT is not reflecting the impact of dental costs on the deductible and out-of-pocket maximum in its development of the medical costs, and these projected dental amounts are intended to represent the estimated incremental cost of dental services relative to the medical cost estimates developed by BCBSVT.

Development of Projected Costs for Orthodontia Services

The orthodontia coverage includes medically necessary orthodontia only. While the State's benefit description does include the criteria that define medical necessity, it was not possible to precisely identify medically necessary orthodontia in the orthodontia data available to us.

We started with a child orthodontia claims probability distribution from the DCGs, area adjusted to statewide Vermont and trended to CY 2015. We assumed that medically necessary orthodontia would have a higher average annual claims amount than non-medically necessary orthodontia. We assumed that 30% of children with orthodontia costs greater than $3000 would have medically necessary orthodontia. This results in just under 30% of the overall orthodontia costs being allocated to medically necessary orthodontia.

We modeled orthodontia claims separately from non-orthodontia claims. We assumed the integrated deductible and out-of-pocket maximum apply to orthodontia, and we applied 50% coinsurance. In the orthodontia development we assumed children with medically necessary orthodontia claims have

twice the level of medical claims on average due to the nature of their conditions, and average levels of non-orthodontia costs.

Limitations

The following limitations apply to our analysis.

- *Data Reliance* – In performing our analysis, we relied on data and other information provided by BCBSVT. We have not audited or verified this data and other information. Such a review is beyond the scope of our assignment. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

- *Variability* – It is certain that actual experience will not conform exactly to the assumptions used in this analysis. To the extent that actual experience is different from the assumptions used in the projections, the actual amounts will also deviate from the projected amounts. We recommend that BCBSVT monitor the emerging experience and make adjustments as warranted.

- *Distribution and Use* – This letter has been prepared for the use of and is only to be relied upon by the management of BCBSVT. No portion of this letter may be provided to any other party without Milliman's prior written consent, which consent shall not be unreasonably withheld but may be conditioned upon the execution by a third party of Milliman's standard release form; provided however, BCBSVT may provide the letter to any applicable governmental or regulatory agency as required by law. In the event such consent is provided, the letter must be provided in its entirety. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

Qualifications

This report may be considered a statement of actuarial opinion under guidelines promulgated by the American Academy of Actuaries. I am a member of the American Academy of Actuaries and meet its Qualification standards to render the opinion contained herein.

Please call me if you have any questions or if there is any additional assistance that we can provide.

Sincerely,

George N. Berry, FSA.
Principal and Consulting Actuary

GNB/pg/jpj
Enclosures

Table 1
Blue Cross Blue Shield of Vermont
Summary of Standard Plan Designs, Revised

Deductible/OOP Max	Platinum	Gold	Silver	Bronze	Silver CDHP	Bronze CDHP
Medical Ded	$150	$750	$1,900	$3,500	$1,550	$2,000
Rx Ded	$0	$50	$100	$300	Combined	Combined
Integrated Ded	No	No	No	No	Yes	Yes
Medical OOPM	$1,250	$4,250	$5,100	$6,350	$5,750	$6,250
Rx OOPM	$1,250	$1,250	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	No	No	No	Yes	Yes	Yes
Family Ded / OOP	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Stacked, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, ER, Dental Class 1, Vision	Prev, OV, UC, Amb, Dental Class 1, Vision	Preventive, Dental Class 1	Preventive	Preventive
Drug Ded waived for:	N/A	Generic scripts	Generic scripts	N/A	Wellness scripts	Wellness scripts
Service Category	Copay / Coinsurance					
Inpatient	10%	20%	40%	50%	20%	50%
Outpatient	10%	20%	40%	50%	20%	50%
ER	$100	$150	$250	50%	20%	50%
Radiology (MRI, CT, PET)	10%	20%	40%	50%	20%	50%
Preventive	$0	$0	$0	$0	0%	0%
PCP Office Visit	$10	$15	$25	$35	10%	50%
MH/SA Office Visit	$10	$15	$25	$35	10%	50%
Specialist Office Visit	$20	$25	$45	$80	20%	50%
Urgent Care	$40	$45	$60	$100	20%	50%
Ambulance	$50	$50	$100	$100	20%	50%
DME	10%	20%	40%	50%	20%	50%
Rx Generic	$5	$5	$12	$20	$10	$12
Rx Preferred Brand	$40	$40	$50	$80	$40	40%
Rx Non-Preferred Brand	50%	50%	50%	60%	50%	60%

Table 2
Blue Cross Blue Shield of Vermont
Non-Standard Plans

Deductible/OOP Max	Gold	Silver	Bronze CDHP	Catastrophic
Medical Ded	$1,250	$2,000	$5,000	$6,600
Rx Ded	Combined	Combined	Combined	Combined
Integrated Ded	Yes	Yes	Yes	Yes
Medical OOPM	$4,250	$6,250	$6,250	$6,600
Rx OOPM	$1,250	$1,250	$1,300	$1,300
Integrated OOPM	Yes	Yes	Yes	Yes
Family Ded / OOP	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind	Aggregate, 2x Ind
Med Ded waived for:	Prev, 3 PCP/MH OV, Dental Class 1	Prev, 3 PCP/MH OV, Dental Class 1	Preventive Care	Preventive Care, 3 PCP/MH OV
Drug Ded waived for:	N/A	N/A	Wellness Drugs	N/A
Service Category	Copay / Coinsurance			
Inpatient	$500	$1,750	50%	0%
Outpatient	$500	$1,750	50%	0%
ER	$250	$250	50%	0%
Radiology (MRI, CT, PET)	$500	$1,750	50%	0%
Preventive	$0	$0	0%	0%
PCP Office Visit	3 visits/member combined PCP/MH at no cost share before deductible then $20 copay	3 visits/member combined PCP/MH at no cost share before deductible then $30 copay	50%	3 visits/member combined PCP/MH at no cost share before deductible then 0% coinsurance
MH/SA Office Visit			50%	
Specialist Office Visit	$30	$50	50%	0%
Urgent Care	$30	$50	50%	0%
Ambulance	$30	$50	50%	0%
DME	$30	$50	50%	0%
Rx Generic	$5	$5	$25	0%
Rx Preferred Brand	40%	40%	40%	0%
Rx Non-Preferred Brand	60%	60%	60%	0%