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July 29, 2014

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

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

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

Filing Description

1. BCBSVT is a non-profit hospital and medical service corporation. BCBSVT provides individual and small group coverage to be sold on Vermont Health Connect (VHC).

2. This filing develops premiums to be used in VHC beginning January 1, 2015.

3. This filing addresses BCBSVT individual members and small groups. There are approximately 58,000 lives affected.

4. The overall impact of this filing is a proposed average 9.8% or $39.67 per member per month (PMPM) increase in premiums. This average increase broken down by metal level is:

Plan	Percent Change	PMPM Change	Percent of Membership
Catastrophic	7.4%	$14.01	0.1%
Bronze	6.6%	$20.73	16.6%
Silver	9.0%	$33.22	44.3%
Gold	11.2%	$48.43	16.9%
Platinum	11.6%	$60.23	22.1%
Overall	***9.8%***	***$39.67***	***100.0%***

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable,

promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received
BCBSVT provided the methodology used to calculate the proposed 2015 individual and small group premiums. The Company provided exhibits and support for each component of the premium development, including trend, network changes, morbidity adjustments, federal programs, administrative costs, taxes and fees.

The changes to the morbidity assumptions and the population based factors are calculated using the 55,000 members enrolled in a QHP product as of late April 2014, and the 3,000 members enrolled in small group coverage that are expected to renew.

Exhibit 3 provided support for the proposed pharmacy and medical trend factors. The historical claims costs are provided for the prior three years split by service category.

For pharmacy trend, the combined utilization for generic and brand drugs are projected and then split by the projection of the generic dispensing rate (GDR) based on the brand drugs that are scheduled to lose patent in the next few years.

For medical trend, utilization and intensity were assumed to be flat for the projected period, based on historical patterns. The unit cost trend for medical trend is projected to be 4.4% based on an analysis of the budget increases implemented during 2013 for hospital budgets as well as other providers in the BCBSVT service area. To validate the prospective trend assumption, the 36-month regression of historical results was analyzed for Inpatient, Outpatient and Professional/Other claims. This regression analysis produced a 4.5% trend estimate for claims through September 2013 and a higher estimate of 7.0% for the period ending December 2013. The Company believes their prospective view of unit cost changes yields the more accurate analysis, and a result that is toward the lower end of the range given by the 36-month regression analysis is reasonable.

Exhibit 5 demonstrated the development of the Market Adjusted Index Rate beginning with the experience period Index Rate. Adjustments were made for population risk morbidity, other factors (such as changes in provider networks), unit cost trend, utilization trend, non-system claims, and market wide adjustments.

Exhibit 9 showed the requested rate increase by plan and the calculation of the average rate increase of 9.8%.

L&E Analysis
The average proposed 9.8% increase to the 2014 premiums is attributed to several factors including trend, updated membership assumptions, and changes to federal programs. To create a consistent comparison for both companies filing VHC products, we categorized the premium increase reflective of the Unified Rate Review Template (URRT), rather than the distinct rating methodology used by each company.

Component[1]	Percentage Change[2]	PMPM Change[3]
1. 2013 Actual/Projected Claims Experience	4.1%	$18.85
2. Difference in trend from 2013 to 2014	1.1%	$5.43
3. Trend from 2014 to 2015	5.1%	$24.21
4. Change to Population Risk Adjustment	-6.9%	-$34.86
5. Change to Other Factor	0.3%	$1.33
6. Changes to the Federal Transitional Reinsurance Recoveries	3.4%	$16.10
7. Changes in Administrative Costs	-2.3%	-$11.20
8. Changes in Contribution to Reserves	0.5%	$2.49
9. Changes in Taxes & Fees	0.8%	$3.70
10. Changes in Single Contract Conversion Factor	2.6%	$12.54
11. Changes in all other Pricing AV factors	1.2%	$5.90

1. *2013 Actual/Projected Claims Experience:* The actual 2013 claim experience was 4.1% higher than the projected 2013 costs. In the prior filing, BCBSVT projected a two year trend without distinguishing between the first and second year trends. For the purposes of this report, we allocated two year trends evenly between both years. Since this change is driven by actual experience, this rate component appears to be reasonable and appropriate.

    - *Increase due to the Catamount Network dissolving:* The 2013 base period claims costs were increased to account for the Catamount members moving to the BCBSVT Point-of-Service Network beginning on 1/1/2014, which increased provider reimbursements by 42.2% as compared to the Catamount Network. The Catamount Network reimbursed providers significantly below the market average. This resulted in an average increase of 11.3% to the overall projected PMPM medical claims costs. Since a similar increase can be found in the 2014 Exchange filing, this does not impact the proposed rate increase to the 2014 premiums.

      The 11.3% increase for network changes combined with the 9.0% unit cost medical trend from 2013 to 2015, results in an annualized unit cost increase of 10.1% that will be paid to providers contracted with BCBSVT. Because the Catamount members were moved to a network that reimburses providers at commercial rates, we would have expected the commercial reimbursement rates to decrease because the providers will no longer receive the low reimbursement rates for Catamount members. However,

[1] The percentages that are attributed to each component may not match the percentages provided by the Company due to the different methodologies that were used; therefore, a direct comparison is not appropriate.

[2] The percentage changes are multiplicative and do not sum to the requested 9.8% premium increase.

[3] The PMPM changes do not add up to the overall average PMPM of $39.67quoted on Page 1 because the PMPM changes seen in this table incorporate the Single Contract Conversion Factor change.

based on our discussions, BCBSVT was unable to negotiate a lower reimbursement schedule.

2. *Difference in trend from 2013 to 2014:* The trend from 2013 to 2014 in the 2015 URRT of 5.1% results in a 1.1% higher rate increase than the trend from 2013 to 2014 in the prior URRT. The assumed 5.1% trend assumption is discussed further in the next section.

3. *Trend from 2014 to 2015:* The Company projected 4.4% medical trend and 8.4% pharmacy trend for a combined trend of 5.1%.

    - *Medical Trend:* To evaluate the reasonableness of the Company's approach, we combined all of the allowed medical claims for the prior 36 months and modeled PMPM claims using an exponential regression. We adjusted the 2013 data to exclude the impact of the benefit rush[4] in the third quarter of 2014.

      Our analysis resulted in an allowed medical trend of 5.0%, which is higher than the Company's requested allowed medical trend. Actual results will vary from the projected amount due to random fluctuations and unpredictable changes in the market. Our estimated range for the actual results is 4.2% to 5.9%. Each of the numbers within our estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.[5]

      The Company's proposed value of 4.4% is lower than our best estimate and fits comfortably within our estimated range of actual results. We consider the Company's requested allowed medical trend to be reasonable and appropriate.

    - *Pharmacy Trend:* We attempted to use the same approach to analyze the pharmacy claims as we did for medical claims; however, this does not account for other factors such as the slowing growth of the generic dispensing rate, drugs losing their patents in the projection period, as well as the adjustments to the future contract terms with the Company's pharmacy benefit manager. Therefore, we used the Company's approach to calculate the pharmacy trends. We consider the Company's requested allowed pharmacy trend to be reasonable and appropriate.

      Our estimated range for the actual results is 6.7% to 10.1%. Each of the numbers within our estimated range are not equally likely, that is the trends on the low and high end are not as likely to occur as the trends in the middle of the range.

      The Company's proposed value of 8.4% fits comfortably within our estimated range of actual results.

[4] BCBSVT experienced a benefit rush in the fourth quarter of 2013 due to a significant increase in utilization leading up to the implementation of Vermont Health Connect. This is expected to be a one-time phenomenon and not the beginning of a pattern of higher utilization.

[5] For example, the probability that the actual trend will be centered around the best estimate (between 4.9% and 5.1%) is 50% higher than being near the low end of the range (between 4.2% and 4.4%).

4. *Change to Population Risk Adjustment:* The Company made several adjustments to the expected morbidity of the 2015 population that result in an overall decrease of 6.9% to 2015 premium rates.

    - *Changes in pool morbidity*: -5.7%

      The PMPM claims in the base period experience for members who renewed in 2014 were 5.7% lower than the PMPM claims for all members in the base period experience. The Company reduced the projected 2015 claims to account for this healthier population that will continue to be covered in 2014.

    - *Impact of the Health Status of the newly insured*: -0.8%

      In addition to the continuing population, the Company estimated the health status of newly insured members. Since no claims data was available for new members, the demographics of the actual 2014 enrollees were used to estimate that the young, new members that enrolled in 2014 would reduce the overall PMPM claims by 0.8%.

    - *Adjustment for unrealized assumptions:* -0.4%

      In the 2014 filing, the Company expected a 0.4% increase in morbidity that did not materialize. Therefore, the Company removed this assumption for the 2015 filing.

    We consider the morbidity adjustments that the Company made to be reasonable and appropriate.

5. *Change to Other Factor:* The Other Factor includes changes such as covered services, anticipated demographics, and Rx rebates. The overall change from the prior filing results in a 0.3% rate increase. We consider this to be reasonable and appropriate.

6. *Changes to the Federal Transitional Reinsurance Recoveries:* The Company expects the net reinsurance recoveries to decrease in 2015 due to updated experience, the change in individual enrollment based on actual 2014 enrollment, official 2015 reinsurance parameters and 2015 reinsurance contribution rates.

    The Company based the reinsurance recoveries on the official 2015 parameters[6]; however, the Final Rule, dated May 27, 2014, proposed that the attachment point be lowered to $45,000.

[6] The 2015 parameters are 50% coinsurance for claims between $70,000 and $250,000.

	2014 Rate Filing	2015 Actual	2015 Proposed
Lower Attachment Point	$60,000	$70,000	$45,000
Higher Attachment Point	$250,000	$250,000	$250,000
Reinsurance Recoveries	-$45.57	-$34.54	-$54.92
Projected % of individual membership	56.8%	40.4%	40.4%
Reinsurance Recoveries across all members	-$25.89	-$13.96	-$22.19
Reinsurance Contribution Rate	$5.25	$3.67	$3.67
Net Reinsurance Recoveries	-$20.64	-$10.29	-$18.53

As proposed by the Company, the 2015 premiums will increase by 3.4%. However, due to the likely reduction to the 2015 attachment point[7], the 2015 premiums would be increased by 1.6%. We consider the use of the proposed parameters to be reasonable and appropriate. We note that the Company does not agree with our recommendation to decrease the attachment point to estimate anticipated reinsurance recoveries.

7. *Changes in Administrative Costs:* The administrative costs in 2013 for the members expected to be in VHC in 2015 were $29.37 PMPM (7.4%). The Company reduced these costs by 12.2% due to onetime expenses in 2013 that will not occur going forward. The remaining costs were not trended forward due to expected increases in membership across the Company's 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.

   The resulting administrative costs of $25.78 PMPM (6.1%) represent a 2.2% reduction as a percentage of premiums compared to the 2014 filing. We consider this to be reasonable and appropriate.

8. *Changes in Contribution to Reserves (CTR):* The Company's assumed CTR is 1.0% in this rate filing, which is higher than the 0.5% approved by the Board for BCBSVT's 2014 Exchange filing. The Company provided support demonstrating that a 1.0% CTR is needed to maintain the current level of reserves due to the impact of claims trend. As stated in the reinsurance section (#6), we recommended the Company modify its assumptions to include the proposed reinsurance parameters from the Final Rule. If HHS does not ultimately adopt these proposed reinsurance parameters, the CTR would be negatively impacted.

   While we believe the proposed CTR is reasonable and allows the Company to offset the impact of trend, the results of the Department of Financial Regulation's Solvency Analysis should also be considered.

[7] The original attachment point in 2014 was $60,000, but was later reduced to $45,000 after the 2014 premiums were finalized.

9. *Changes in Taxes & Fees:* The total taxes and fees increased from 3.0% of premium in the prior filing to 3.8% of premium in 2015. The main driver of this change accounts for the health insurer fee increases. The nationwide health insurer fee that will be collected in 2014 was $8 billion and will increase by 41.25% to $11.3 billion in 2015. As a result, the Company increased the 2014 estimated insurer fee of 2.0% of premiums by 41.25%, which results in a 0.8% increase in premiums and an insurer fee of 2.8%.

   The Company's calculated 2014 insurer fee was rounded up to account for unknowns in the actual amount that will be assessed. Examples of unknown factors could include incentives for large groups to become self-insured as a means of avoiding federal and state fees and mandates, as well as a potential reduction in the premium base for the collection of the federal assessment[8]. The Company felt that these unknowns could result in the misestimation of the BCBSVT share of total insured premiums. Therefore, the Company feels that it is necessary to collect a higher percentage than the unrounded 2014 calculation in order to fully fund the federal assessment. Lacking a means to perform a more specific estimate of this impact, the Company simply rounded up to the nearest whole percentage in the 2014 Exchange filing.

   The rounded estimate was not quantifiably supported. Therefore, we recommend modifying the insurer fee to 2.5% of premium.

10. *Changes in Single Contract Conversion Factor:* A conversion factor [9]adjustment is essential to convert and allocate the gross claim costs to a premium based on the state-mandated tier factors. The shift in the expected membership from 2014 to 2015 resulted in a 2.6% increase in the single contract conversion factor. The projected 2015 membership is based on actual 2014 enrollment. We consider this reasonable and appropriate.

11. *Changes in the all other Pricing AVs:* This reflects other Pricing AV changes such as changes in Metal AVs of plans and changes in projected enrollment among plans. The assumed 2015 distribution is more heavily weighted towards richer plans. Since the 2015 plan distribution is based on actual 2014 Exchange enrollment, we find this to be reasonable and appropriate.

    The Changes in Family Tiering factor reduces the base premium to account for the difference between the state-mandated tier factors and the actual cost[10] of providing coverage to each tier. Based on guidance received during last year's rate review process, the Company adjusted the index rate for the Changes in Family Tiering factor. This inappropriately reduces the index rate because this adjustment should only affect premiums (not the index rate).

[8] The 2015 insurer fee is measured using the 2014 premium. To the extent that large groups move to self-insurance in 2015, the estimated 2015 insurer fee will need to be increased.

[9] The conversion factor adjusts the premium that is developed on a PMPM basis to be on a tiered basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, Vermont's tiered premiums require the base premium to be for a single adult.

[10] Without this adjustment, the Company would receive 3.6% more premium than necessary.

We recommend applying the Changes in Family Tiering adjustment to the Pricing AVs rather than the index rate; this will have an immaterial impact on rates.

12. *Other Key Assumptions:*

- *Benefit Richness:* The Company used their group claims and membership data from January 2009 to August 2013 to model the correlation between utilization and the cost sharing design of a plan. Group data was used to mitigate the impact of selection of plans based on a member's health status because members in groups have limited choices for plan designs. This is necessary because the benefit richness adjustment must not include any differences in utilization due to differing health status of people with different cost-sharing designs[11].

  We agree that group data reduces the impact of health status on the benefit richness adjustment, but we do not believe that this data eliminates the impact of health status. Members in the Company's group experience have an average of three choices of plans. Given the choices between plans, unhealthy members will typically choose plans with lower cost sharing, and the healthy members will typically choose plans with higher cost sharing in exchange for lower premiums. Therefore, the benefit richness factors used by the Company do not entirely exclude the impact of health status as required by the Affordable Care Act.

  We recommend modifying the benefit richness factors to the standard HHS induced utilization factors in order to insure that health status is not reflected in the benefit richness factors.

  The Company proposed rate increases by plan that range from 4.8% to 11.8% over the final approved rates in the prior filing. We estimate the rate increases by plan will range from 7.1% to 13.2%, if the standard HHS induced utilization factors are used. This will decrease the overall average rate by 0.2%.

[11] URRT Part I Instructions March 2014

Recommendation

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

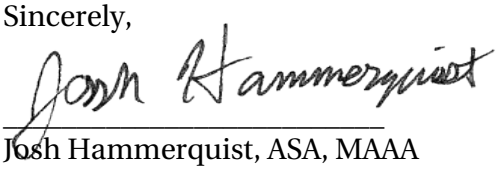
- Use standard HHS induced utilization factors for the Benefit Richness factors: -0.2%;
- Adjust the Pricing AV by the Changes in Family Tiering adjustment factor: 0.0%;
- Reduce the insurer fee to 2.5% of premium: -0.4%; and
- Use the reduced reinsurance parameter of $45,000 to estimate the reinsurance recoveries: -2.0%.

After the modifications, the anticipated overall rate increase will reduce from 9.8% to 7.2% ($29.00 PMPM).

Plan	**Proposed Rate Change**	Modified Rate Change	Percent of Membership
Catastrophic	7.4%	5.9%	0.1%
Bronze	6.6%	6.5%	16.6%
Silver	9.0%	7.0%	44.3%
Gold	11.2%	8.0%	16.9%
Platinum	11.6%	7.2%	22.1%
Overall	***9.8%***	***7.2%***	***100.0%***

Plan	Proposed PMPM Change	Modified PMPM Change	Difference	Percent of Membership
Catastrophic	$14.01	$11.30	-$2.71	0.1%
Bronze	$20.73	$20.59	-$0.14	16.6%
Silver	$33.22	$25.78	-$7.44	44.3%
Gold	$48.43	$34.76	-$13.67	16.9%
Platinum	$60.23	$37.44	-$22.79	22.1%
Overall	***$39.67***	***$29.00***	***-$10.67***	***100.0%***

Sincerely,



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ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations12, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct13, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

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

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

Identification of Actuarial Documents
The date of this document is July 29, 2014. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is July 17, 2014.

Disclosures in Actuarial Reports

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

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

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

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

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

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

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

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